



Deliverable 3.1

National Case Study Reports

Austria, Belgium, Denmark, Estonia and Italy

September 2025



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Deliverable 3.1

National Case Study Report - Austria

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1. Introduction

In Austria, as in many other countries, public awareness of mental health challenges has increased, and this is not only due to the Covid-19 pandemic. Discussions about psychosocial risks at work have been conducted for decades, with varying emphases from mitigating stress, preventing burnout and mobbing, supporting ageing workforces to sustaining work ability. Most earlier initiatives involved social partners but fell into the domain of health promotion at work and thus were voluntary activities by companies and public sector organisations. In combination with the services of occupational physicians and health and safety engineers they contributed to the professionalisation of both work-related health promotion and Occupational Safety and Health (OSH), prevention and mitigation in Austria.

The mandatory assessment of psychosocial risk was already included in the OSH Law of 1995, whereas the version of 2013 made it explicit. This amendment was accompanied by research and various guidelines and offers of support by social partners and OSH bodies. However, the prevalence of work-related mental health conditions has been increasing, and the actual impact of legal and institutional OSH measures to prevent them or mitigate risk appears to be hard to assess. Yet in Austria, a Continental country with a comparably strong social partnership and fairly ambitious legislation, progress in implementation is slow. Especially the continuous improvement process foreseen for OSH risk assessment in the law is rarely followed through.

In the healthcare sector some larger public and private/nonprofit healthcare providers have a tradition of mental health initiatives. Trade unions focus their demands on such aspects of working conditions such as staffing levels and reliable work schedules. However, they also address issues such as third-party aggression and violence. As the widespread staff and skills shortages in the sector centrally contribute to work intensity and time pressure and may undermine some efforts directed at mental health per se, unions deem these risk factors to be root causes of psychosocial strains.

1.1 Methodology of this study

This national case study is based on desk research, ten expert interviews and the PSYR-IR survey. Desk research and expert interviews covered both psycho-social risk in OSH at large and in the health sector specifically, while the survey in Austria focused on the health sector.

We analysed documents and online sources by OSH actors and social partners as well as research literature. Such documents range from position papers to guidelines and information to members and the general public. Some research has been commissioned by social partners and/or OSH actors themselves, and these and other studies feed back into their positions and priorities. Within this project we could not cover the entire range of studies on mental health or psychosocial risk at work but selected recent papers and reports and those that had made an impact among social partners.

Experts were identified through their organisations' websites and previous contacts. Interviews were based on a topic list developed for the PSYR-IR project at large, translated and adapted to the Austrian context and developed into an interview guideline. This was used flexibly, considering the respective expert's domain of experience and knowledge. Seven interviews were conducted online, another three took place in person. Six interviewees were recruited as mainly OSH experts

whereas four were in the healthcare sector. However, both OSH consultants had experience in the healthcare sector as well, since especially large healthcare providers have been conducting health promotion and OSH initiatives from early on. Experts were informed about the purpose of the project and signed a consent form. All interviews were recorded and transcribed anonymously and then analysed using MaxQDA data analysis software. We combined deductive coding following the topic list and open coding of subjects that emerged in the interviews. Interviews are numbered in the sequence they had been arranged. For anonymity's sake, we obfuscate some of the information on the organisations the experts are representing.

Table 1: List of experts interviewed

Interview no.	Area of expertise	Organisation	Region
1	Healthcare	Healthcare professional association	national
2	Healthcare	Public sector union and supervisory board member of large healthcare provider	National / Vienna
3	Healthcare	Chamber of Labour	Federal province
4	OSH	Chamber of Labour	National
5	OSH	Chamber of the Economy	National
6	OSH / healthcare	OSH professional association, research, consultant	National
7	OSH / healthcare	OSH expert, consultant	national
8	OSH	Private sector union	national
9	Healthcare	Private sector union & works councillor in hospital	National / Vienna
10	OSH	Central Labour Inspection	national

In addition to sharing their experience and knowledge, experts did the study another service: those who represent member organisations of workers in healthcare agreed to distribute the project's survey through their organisation's communication channels. This reached some 187 respondents from the sector, among whom unionised workers and those in larger organisations are overrepresented as well as workers in Lower Austria and Vienna. The sample was complemented by another 76 healthcare workers recruited through the survey company NORSTAT. The sample cannot be considered representative, and we find some deviations from other survey data on the sector. Especially, respondents' work-related health challenges are above the figures reported for the health sector by the Austrian LFS module on OSH conducted in 2020. We do not have evidence that our respondents' employers have particularly poor OSH provisions, but respondents may well have self-selected on health concerns. The survey was developed for the PSYR-IR project at large, with sector-specific adaptations and was administered in the respective national languages. The authors warmly thank all interviewees and survey respondents who contributed their insights and experience to the study.

The project team attended four events related to the subject: a meeting organised by the national EU-OSHA contact point for the Austrian stakeholder network in November 2023, a workshop on impacts of digitalisation and AI on OSH by AUVA, an event organised by the private sector trade union GPA to inform nursing students in Vienna of the trade unions' initiatives in healthcare in March 2025, and a viewing of the German/Swiss feature film "Heldin" (R: Petra Biondina Volpe, D/CH 2024) organised by the private sector trade union vida in Vienna for its health sector members followed by a panel discussion with healthcare experts in April 2025. All of these

provided further information and contacts and helped to validate some insights and interpretations.

2. Context

2.1 State of play of psychosocial risks and mental health

During the 2010s, public and policy attention to mental health at work rose. Increases in psychosocial risk were considered to result from “changes in the nature of work, such as digitalisation, self-regulated work, remote work, flexible and atypical work hours, multitasking, high work pace and overtime” (Kloimüller, 2020, p. 6). This ran counter to the notable decreases in work-related accidents that result from improved prevention as well as shifts in the employment structure to the service sector.

In the European Commission’s 2020 peer review on legislation and practical management of psychosocial risk at work, Austrian OSH expert Irene Kloimüller concluded that in Austria the legal and enforcement initiatives and some professionalisation of psychosocial risk prevention in companies

„are slowly beginning to show positive effects insofar as the awareness of this topic has risen among employers and employees and that organisational measures are taken to ensure healthy and safe work conditions. But the regulation and consulting provided is not yet efficient enough to fully cope with the problem of the new work conditions and their negative impact on health“ (Kloimüller, 2020, p. 9).

Five years later, the same author sees further progress which still is slow-moving and uneven:

„a deeper understanding of mental health at work is slowly being reached, including, for example raising awareness of (assessment of) PSRs in companies, especially in large companies. A general understanding of PSRs that need to be addressed, with priority being given to prevention, and always targeting general technical and organisational measures first, is seen as very pertinent in order to ensure the correct implementation of PSR prevention.“ (Kloimüller, 2025, p. 21)

Experts interviewed in the present study agree that improvements have developed in general awareness of companies, workers and the general public, in the quality of assessments, and a de-stigmatisation of mental disorders. Yet on the company level, psychosocial challenges are still often ascribed to individuals:

“However, [managers] tend to look at the individuals, the story where people are quickly offered some anti-stress training and then that’s done. To a lesser extent, they look where does the problem come from. Not, why is that person so stressed? Why aren’t they well? Because that might be in my own responsibility [as a manager]” (Intv6_osh_AOPsych, Pos. 59)

In addition, new challenges have emerged with working from home, driven first by the Covid-19 pandemic (see section 2.2.2), the proliferation of platform-based and other delivery services (who are often self-employed and hence outside of the legal scope of OSH) of the gig economy, and the persistent recession in Austria (since 2023).

2.1.1 Austrian data on OSH, psycho-social risk and mental health at work

The Austrian Labour Force Survey (Arbeitskräfteerhebung) contained a module on accidents and work-related health problems in 2020 (Statistik Austria, 2022) and previously, in 2007 and 2013. It asked about health problems in the last twelve months that were caused or exacerbated by work. People (aged 15-75 and having had at least one paid job in their life) were also asked about exposure to risk factors at work.

13.4% of those surveyed in 2020 reported at least one work-related health problem, and 82.7% of those affected said that problem restricted their daily life activities. Problems increased with age, and women were slightly more affected in all age groups except 60+¹. In this oldest group, men reported higher shares of work-related health conditions. Lower-educated workers and first-generation immigrants especially from Turkey and other non-EU European countries were more affected. Among sectors, agriculture had the highest incidence at 22.8%, followed by the health and social sector as well as construction at 15.2% and 14.5% respectively. Among healthcare professionals 20.7% were affected by work-related health problems generally. Musculo-skeletal disorders were most common. They were followed by depression and anxiety, reported by 6.6% of all people with at least one work-related health problem, 5.3% of men and 8% of women. Stress as a work-related health condition was reported by 4.8% of people affected by work-related health issues. Indeed, the prevalence of mental health conditions has increased since 2007. Then, slightly less than 1% of working or formerly working people suffered from stress, depression or anxiety, whereas in 2020 (and already in 2013), the share was 1.5% (Statistik Austria, 2022, p. 37).

Psycho-social risk factors were reported by 59.2 % of respondents, 58.2% of men and 60.3% of women. The higher educated reported more exposure to psycho-social risk factors, whereas they encountered less physical risk. Generally, work overload or time pressure was most common and challenged 38.3% of respondents. Women noted less of that than men (37.2% and 39.4%). They were even more exposed to working with difficult clients, or difficult patients or students (39.6% vs. 29.9% of men). Poor communication at work ranked third and was reported by one in eight working people. Lack of discretion was evenly distributed among women and men, whereas women were more exposed to violence, harassment and mobbing, and to “other” factors.

Specific frontline occupations in the healthcare sector are among the most exposed to psycho-social risk factors overall: graduate and equivalent nursing staff at 89.7%, doctors 79.8%, skilled medical and pharma occupations 78.8%, other academic and related healthcare staff 72.2%, and care workers 71.6% (Statistik Austria 2022, p. 48f.).

Multiple, that is three and more, psycho-social risks were reported by 12.7%. The share in health and social services was nearly twice as high with 24.9%, followed by education and public services. The health and social sector distinguishes itself especially by the risk of difficult clients or patients (59.4%) and also by exposure to (threats of) violence (16.6%). Harassment and mobbing affect 3.2% of workers generally but, again, twice as high a share of workers in the health and social sector. Time pressure is also higher with 45.5% compared with 38.3% across sectors.

According to the most recent Austrian report on illness-related absences (Mayrhuber & Bittschi, 2024), mental health issues in 2023 accounted for 2.6% of all absences but for 10% of all days of sick leave, which means that mental health-related absences tend to be longer (at an average of 37.2 days) than those in many other cases of illness. Similar to other countries such as Germany, mental health conditions have increased their share among days of sick leave considerably since the 1990s. Mental health conditions were also the most frequent diagnoses of new entrants to disability pensions in 2023 with 4,069 cases, of which 2,222 were men and 1,847 women (Dachverband der Sozialversicherungsträger, 2024, Table 3.34).

¹ 60 is the statutory retirement age for women born before 1964 and working in the private sector

Mayrhuber and Bittschi (2024) point out that evidence for increased actual incidence of mental conditions is controversial and increases may also be related to increased awareness and changing diagnoses and prescriptions (p. 53), and to the ageing of the working population. Working conditions are likely to play a part with work intensification and increased psycho-social demands due to the expansion of the service sector and especially the increased demands on “essential workers” during and after the Covid-19 pandemic (p. 54).

2.1.2 Austria in European data

In spite of Austria’s long history in OSH (or because of it, if it has raised employees’ awareness of the subject) workers in Austria reported psycho-social risk factors above the European average in OSH Pulse.² As almost everywhere, time pressure is the most common, reported by 48% of surveyed (46% average), followed by lack of autonomy at 32% (18% average). Poor communication in the company was noted by 29% (average 26%), third party violence or abuse by 21% (average 16%), and harassment or bullying by 9% (average 7%). 35% report “other” strains (average 29%) (EU-OSHA, 2022b, S. 22).

Yet, actual mental health problems such as stress, depression or anxiety are reported by 24% of workers in Austria, compared to 27% across Europe (EU-OSHA, 2022a). Austrians are slightly less comfortable than the European average talking to their supervisors about mental health (55% say they would feel comfortable doing so compared with 58% across Europe). Yet they are most confident in Europe that disclosing a mental health condition would not harm their careers: 67% disagree or strongly disagree with negative impact, compared to a European average of 45 %.

Austrians encounter more prevention and support initiatives in their workplaces than average Europeans: Almost two thirds observe awareness raising and information provision on OSH at large, 60% find that workers are consulted about stressors at work, 55% have access to counselling and 52% receive information on well-being and coping with stress.

However, they are notably less sure than other Europeans that safety rules at work are unambiguously positive: 63% of interviewees in Austria see such provisions as a good thing whereas 23% think they make their job more difficult, compared to an average 81% and 10% across Europe respectively.

The OSH ESENER survey asks employers about OSH risk assessments, risk factors and measures. Based on the data for 2019, we compare some of the insights on psycho-social risk for Austria and the EU-27. Generally, in Austria fewer employers than in the EU say they conduct regular risk assessments (64,7% compared with 76,6%). In the health and social sector, the share is even lower at 60,7%, whereas EU-wide the share of that sector is at 79,9%.³ The authors of the ESENER summary report comment that

„in Austria, there have been significant efforts to encourage regular completion of risk assessments, especially among micro and small firms, with fines issued when necessary. Although Austria sits below the EU-27 average, it was felt that the way to increase compliance was through inspections, given that companies may not provide accurate information through online procedures“ (Howard et al., 2022, S. 24).

This reflects the Austrian Labour Inspectorate’s strategy of prioritising advice over sanctions and their resistance to online reporting and monitoring (see section 4.1).

2 For more information about the European datasets and additional insights from the European Working Conditions Survey and Working Conditions Telephone Survey see (Heylen et al., 2024).

3 All these figures were gathered from the survey website and data visualisation: <https://visualisation.osha.europa.eu/esener/de/survey/datavisualisation/2019>.

Among risk factors, most employers consider difficult clients a psycho-social risk: 59.4% in Austria and 59.7% in the EU. In the health and social sector, 86.3% of Austrian and 83.5% of European employers report that risk. Time pressure is noted as a risk factor by 55.3% of Austrian respondents, ten percentage points (pps) more than the European average (45.1%). Health and social sector employers note even more time pressure at 61.3% (58% across Europe). “Lack of communication” is perceived as less of a risk factor in Austria (14.4%) than in the EU (17.9%) and not much more frequently in the health and social sector (16.5%), whereas EU-wide the sector appears rather more burdened by poor communication (27.7%). Employers also see less psycho-social risk in concerns over job loss in Austria (7%) than in the EU (11.1%), but in the health and social sector concerns are reportedly slightly higher, with 12.5% in Austria and 13% in the EU. Risks of working long or irregular hours are acknowledged similarly in Austria and the EU at 23.2% and 21.5% respectively. In the health and social sector, this is more of an issue at 32% and 31.1%. Hence, health and social care in the view of employers emerges as an above-average risky sector, but this is matched by employers’ awareness of risk. Time pressure and difficult clients/patients especially distinguish this sector. This pattern is similar in Austria, but there, generally more time pressure is perceived than in the EU.

In spite of fewer formal risk assessment procedures compared to the EU, Austrian employers report higher shares of measures in place than the EU average to mitigate psycho-social risks. Exceptions, where Austrian employers do less than the average, are procedures to handle mobbing or harassment and to address third party violence. With increased discretion at work and training for conflict resolution, the difference is 2 pps or below.

The health and social sector, both across Europe and in Austria, has more measures in place than the economy at large. Mostly, Austrian employers in the sector report even higher shares of measures than their European counterparts. Measures to address 3rd party violence are the most common in the Austrian health and social sector at 80.2% (75.6% across Europe), followed by very common increases in discretion (76% in Austria, 76.5% in the EU-27), and a high 73.7% of organisations in the sector that reorganise work to mitigate stress (57.8% European average). 63.4% of Austrian employers (and 50.3% in the EU-27) say they have action plans to avoid work overload, and 62% (against a 38.4% European average) intervene against overly long working hours in the sector. Austrian health and social care employers are below the average, as in the economy at large, in procedures to handle mobbing or harassment (53.6% compared with 60.7%), and to a lesser extent in providing confidential counselling (at a still high 61.8% and 64.3%). Training for conflict resolution is in line with the European average at 55.4% in both Austria and Europe and so are increases in discretion for workers in the health and social sectors (76% and 76.5%).

ESENER asked those companies that reported psycho-social risks whether they found their assessment more or less difficult than the assessment of other OSH risks.

Among companies that found psycho-social risk assessment more difficult, the most-reported reason for these difficulties was employees’ reluctance to talk about the subject – which is contradicted by employees’ more sanguine view in OSH-Pulse. 61.9% of employers in Austria and 60.6% across Europe noted that reluctance. Lack of awareness of staff followed at 49.9% in Austria and 44.6% across Europe, then a lack of knowledge and support in psycho-social risk assessment mentioned by 36.1% of Austrian employers and 46% in the EU. Fewer but still, a non-negligible number of employers attested themselves a lack of management awareness: 27.2% in Austria and 33.6% in Europe.

In both Austria and Europe, fewer health and social sector employers than others reported these difficulties even among the companies that found psycho-social risk-assessment more difficult. Hence, in the light of its high risk exposure, this sector’s expertise does appear to be applied to its own working conditions, at least in the view of employer representatives. Health and social care workers appeared to be considerably less reticent in talking about mental health issues than

others – although expert interviews and comments by workers still show some stigma and reluctance attached. In Austria 34.6% of employers in the sector reported a reluctance to talk about the subject, whereas across Europe 51.2% did. A lack of knowledge and support was noted by 32.7% of Austrian health and social sector employers and 34.3% across Europe. Awareness of both health and social sector staff and management is considered above average in Austria with 23.8% of Austrian and 33.3% of European employers noting lack of staff awareness, and 18.5% and 22.8% respectively noting lack of awareness among management.

2.2 Problem areas

In the data and research for Austria, psycho-social risks are generally operationalised in line with European research:

- work overload or time pressure,
- job insecurity,
- difficult clients, patients or students,
- harassment, mobbing or violence,
- poor communication at work,
- and lack of discretion (Statistik Austria, 2022).

Yet some known psycho-social risks such as long or unpredictable working hours, perceived unfairness of pay or treatment at work, or discrimination have not yet been explored in the large-scale surveys.

Experts interviewed (in Spring 2025) in addition note a more generalised sense of insecurity and multiple crises, in Austria exacerbated by three years of economic recession:

“Economic insecurity is wearing people down, the current global situation isn’t cheering anyone up, and then the unemployment rates. All of these are things we can’t do much about” (Intv3_health_labour, Pos. 48).

One work psychologist interviewed points out that in their studies, people’s reaction to unsatisfying jobs and working conditions has been changing in recent years:

„The point that people look for other jobs, that hasn’t increased. People don’t risk changing jobs if they don’t like them. They think about it but do it less. There are fewer options in their minds than some two years ago“ (Intv6_osh_AOPsych, Pos. 36-38).

Violence at work includes sexualised violence, harassment and mobbing both within the company and third-party violence by clients, customers, patients or students. This subject has gained attention during the Covid-19 pandemic but has been addressed already before, from 2010 onwards, first focussing on public transport and the health sector, especially mobile care. Hence, in Austria penalties on violence against train conductors, bus drivers, firefighters or health and emergency staff were increased to align with attacks on civil servants in the penal code since 2017. In 2024 workplace violence was a dedicated priority of the Labour Inspectorate. Currently OSH actors are working on updating information materials to feed into the European and Austrian OSH strategies from 2026 onwards.

Yet increasing awareness especially of sexualised violence beyond those sectors where the issue is evident appears to be difficult. Whereas awareness on workplace and third-party violence has increased, some debate with employers is still ongoing on how sexual harassment is a psycho-social risk at work.

Through the Covid-19 pandemic, the issue became more visible and also affected sectors that were not known for it previously such as banking (Holtgrewe et al., 2024). The trade union GPA

commissioned a survey on violence and aggression at work (Zeglovits, 2022) to feed into an “action week” on the issue in 2022,

Social partners meanwhile have initiated further targeted actions, for example in transport or hospitality. In the Viennese hospitality sector, social partners initiated a survey of hospitality employees in 2024 in which 79% of women and 54% of men working in the sector reported they had encountered or observed sexual harassment, primarily by guests (78%) but also by colleagues (48%) or supervisors and landlords (35%). Respondents said that an external support contact would be helpful. Social partners created information materials and planned trainings for employees and supervisors to raise awareness, develop procedures, and prevent additionally harmful comments such as “take it as a compliment, why don’t you”.⁴ The related campaign has the heading “No respect, no service!”

2.2.1 Discrimination and vulnerable groups

Gender and increasingly diversity are being addressed by OSH for some ten years. The Austrian labour inspection addresses gender- and diversity-related vulnerabilities through a dedicated guideline for risk evaluation published in 2019 under the heading of “underestimated risks in OSH” (Arbeitsinspektion, 2019; Kloimüller, 2025):

“when we started with the evaluation it really was the norm of a [generic] human in the background, but that evaluation means it must be gender- and diversity-aware. This was raised strongly by SWR, the Swedish authority and was picked up in Austria [ca. 2015], and that has brought changes in the mindset” (Intv7_osh_xp, Pos. 155).

This covers both the classic person-related categories of gender, age, ability, or migrant status and the vulnerabilities resulting from workers’ employment status. Hence, the approach mirrors the principle of taking the organisational and workplace level into account first in OSH:

„those employees who for gender and diversity reasons are less in the centre, such as employees with diverse languages and cultures, with health impairments or disabilities, part-time workers, agency staff, workers external to the company, and employees in male- or female-dominated jobs“ (Arbeitsinspektion, 2019, p. 1)

The guideline and the Labour Inspectorate’s strategy take a very didactic, exemplary approach to make the subject accessible to managers, OSH representatives and professionals. They are advised to select a specific area of work, take stock of the groups working there, and then select a specific subject:

“one of the three subjects we have for beginners, where evaluation is totally easily accessible, for example looking at the instruction of women in final assembly [in manufacturing], how do you make sure that they understand the instruction and can apply it? Ideally, if we find that there are many white men instructing many immigrant women, then we may discuss that and say, are there any alternatives to that? (Intv10_osh_min, Pos. 132-134)

Suggestions in the guideline have been piloted with works councillors who applied the guideline in their companies and provided feedback and evidence that this procedure was feasible.

Experts identify vulnerable or at-risk groups of workers along the interrelated and intersecting lines of sociodemographics, employment contracts, workplaces, and sectors. **Migrants** often work in low-wage and precarious sectors but face other challenges such as poor language skills.

⁴ <https://www.diepresse.com/18338351/gastronomie-sexuelle-belaestigung-ist-alltag>

A specifically vulnerable group are **migrant women**, who tend to concentrate in low-paid and precarious work and may have high burdens of domestic and care work as well,

“and I could well imagine that the subject of migration and strain living in a different culture isn’t so different from strain at work” (Intv3_health_labour, Pos. 63).

Generally, experts note that the marginally or **precariously employed** – or self-employed, to whom OSH regulation does not apply – are at risk as they may not have much contact with their employer or are subcontracted or combining several jobs. Delivery drivers of all kinds are mentioned, from conventional logistics to couriers and platform workers.

“And there I have a sense that control is forever lagging behind, [new types of jobs] emerge faster than anyone can react to them” (Intv7_osh_xp, Pos. 80).

Other **mobile workers** are affected as well: mobile care and domestic support workers may be exposed to safety risks in households that are hard to address (such as unsafe electrical installations), and to violence and harassment by clients, patients or clients’ family members. An at-risk group identified recently by regional Chamber of Labour and union initiatives is **young apprentices**.

This is something very specific: we look after suicidal apprentices. apprentices, if at all, talk to peers the same age, not to superiors or older physicians. So we had to catch the peer group somehow and started with the youth representatives [elected young union representatives in the company]. But that was a first attempt, knowing that they only exist in the very well-unionised sectors and companies ..., and we reached our limits fairly soon, and extended the training to other apprentices who were interested (Intv3_health_labour, Pos. 6).

Generally, **services** are at risk psycho-socially and often physically as well. Retail workers face low staffing levels, long work hours, and cost and time pressure (cf. Adam et al., 2024). **Cleaning** is a precarious field often filled by immigrants, in which work in isolation, high turnover and some indifference of employers combine.

“I have no evidence that in the cleaning sector the subject of evaluation of psycho-social strains is taken seriously by any means” (Intv3_health_labour, Pos. 66)

Teachers and other educators as well as other public and private services such as security are often exposed to increasingly “super-diverse” clienteles, increased expectations by society, and the outcomes of various rounds of cost-cutting in the public and private sectors. The next quote is about carework, but the dilemma of caring (about people, tasks or products) and time pressure extends to a wider tension of the need and motivation to do one’s job well and the constraints of resources, cost and time:

“I want to care, I want people to be well, and on the other hand I have such time pressure that I can only do that marginally” (Intv4_osh_labour, Pos. 26)

2.2.2 Impact of the Covid-19 pandemic

The Covid-19 pandemic had considerable impact on mental health in Austria generally, and mental health at work as well. As Dörflinger and Tisch (2023) put it,

„the Covid-19 pandemic [...] challenged the world of work as well as labour market and social policy actors in many ways, and it showcased a number of gaps in the existing OSH

frameworks, leading to unequal protection for different groups of workers“ (Dörflinger und Tisch, 2023, p. 243).

Impacts were found at both ends of the occupational spectrum: people working from home faced an accelerated round of digitalisation with social isolation, multiplied and simultaneous demands when the spheres of (digitalised) work, school, and family life converged at home, extended working hours, a sense of boundaryless work and limitless availability, and often challenges with new technology uses. Others working on-site were affected by job insecurity, heightened or unpredictable workloads and time pressures, fear of infection and in the early stages, unavailable personal protection equipment and later the discomfort of using it, and angry and potentially violent clients. In healthcare, this was most obvious and most discussed with some policy successes (see section 5.1.2), but food industry workers, delivery drivers (including platform-based food delivery), and workers in retail, security, infrastructure and IT, maintenance or cleaning faced similar challenges. Indeed, many of these workers overlap with the vulnerable groups identified in section 2.2.1. For these and other groups providing essential services, a short time into the pandemic a new category of “systemically relevant” workers was invented in public discourse, meaning workers that ensured the satisfaction of basic needs also during lockdowns. A recent study, commissioned by the Chamber of Labour, was based on a regular Austrian job quality survey, the “Arbeitsklimaindex”, and conducted personal interviews with “systemically relevant” workers after 2020 (Schönherr et al., 2025). As such occupations, it lists: retail workers, healthcare workers (doctors, pharmacists, assistants etc.), teachers, professional drivers, workers in childcare and elderly care, IT workers, plumbers and electricians, workers in energy and water supply and recycling, banking employees, cleaners and public security staff. This group, mixed in terms of skills and income, counts for about 1.4 million, roughly a third of all employees in Austria, of whom 61% are women. At the lower-paid end of the spectrum, migrants concentrate. The “systemically relevant” were specifically affected by the extended and unpredictable working hours during the pandemic. A large proportion of them remained “stuck” in pressurised working conditions afterwards, as many of their colleagues left the sector and low staffing levels persisted (Schönherr et al., 2025). “Systemically relevant” workers also reported declines in working climate and cuts in bonuses – but 40% noted temporary increases in societal appreciation of their work around 2020. However, among the low-paid segment, only 25% of cleaners, drivers and care workers say that society values their work, whereas 32% of this group note that labour law isn’t always adhered to in their jobs. The authors comment:

“The indispensability of their work has the paradox effect that the concerns of some systemically relevant employees appear dispensable and democratic rights and regulations are not applied to them” (Schönherr & Zandonella, 2025).

Experts interviewed for this study similarly observe a sense of disappointment among workers after the pandemic:

“Many psychological promises haven’t been kept, that were given at the time to people who were putting in the effort to ‘sustain the system’. And these people see their work situation much more critically than previously, and turnover is increasing and sick leave is increasing. And that’s an expression of that discontent that framework conditions haven’t been improved as they expected them to be” (llntv7_osh_xp, Pos. 13).

With regard to working from home,

„companies basically know that they should be looking out for the risks. But partly, they don’t know how to do that. ... How to assess and evaluate and implement that, well, it’s difficult. However, I do know companies that did that and really implemented measures, for

example to improve communication, to overcome this fear of monitoring, to better regulate breaks” (Intv7_osh_xp, Pos. 17).

2.2.3 Digitalisation

One unionist aptly summarises the issue of digitalisation that is increasingly discussed under the heading of “artificial intelligence”.

“the subject digitalisation and AI is a huge one. Cuts across all sectors and nearly all workplaces. It starts with increased work intensity, enabled digitally. Connectivity, boundaries [of working hours and private time] dissolve. Work gets compressed and accelerates, but also issues such as multitasking, interruptions, cognitive overload. And this insecurity and control by surveillance, and finally the pressure to adapt, because digital tools develop ever faster and you’re required to continually adapt and acquire the necessary skills” (Intv4_osh_labour, Pos. 27).

Algorithmic management and platform work create additional uncertainty about monitoring and the criteria of performance appraisal and task assignment (Heiland, 2023). Especially since the pandemic, home office work is known to present its own challenges of social isolation and poor communication, and uncertainty about the informal rules for short breaks or responsiveness that are clearer in an office context. In addition, labour inspection is not extended to private homes although employers are obliged to include working tools and conditions in WFH situations into the risk assessment – which only 17% of works councillors surveyed by Adam et al. (2024) said the company actually did. However, digitalisation may also relieve certain stressful aspects of work, such as

“everything affecting the unnerving, repetitive, annoying things across the world of work. If you aren’t a bit lazy you don’t make progress” (Intv6_osh_AOPsych, Pos. 67)

In healthcare (see section 5.3.1.3) works councillors especially have plenty of ideas and examples for incremental improvement of tasks and workflows, especially regarding documentation. Digitalisation also presents new options for labour inspection and OSH services, but they are somewhat contested. In the remoter and mountainous regions of Austria, slow travel of labour inspectors and OSH professionals subtracts resources from actual inspecting and advising. Some research and experimentation goes into remote inspection of physical workplaces by drones and into telemedicine for advice. Information and instruction of workers may already happen remotely, and AI-based translation and speech recognition may indeed improve communication in multiple languages if insights can be applied to actual workplaces.

However, so far, the Labour Inspectorate itself does not allow purely remote inspection and insists on in-person inspection of exemplary workplaces and direct conversations with workers.

The Chamber of the Economy argue in favour of remote inspection and point out that employees appreciate it and that it might also support discussion with non-German speakers. For some hard-to-reach physical work environments this may be an additional option, although for psycho-social risks, as one OSH expert puts it,

“it’s also about, well, atmosphere that you need to pick up. And that this can be covered 100% digitally, I don’t think so” (Intv7_osh_xp, Pos. 60)

For supporting the inspection and assessment of digitally induced stresses and designing healthy digitalised work systems, following the EU-OSHA and national campaign 2023 - 2025 the Labour Inspectorate has developed a “matrix”⁵ in its characteristically co-creative mode:

5 https://www.arbeitsinspektion.gv.at/Gesundheit_im_Betrieb/psychische_Belastungen/Digitalisierung_Belastungsmatrix.html

„We've taken the input by EU-OSHA, ran a large literature review to find if there's anything else on stress factors, enriched that and then with experts from the professional associations reviewed that and elaborated it and checked it again. Somehow feasible and helpful nevertheless, we're hoping“ (Intv10_osh_min, Pos. 79).

This is so far unique in the EU and has been shared with other EU member states. In Spring 2025, the tool addresses platform work, task automation through robotics or AI, remote work, and algorithmic management. For each of these work types it explores characteristic OSH challenges on the levels of tasks, workflows and work organisation, social relations, and the work environment (in line with OSH law). It outlines exemplary suggestions for job design in each cell and lists the most relevant references. The matrix references materials by EU-OSHA, research and information by various German OSH bodies such as BAuA (=German Federal Institute for Occupational Safety and Health), regional, sector- and stakeholder-specific materials, and Austrian stakeholder contributions as well as related research.

Experts are largely confident that the Austrian OSH regime and social partnership are capable of addressing emerging and future issues and technologies, by using existing regulation rather than introducing a “right to disconnect”. One unionist comments,

“generally there are existing rules for working time that stipulate that you are not available round the clock, that there should be clear rules. The point is not to allow this blurring of boundaries and to make it clear that, ... if my work is demanded [outside regular working hours], then this is working time. So, sure, ‘right to disconnect’ in this sense, but in our view the legal provisions are in place already. They need to be insisted on and put into practice” (Intv8_osh_union, Pos. 50-51).

Whereas employer representatives tend to claim, in a similar vein but with a different emphasis, that there is quite enough regulation already and employers must be given the space to exert their responsibilities, the labour side argues that it is less the legal OSH framework that needs adapting but its implementation and enforcement in the light of changing work environments.

3. Regulatory framework on psychosocial risks and workers' health and well-being

3.1 Legislation

The key regulation of OSH in Austria is the Occupational Health and Safety Act (ArbeitnehmerInnenschutzgesetz, ASchG) that first came into force in 1995 and has been adapted and amended several times since. It applies directly to private sector employees.⁶ OSH in the public sector, agriculture, forestry and private households and for homeworkers is regulated by other legislation but in the public sector follows similar procedures. The self-employed do not fall under the domain of the OSH Act.

In 2001, the Safety and Health at Work Reform Act first integrated occupational psychological services into the provision of OSH services. The Labour Inspectorate developed dedicated guidelines for psycho-social risk assessment from 2010 and in a pilot found that fewer than half of the companies inspected on these grounds had assessed psycho-social risk – which led to the 2013 amendment of the OSH Act (cf. Kloimüller, 2025). This explicitly obliges employers to assess and prevent psychosocial risk. Other legislation such as the Labour and Health Act of 2011 and the Part-Time Reintegration Act of 2017 enable a gradual return to work after long periods of sick leave and require an assessment of psychosocial risk as well. A period of subsidised part-time work with some medical and psycho-social advice and monitoring for both employees and employers is offered. This applies to long-term illnesses in general but also supports the reintegration of workers with mental health conditions.

According to the law, employers are responsible for the prevention of OSH risks to workers. They must assess risks, provide information and instructions, prevent risks and design safe and healthy working conditions. If they do not employ in-house specialists for this, companies with more than 50 employees are obliged to use the services of external specialists, safety professionals (with technical backgrounds and an 8-week certified training course) and occupational physicians or those of multidisciplinary OSH and occupational medicine centres. Such consulting services must cover a legally required minimum of 1.5 hours per year and workplace (1.2 hours for office workplaces).⁷ Safety professionals must cover a minimum of 40% of this time and physicians at least 35%. For the remainder, “other” experts such as work psychologists may be hired. The status of these and other professions in OSH has been a traditional field of contestation.

SMEs below 50 employees must commission annual visits by a safety professional and an occupational physician (every 2 years in cases that have fewer than ten employees, or every three years for office workplaces) or may use the services of AUVA (= Workers' Compensation Board) which for SMEs are free of charge. Employers with more than ten workers must also

⁶ This overview is based on <https://oshwiki.osha.europa.eu/en/themes/osh-system-national-level-austria>, <https://www.eurofound.europa.eu/en/resources/article/2024/working-life-austria>, and (Kloimüller, 2020, 2025).

⁷

https://www.arbeitsinspektion.gv.at/Uebergreifendes/Uebergreifendes/Praeventivdienste_Allgemeines.html

appoint an internal safety representative (Sicherheitsvertrauensperson), a regular worker who receives some 3 days' training and acts as intermediary between employer and employees.

As in other countries, there is a legal and institutional distinction between work-related health challenges and recognised occupational diseases (Kloimüller, 2020). Work-related conditions are caused or aggravated by work, such as many musculoskeletal or mental disorders, but are not monitored by labour inspection or covered by the Workers' Compensation Board. In Austria in 2024, there are 73 occupational diseases⁸ that are insured by the Workers' Compensation Board. Occupational diseases must be reported, their causes at work analysed and working conditions adapted. Such diseases are physical conditions caused by exposure to infections, noise, harmful substances, and work-related strains. Mental health conditions so far are not covered. In 2023, 2,820 cases of occupational diseases were recognised.⁹

Politically, OSH is operationalized in the National Occupational Safety and Health Strategy, which is now in its third period from 2021 to 2027. This is strongly influenced by the European OSH Framework¹⁰. The strategy brings together Austrian OSH stakeholders to orient OSH initiatives and set priorities for OSH activities and projects. The website mentions the following groups of stakeholders: "Austrian labour inspectorate, social partners, social insurance institutes, other Federal ministries, professional associations, research institutes and other actors in OSH".¹¹ The current Strategy, like the European one, focuses on the Green and digital transformations, minimising workplace accidents ("Vision Zero"), prevention of work-related diseases with a focus on chemical agents, and of ergonomic and psychosocial risk (ibid.), and preparedness for future pandemics.

3.2 Key actors in OSH

Since OSH activities in Austria as well as social and labour market policy in general are largely conducted by tripartite bodies (social partners and the Ministry of Labour), we first introduce the Austrian industrial relations system here.

3.2.1 The Austrian industrial relations system and its key actors

Austria is a Continental European federal country with a comparatively strong social partnership. The country has a dual system of representation with unions on the societal and sectoral level, and works councils elected on the company level. Works councillors, in addition to the safety representatives and OSH professionals, also play a part in company-level OSH. Generally, OSH legislation, policy and initiatives are strongly influenced by social partners, and social insurance bodies such as AUVA also have a tripartite mode of governance. Recent Conservative/Far-Right governments have attempted to limit the influence of trade unions in social insurance but had limited success.

In 2019, union density in Austria was at 26.35% (OECD, 2021). Nevertheless, Austria is known for its high collective bargaining coverage of some 98%. The reason for that is that on the employer side, the Chamber of the Economy (WKÖ) negotiates collective agreements, and for private sector employers, membership in the Chamber is obligatory. WKÖ has a sectoral and a federal

⁸ https://auva.at/media/4ibhluwm/auva-liste-der-berufskrankheiten_bf_2024-08.pdf

⁹ <https://auva.at/auva-ihre-leistungen/leistungen-auf-einen-blick/versicherungsschutz/berufskrankheiten/>

¹⁰ <https://oshwiki.osha.europa.eu/en/themes/eu-osh-strategic-framework>

¹¹ https://www.arbeitsinspektion.gv.at/Information_in_English/National_OSH-Strategy/National_Occupational_Safety_and_Health_Strategy.html. For more details on stakeholders see <https://oshwiki.osha.europa.eu/en/themes/osh-system-national-level-austria>.
Figure 3.

structure and advice to its members, campaigns and initiatives are often provided by the provincial organisation.

On the employee side, unions negotiate collective agreements. They are supported by the Chamber of Labour in which employees are obligatory members. The Chamber of Labour (AK) provides legal advice to employees on labour, social security, and consumer protection issues, represents workers at large, and acts as a labour-oriented thinktank that gathers data, commissions research and provides expertise and analyses to support unions in collective bargaining. Unions are unified and organised along sectoral lines, with a union federation (ÖGB) representing organised labour at large.

3.2.2 OSH key actors

The Austrian Federal Ministry of Labour, Social Affairs Health, Care and Consumer Protection (since 2025, previously Labour was located in the Ministry for Labour and the Economy) – hosts the Labour Inspectorate¹² (which was established in Austria in 1884) which is the largest enforcement body of OSH in Austria. This department of the Ministry also acts as EU-OSHA's contact point in Austria together with the Workers' Compensation Board (AUVA). It covers most employees in Austria, with the exception of provincial and municipal employees, agriculture and forestry¹³, and private household employees, and those employed by institutions that belong to legally recognised religious communities.¹⁴

The Labour Inspectorate has the mission of “Good advice and fair control”.¹⁵ It monitors companies' risk assessment, inspects workplaces and provides OSH information that acknowledges the gap between legal stipulations and on-site practices and aims to bridge it. For instance, some sector-specific checklists for risk assessment have been developed. It sets annual priorities on OSH issues and regional activities. In 2024, the priorities were advice on personal protective equipment, OSH in parcel and delivery services, and, with direct mental health relevance, “violence as an occupational risk” (continued in 2025). In 2025, “risk-prone workplaces” are also in focus.¹⁶ Psychosocial risk was already a focal action in 2010-2011, which fed into the 2013 legislation and also into the labour inspectorate's guideline on workplace evaluation of psychosocial risk in labour inspection and advising (BMASK, 2013).

The number of labour inspectors in Austria is below the recommendation of ILO which foresees one labour inspector per 10,000 employees. At the time of the first OSH Law (Arbeitsschutzgesetz) in 1994, 316 labour inspectors covered fewer than three million employees. In 2022, there were 296 labour inspectors, plus administrative staff and 19 labour inspectors in transport, which at 3.9 million employees gave a ratio of one labour inspector to 13,176 employees (Adam et al., 2024, S. 51f.). The number of labour inspectors thus did not increase in line with the increasing employment in the country.

Another central actor in social insurance and OSH is the Workers' Compensation Board (Allgemeine Unfallversicherungsanstalt, AUVA). It was established in 1889 to cover employers' liability in cases of occupational accidents and now is responsible for preventing occupational

¹² https://www.arbeitsinspektion.gv.at/Information_in_English/Information_in_English.html

¹³ For this, there are distinct Inspectorates in the domain of the federal provinces.

¹⁴

https://www.arbeitsinspektion.gv.at/Information_in_English/The_Labour_Inspectorate/The_Labour_Inspectorate.html

¹⁵ https://www.arbeitsinspektion.gv.at/Agenda/140_Jahre_Arbeitsinspektion/140-Jahre-Arbeitsinspektion.html

¹⁶

https://www.arbeitsinspektion.gv.at/Agenda/Schwerpunkte_der_Arbeitsinspektion/Schwerpunkte_der_Arbeitsinspektion.html

accidents and diseases, compensating industrial injuries and accidents, and for rehabilitation. It is funded by contributions of employers of currently 1.1% of gross payroll – which was decreased from 1.4% since 2014 (Adam et al., 2024, p.51). AUVA covers employee's compensation as well as statutory accident insurance for school children, students and the self-employed, offers advice, training, and OSH services free of charge to SMEs, runs OSH campaigns, offers further training to OSH professionals, and runs its own trauma and rehab centres. Its services, in coordination with those of the Labour Inspectorate include guidelines, information and some free-of-charge assessment tools for psycho-social risk. It has also contributed to improving the training and knowledge base of OSH professionals in psycho-social risk assessment (for more detail, see Kloimüller, 2025).

As both the Labour Inspectorate and AUVA work closely with EU-OSHA, the European campaigns are implemented on the national level and Austrian inputs also taken up. Collaboration according to the Ministry's expert is *"pleasant and full of mutual appreciation"* (Intv10_osh_min, Pos. 102). In addition, the Labour Inspectorate makes use of the SLIC (= Senior Labour Inspectors' Committee) infrastructure of DG Employment¹⁷:

"We often put questions to SLIC or receive SLIC questions ... they ask questions, we ask questions and you always get answers ... and an overview of how the other EU member states do it" (Intv10_osh_min, Pos. 109-111)."

3.2.3 Current policy perspectives of social partners

Experts agree that in spite of its limitations and gaps in implementation and enforcement, the Austrian OSH system is so far well aligned with its strong involvement of social partners, mandatory assessment and underlying philosophy. The quality of assessment tools is also appreciated since they allow for company-specific solutions.

Unions and employer associations negotiate the legislation, strategies and initiatives of the OSH institutions, and the Austrian OSH strategy. Much information provision for their respective constituencies, awareness raising and campaigning is conducted by joint or accorded actions of all these actors.

Nevertheless, the interests and activities of employers and workers differ. The WKO expert summarises the Chamber's position:

„That is our general request, that companies do not need anyone from the outside, except the OSH professionals and occupational physicians, but that they can address these [OSH] subjects by themselves with the tools AUVA and we have developed" (Intv5_osh_emp, Pos. 9)

They favour sector- and situation-specific approaches and claim that the legal responsibility of employers should not be detailed and regulated further since employers will initiate activities if and when needed. With this outlook, WKO informs about psychological burdens and stress in the workplace and advises companies about the guidelines and tools for OSH risk assessments. It provides support and some funding, for instance for consultancy services for companies conducting the evaluation. More specifically, the WKO also represents the private health sector. For its healthcare and personal services sections, work-related health is also a market. In collaboration with social insurance, they develop offers for prevention and rehab that include mental health modules.

Whereas employer organisations interpret employers' responsibility in the sense of leaving adequate measures to their judgement and oppose further regulation, the labour side demand

¹⁷ https://employment-social-affairs.ec.europa.eu/policies-and-activities/rights-work/health-and-safety-work/senior-labour-inspectors-committee-0_en

tighter regulation and an expansion of OSH services. They aim for an implementation ordinance for the obligatory risk assessment to further specify the law and for a strengthening of the Labour Inspectorate. This ordinance should explicitly require a mandatory evaluation of working time regulations (in particular shift schedules and flexible working hours) with regard to their impact on health as well as the impact of digital technologies. As one unionist puts it,

“really looking into the working time situation in a company. That doesn’t just cover adherence to maximum working hours but such things as boundaryless work, overtime, predictability of working schedules and workers’ discretion, and mandatory initiatives resulting from that analysis. That would be important and would apply to digitalisation as well. [...] This really needs to be part of a structured assessment of the impacts on mental health, [...]” (Intv8_osh_union, Pos. 96-97).

In the assessment of psycho-social risk, the Chamber of Labour and trade unions demand that the involvement of work and organisational psychologists (who currently are mentioned but have no dedicated mandate in the law) should become mandatory and the “prevention times” of OSH experts in companies be extended accordingly. In addition, workplace evaluations should be mandatory upon the return of an employee to work after an absence due to mental ill health.

They also demand the establishment of a competence centre for the assessment of survey and assessment instruments for psycho-social risk at work, and more scientific studies commissioned by AUVA on the mental and physical risk potential of new and emerging forms of employment (e.g. teleworking, virtual teamwork, or crowdsourcing and platform work) as well as suitable prevention measures.

Labour actors also demand measures to ensure the independence of OSH professionals, whose services are currently directly paid for by the employer. This may result in tensions between their legal mandate and the company's wishes. New models of funding and reimbursement could improve their independence, for example through a dedicated fund for prevention specialists that employers pay into collectively. To further extend professional OSH services, they would like to see health promotion at work (see section 4.2), a recognised source of good practices, becoming mandatory as well.

In addition, unions demand the inclusion of conditions related to shift or night work such as biorhythm disorders or psychosomatic illnesses as well as anxiety and depressive disorders caused by working conditions into the list of occupational diseases. This would improve access to treatment and rehabilitation, to reskilling if needed, and a pension in case of lasting impairments. In addition, such recognition would incentivise prevention efforts by employers and social insurances.¹⁸

More general demands of the labour side such as a reduction of working hours or increased discretion of workers over working hours and flexibility are also motivated with likely improvements in healthy working conditions.

One expert from the labour side would like to see general progress in impact assessment of initiatives beyond the company level:

„As a first step, a really good monitoring of the companies that have done the assessment and that haven’t, and also monitoring of necessary re-evaluations, because the law requires something to happen, and there, we’re really flying blind. Secondly, a discussion on evidence-based measures. Because what we’re doing is, we look at things but we don’t know if they have any real effect. Because, [...] we still have extremely high sickness absences and long duration of sick leave due to mental illness, and ever-increasing cases

¹⁸ <https://www.gesundearbeit.at/gesundheit/berufskrankheiten/arbeitsbezogene-psychische-erkrankungen-auf-die-berufskrankheitenliste>

of early retirement due to mental illness. [...] We won't really know why, but it shows that these interventions that have been intensified since 2013 in fact have not had any success. Then the question is, why continue that? To be blunt, not that I want that, but if you do something it should have an effect.”. (Intv3_health_labour, Pos. 69-70)

The experts interviewed in spring 2025 see the current political climate for OSH somewhat ambiguously. One expert says,

“I always have a sense that in economically strained times, OSH is being relaxed, and I think that is a bad thing” (Intv7_osh_xp, Pos. 116)

The Austrian economy has been in a recession since 2023 which is expected to continue through 2025.¹⁹ Austria has a coalition government of the Conservative, Labour and Liberal party since March 2025, after an extended period of negotiations in which a conservative/far-right coalition was also an option after the general election on September 29th, 2024. The current government prioritises considerable cuts in public spending, but the Ministry of Labour, Social Affairs, Health, Care, and Consumer Protection is now headed by a social-democratic trade unionist. Hence, OSH experts are tentatively optimistic:

“Yes, we're in the third year of a recession, that has a very strong impact, [...] but on the other hand, health of course is elementary right now. It's not always obvious, I think, investing even more into the health of employees, and managers, and one's own health [in this situation]. The climate has clearly become harsher. And on the other hand there is a totally high awareness of health, and really high-level initiatives [...], so it's both sides” (Intv10_osh_min, Pos. 81-92).

As the cost of pensions figures strongly in the government's cost-cutting efforts, ensuring that people can “*work healthily until their regular pension age*” is part of the government's programme as well as an unspecified promise to “*modernise*” OSH law (ÖVP et al., 2025, S. 97). From the union view, this emphasis (as opposed to increasing the pension age) gives weight to OSH at large and to the prevention of psychosocial risk in particular:

“But to achieve exactly these objectives it takes things that have to do with strengthening mental health. But then, the immediate impact of that can't so easily be demonstrated, not enough [for the government] to keep them in focus or make them an immediate objective, or to prescribe measures” (Intv8_osh_union, Pos. 38).

3.2.4 Beyond lobbying: social partners' involvement in the prevention and management of psychosocial risks

Increasingly WKO initiatives focus on integrating people with mental health problems into the labour market – not least as a way to address staffing shortages. For instance, WKO's provincial branch of Upper Austria started a collaboration with pro mente (an Austrian Federation of non-profit organisations that promote Mental and Social Health) in 2023 to provide companies with information and training on mental health, support in cases of psychological stress in existing employment relationships, and to foster employment opportunities for people recovering from mental health challenges.²⁰

¹⁹ <https://www.wifo.ac.at/news/rezession-in-oesterreich-haelt-an/>

²⁰ <https://www.wko.at/ooe/news/gu-inklusion-pro-mente-2024-rz-druck-1.pdf>

On the side of labour, trade unions and the Chamber of Labour address psycho-social risk on the national and the provincial level. They say especially white-collar unions have been aware of psycho-social risk for a long time, under the heading of stress in the 1980s and 1990s.

They inform employees about psycho-social health risks related to the job and about employers' responsibilities to evaluate and prevent them. Brochures address specific issues such as working from home or digitalisation and recommend prevention measures for workers and companies (Seubert et al., 2022). For works councillors, safety representatives and OSH professionals, AK and ÖGB run a dedicated website on occupational safety and health, gesundearbeit.at and disseminate it on several social media channels.

Unions also provide training and advice for works councillors who encounter psycho-social challenges among their colleagues and may not by definition have the knowledge and skills to offer support and advice:

*„also to show them how important it is to draw boundaries for themselves, to figure out how far the role of the works council can go. But also to help them, very often it's about knowing offers of counselling to send someone to. ... And still, as a works councillor in this way you get insight into work situations, stress situations that emerge in the company”
(Intv8_osh_union, Pos. 29-32)*

The Chamber and some trade unions commission research, collaborate with research institutions, and run conferences and workshops. A report about work-related psychological burdens and their consequences already fed into the 2013 OSH law (Biffl et al., 2012). For the 30-year anniversary of the first OSH law in Austria, the Chamber commissioned a comprehensive study that outlined the political and legal development of OSH in both Austria and Europe, conducted an online survey of works council chairs and safety representatives in Austria on the implementation of the obligatory risk assessments, and provided sector-specific company case studies in the construction, retail and care sector (Adam et al., 2024).

4. The company level

4.1 Psychosocial risk assessment

The mandatory assessment of psychosocial risks in the workplace OSH evaluation by employers consists of planning the process, assessing working conditions, documentation, and development of measures to prevent psycho-socially hazardous working conditions. Measures then are implemented, their impact assessed, and adapted if necessary, all with an aim to improve working conditions.²¹ The evaluation addresses the organisation and environment of work, the tasks and the atmosphere in the workplace.²² Employers are free to use their own instruments or those by other providers, but procedures and tools must conform to ÖNORM EN ISO 10075-1 and 10075-2 (Jelenko & Strobach, 2018). The law foresees an approach that focuses on continuous improvement through this cycle – which, however, is not necessarily implemented fully by companies.

Experts interviewed agree that the 2013 reformulation of the law has brought some advances, especially in conjunction with the ÖNORM:

“With this, we made explicit that health means both physical and mental health and that risks are both physical and psychosocial. That was quite important, and we also have put in the four dimensions of the norm [ÖNORM EN ISO 10075-1], the work itself, the tasks, the organisation and social relations, working hours we take along wherever they come up, and the work environment, we put all that into the law through talks with the social partners, and all institutions brought it into the companies, both employer and worker representation, and then we intensively trained the labour inspectors” (Intv10_osh_min, Pos. 4).

AUVA provides further information and exemplary tools for the assessment such as individual and small group interviews, focus groups and surveys.²³ It emphasises that the assessment is about working conditions, not about employees’ job satisfaction, performance or stress. Tools cover working conditions in the sense of task content (variety and completeness of tasks), climate in the organisation (worker voice and participation and benefits such as availability of training), stressors (qualitative such as lack of skills and quantitative such as time pressure), interruptions of work, environmental factors), and resources (such as discretion, social support and collaboration and feedback) (Prümper & Vowinkel, 2019).

From the results, needs for intervention are identified and measures developed. Priorities are to be defined with the support of prevention experts, the works council (where there is one) and employees themselves. Stressors that are considered risky and measures to prevent or mitigate them need to be documented and communicated to everyone involved in the process. Measures then are implemented and assessed for their efficacy. A reassessment of psycho-social risk is required especially after incidents of heightened psycho-social strain (BMASK, 2013).

²¹ https://www.arbeitsinspektion.gv.at/Gesundheit_im_Betrieb/psychische_Belastungen/Arbeitsplatzevaluierung_psychischer_Belastungen.html

²² <https://www.gesundheit.gv.at/leben/lebenswelt/beruf/psychische-belastung/gesundheit.html>

²³ <https://auva.at/praevention/sicher-arbeiten/evaluierung/psychische-belastung/>

Measures to prevent and mitigate risks are supposed to follow a hierarchy known as the STOP principle in OSH (cf. Kloimüller, 2025): Substitution (of dangerous substances or similar) takes precedence over technological, organisational, and finally, person-level measures such as training or protective equipment. A representative from the Central Labour Inspectorate says,

„that is something we always tell companies: oh, super, you're taking measures. But you might give some thought to how to note that things are improving, what would that be? It's often indicators that you can measure, such as the number of interruptions, but not always” (Intv10_osh_min, Pos. 32-34)

They say, currently roughly a third of companies inspected are required to improve their assessment along these lines, but

“I think that figure ought to be higher” (ibid.).

In sum, OSH actors promote the law's philosophy of continuous improvement and monitoring which, in spite of advances being made in recent years, has not been entirely absorbed by employers and companies:

“Many say, okay, I've done my survey so I've done the assessment, or an interview , or a group workshop – but that is only a small part of the assessment. So I think it would be really important to understand the entire cycle. Everybody tries to explain that all the time, but that in parts hasn't yet been absorbed into the mindset of companies” (Intv7_osh_xp, Pos. 114).

So far, it is largely actors from the labour side in alliance with work psychologists who argue that psycho-social risk prevention in this holistic sense is a win-win arrangement:

„Because this prevention, if you take care that people don't fall ill through poorly designed work, this benefits employers as well. You avoid suffering but also cost. And that's good for the economy at large as well, because it's work-related diseases are prevented“ (Intv4_osh_labour, Pos. 11)

Or in psychological terms:

“If I really see people, if I don't just offer them jobs, if I design tasks in a way that they are engaging, that people enjoy doing something, that they are fully engaged, that they experience meaning and so on. All of these arguments. Then they do it enthusiastically, in the company's interest, and then you have this win-win-win situation” (Intv6_osh_AOPsych, Pos. 44-45).

A recent Austrian survey – commissioned by the Chamber of Labour to celebrate the 30th anniversary of the OSH Law – asked works councillors (n=1908) and safety representatives on the implementation of the law in 'their' companies (Adam et al., 2024). It found that 90% of works councillors said the company generally took an interest in workers' health and safety. However, 18% said that tasks and jobs were not or rather not designed in a (physically and mentally) healthy way, and 30% did not or rather not think employees would be able to do their jobs safely and healthily until they reached regular pension age.

28.6% said the legally mandated OSH risk assessment did not take place regularly in the company. Results were generally influenced by company size (SMEs with 21– 50 workers had the poorest results) and positively by participation of the works council in OSH.

For the assessment of psycho-social risk the outcome was considerably worse: a mere 47.1% (n=898) of surveyed works councillors had had a psycho-social risk assessment conducted in the

company and were informed about the outcomes. Of this group, 52.1% (466 respondents) reported that actual psycho-social risks were found. 67.1% of these (313 people) confirmed that the company had taken steps to mitigate these risks, and from that group 74.4% (233 persons) said that these measures were also assessed for impact (Adam et al., 2024, p. 95). In sum, less than one eighth of works councillors reported that 'their' company addressed psycho-social risks through the whole legally mandated cycle of improvement (own calculation following Adam et al., 2024).

4.2 Workplace health promotion at the company level

In addition to the mandatory employee protection mandated by the Occupational Health and Safety Act (ASchG), companies can put in place workplace health promotion (BGF) and reintegration management for workers returning after a longer illness.

The Austrian Network for Workplace Health Promotion (ÖNBGF), again, a partnership of social partners, social insurance, and the FGÖ (= Fonds Gesundes Österreich, an agency in the domain of the health department of the Ministry of Social Affairs) discusses the complementarity and potential synergies of these three pillars and provides leaflets²⁴ and guides to support enterprises in the joint implementation of the workplace health promotion and the workplace evaluation of mental distress (Blattner & Elsigan, 2015). They also offer tools for surveying occupational health that cover both the mandatory and optional aspects.²⁵

ÖNBGF also award prizes to businesses who implemented health-promoting measures (best practices)²⁶. Beyond their involvement in health promotion as social partners, WKO regional and sectoral organisations pursue further optional activities around health promotion at work (Betriebliche Gesundheitsförderung).

Like OSH initiatives, many health promotion initiatives are conducted in tripartite configurations. Health promotion covers a wider range of subjects, carries fewer legal obligations, and is implemented through project funding, incentives, awards and good practice communication in the domain of health policy. Social partners agree that they have additional value in generally raising awareness:²⁷

„I think, all of this is well and good but should be an addition to the basics, the legally mandatory things” (Intv8_osh_union, Pos. 70)

In addition, optional measures can be a source of more ambitious good practices as they are pursued by companies with the capabilities and interest in making improvements beyond legal requirements:

„perhaps the best success stories can be found looking at the subject of in health promotion at work. Because distinguished companies in that field always have the psychological component on board. It's about working conditions with regard to the company,[...] and there are some 15 quality criteria for health promotion at work, and in the background they are driven by the need for sustainable results which are well embedded in a psychological approach.” (Intv6_osh_AOPsych, Pos. 90)

²⁴ https://oeffentlicherdienst.gv.at/wp-content/uploads/2023/03/Leitfaden_fuer_ArbeitgeberInnen_zur_Foerderung_psychischer_G.pdf

²⁵ <https://www.netzwerk-bgf.at/cdscontent/?contentid=10007.890883&portal=nbgfportal>

²⁶ <https://www.wko.at/plattform-gesundheitswirtschaft/best-practices>

²⁷ <https://www.wko.at/plattform-gesundheitswirtschaft/foerderungen-und-services>

4.3 Participation

In addition to full implementation of obligatory assessments and improvements and optional health promotion, unions' OSH experts see further possibilities for progress in the dimension of direct worker participation.

“Simply to have conversations about ways to address psychosocial risk and develop solutions. Where participation is made possible, small, small steps can be taken, but these can bring quite some relief. Simply by reorganising work schedules or communications, [...] Or, thinking of open space offices, considering how not to simply mix people but consider their tasks, and their needs. [...] That happens. Not in the amount that we would wish for, but it happens. [...] If that isn't just something the HR person thinks about, or the works council thinks about, what is a good solution? But if the colleagues themselves can make suggestions, these suggestions are considered and implemented in the best case.”
(Intv8_osh_union, Pos. 80 - 86)

This should enable specific solutions rooted in workers' expertise but may require a certain effort upfront in developing processes and knowledge for participation. Compared to the long German, UK, Nordic or Benelux countries' traditions in “humanisation of work”, “human relations” and participation, supported by both social partners and some public investment, this aspect is somewhat less established in Austria and initiatives in that respect occur on a smaller scale. In recent years, the Chamber of Labour through a funding programme for research and practice projects on worker-oriented digitalisation is building some critical mass also in worker participation²⁸ and there are several, often sector-specific, regional, or company-specific initiatives. Hence, there may well be space for developing participatory processes in OSH.

²⁸ <https://wien.arbeiterkammer.at/digifonds>

5. Sectoral deep-dive: Industrial relations and psychosocial risks in the health sector

5.1 The state of play in the health sector

As noted in sections 2.1.1 and 2.1.2 already, the health and social care sector is known for particularly high exposure to psycho-social risk at work. This appears to be due to some (more or less) hard-to-change working conditions such as shift work and work at unfavourable hours, working with suffering people or those in difficult situations. Other factors look more amenable to changes such as high and increasing workloads, staff shortages, resulting unpredictable work schedules in addition to the unfavourable hours, steep hierarchies, and aggression and violence by patients or coworkers. In some segments, low pay and poor recognition also play a part. However, much work in the sector is clearly and obviously meaningful, training is provided, and well-functioning teams may well offer mutual support, solidarity and a shared sense of purpose.

Many challenges to mental health in the sector, especially with regard to the nursing and care professions have been well known for decades, and indeed, much research on job quality, OSH, organisations and subjectivity (Menzies-Lythe, 1988) and related concepts such as burnout (Schaufeli, 2017) has been developed in the sector. This report cannot cover the entire field even focusing on Austria. Hence we focus on recent research, especially those studies that stakeholders have mentioned in the interviews and have been drawing on in their policies. This evidence shows that clearly psycho-social and also physical risks of workers in the healthcare sector massively increased during Covid-19, but after the pandemic, and that several of the strains and their causes in low staffing levels and increasing work pressure persisted.

5.1.1 Data on mental health in the Austrian healthcare sector

Shortly before the pandemic, the Ministry for Social Affairs commissioned an analysis of the Austrian Working Climate Index (“Arbeitsklimaindex”), an annual representative survey of ca. 4,000 employees dedicated to job quality and job satisfaction, on working conditions in nursing and care occupations (Schönherr, 2021). This was motivated by notable staffing shortages, pending retirement of the strong older cohorts of care workers, and expected increased demand for care due to demographic change and an ageing population. In this study, 65% of the accumulated (from 2010 to 2020) 1,992 respondents in nursing and care said they thought it unlikely that they would work in that sector until retirement, and 15% were intending to leave their field or the sector generally. In elderly care, 75% did not expect to be able to retire in their current jobs. Women were 2.5 times and immigrants twice as likely not to expect that. Incomes seen as insufficient, psychosocial risk factors and atypical working hours increased workers’ concern over remaining in the sector. Higher education and resources at work such as voice, discretion and career perspectives decreased it by ca. a third each.

Plans to leave the current field of work or the sector altogether were increased 3.6 times by fixed term or agency employment, by two thirds in the presence of physical work strains, and by a third each by higher education (Matura) and commuting. Women were half as likely to look for job alternatives. Older workers and those who were confident their training would still be sufficient in five years’ time were also less likely to have plans for a job change. Among those with lower skills and migrants plans for job changes were also rarer.

In the period of 2010 – 2020 already, one third of the surveyed already were stressed “much” or “quite a lot” by time pressure, and a quarter reported such stress by ongoing pressurised working without being able to take breaks. Only in caring for people with disabilities, the pace appeared to be lower. Indeed, in that segment satisfaction with resources at work was above the average of all nurses and careworkers. “Much” or “a lot of” stress by emotional demands was reported by 46% in nursing, 41% in caring for the disabled, and 38% of carers for the elderly.

An influential study on “missed nursing care”, “MISSCARE” was conducted in 2021 by Cartaxo, Eberl and Mayer (Cartaxo et al., 2022a, 2022b, 2022c) among 1,006 nursing staff on general hospital wards across Austria. MNC is defined as „any aspect of required patient care that is omitted (either in part or in whole) or delayed“ (Kalisch et al., 2009, S. 1510), hence an indicator for nursing quality that affects both job quality of workers and care quality of patients. It is measured by asking nurses for the frequency of their team omitting nursing interventions deemed professionally necessary during recent weeks. Internationally, 55% - 98% of nursing staff reported MNC in surveys, with high shares of 93% also in Germany. In Austria, 84.4% of respondents said one or more care interventions had been omitted in the two previous weeks. More than half said that more than ten of the 30 listed activities had been omitted (Cartaxo et al., 2022a, S. 34). The most frequently omitted activities were emotional support and conversations with patients or, even more frequently, with patients’ relatives (all above 60%). More than 40% said interdisciplinary team meetings, supervision of cognitively impaired patients, counselling and instruction, mobilisation of patients, and documentation were omitted. Younger nurses and those with less experience, nurses with diplomas or degrees without a management position, full-time workers and those on larger wards reported MNC more often.

Nurses noted multiple causes of MNC: Most mentioned multitasking (85.9%) and interruptions at work (82.4%), followed by increases of numbers of patients with high care needs (81.4%) and shortages of nursing (78.6%) and support staff (62.9%). Other increases in workload causing MNC ranged between 75% and above 60%. Nurses’ own emotional or physical exhaustion was reported by 57.7% and 57.0% respectively to result in MNC, followed by insufficient support by supervisors (49.8%). This suggests that the well-known and interrelated factors of ineffective work processes, insufficient staffing levels, exhaustion and poor management, through the working and coping modes of nurses and teams led to an implicit rationing of care that put both patients and workers at risk.

Cartaxo et al. (2022b) also explored the impacts of MNC on job satisfaction and nurses’ intentions to quit the profession, taking other data on their working conditions into account. In itself, job satisfaction was found to be not extremely low in the sample. 85.9% were satisfied with cooperation on their ward, 70.3% with being a nurse, and 63.5 % with their current job situation. MNC significantly decreased that satisfaction. Nevertheless, 74.6% of respondents said they thought about quitting the profession, and 42% did so once a week or more often. Again, MNC had a significant positive impact on intentions to quit. In a logistic regression, intention to quit was shown to increase 2.8 times by a diploma in nursing, 1.5 times each by age below 45 and by MNC, and by 3.8% by overtime among those with regular shifts. Satisfaction with being a nurse decreased thinking about quitting.

The authors conducted other analyses (structural equation modelling and QCA) of antecedents of MNC (Cartaxo et al., 2023, 2024) to find other influences on MNC reported in the literature, but found that in Austria, these appeared to be statistically eclipsed by staffing shortages:

„could it be that, once labor resources have passed the minimum acceptable level, there are no other factors that could sufficiently influence the capacity of nursing care—until the requirement for sufficient nursing staff is met?“ (Cartaxo et al., 2023, p. 3581).

The union GPA commissioned an online study on burnout in health and social care occupations in 2023 (Schadauer & Allinger, 2024) which reiterated a previous study from 2008. Burnout was operationalised in the way developed by Maslach and Jackson (1981) as emotional exhaustion, emotional detachment, and negative self-evaluation. Some 1,285 health and social care

professionals responded. In this study, 42.2% confirmed a “strong” increase of hours worked during the pandemic and 22.8% a “light” one, and working hours emerge as a central factor for burnout risk: in 2023 36.4% of the surveyed had a high risk of burnout whereas 32.9% were at “moderate” risk. Risk increased with both contracted and worked hours, with overtime, and with the number of hours a person would like to work less. People who perceived their wages as less adequate or felt treated more unfairly at work also showed higher burnout risk – however, causes and effects may have worked in both ways, as exhausted workers may take a bleaker view of their working conditions. The 2008 burnout study is not entirely comparable since at that time, an online survey was more selective than in 2023. However, on all scales the share of respondents with higher stresses increased, in sum, from 20.2% of respondents at high risk in 2008 to 36.4% in 2023, and from 25.8% to 32.9% at moderate risk. The authors cautiously conclude that

“we can clearly state that in the last 15 years there have been no improvements in burnout risk. [...] Whereas in the 2008 survey, 41% responded that they felt ‘used up’ at the end of a workday, this is the case for 63.3% in 2023. This difference is so high that it cannot be explained by the different approaches and classifications in the respective surveys” (p. 55).

Regional stakeholders also conducted surveys recently, for example the Chamber of Labour in Lower Austria of workers in health and care²⁹. In 2023, 41% of respondents there expected to have to leave their profession before retirement under the current conditions. In a regression analysis, this expectation was driven by the professions’ poor compatibility with family obligations, dissatisfaction with the income, and to a lesser extent by job content, amount of hours worked, and societal appreciation. This survey found that about 30% reported psychological exhaustion and 20% suffering from sleep problems after work. Respondents mainly wished for a higher salary and more personnel in their organisation (more pronounced amongst workers in long-term care and carers for people with disabilities).

5.1.2 Impact of the Covid-19 pandemic

Especially through the Covid-19 pandemic social scientists, psychologists and nursing scientists soon conducted surveys and further research into the emergency that like elsewhere hit an already strained healthcare system. For that reason, the studies analysed do not distinguish impacts of the pandemic from those of already-problematic working conditions in the sector. Notably, some found stress to increase over the course of time, and generally, neither surveys nor expert interviews give the expression that some “normality” has been restored after the pandemic with the exception of the use of personal protective equipment.

Of 2,470 hospital nurses surveyed in 2021 by Gferer & Gferer (2021), 86% said their work situation had worsened compared with the time before the pandemic and 60% noted a further decline from 2020 until 2021. Similarly nursing staff in nursing homes noted further increased stress from 2020 to 2021 (S. Bauer et al., 2023). Gferer & Gferer (2021) found that workloads had increased, workflows become more complicated, staffing levels decreased, and personal protection equipment was burdensome. 41% reported strong or very strong mental strain and 49% noted physical strain. 57% did not sense increased appreciation of their work in society, and the same percentage did not feel well supported by their employer (whereas 40% did). 77% were affected by third-party aggression and violence, and 44% noted that this had increased. 45% of nurses said that they thought about leaving the profession repeatedly.

In terms of improvements, 91.8% wanted higher pay, 75.8% demanded more staff, 49.2% a better work-life balance, and 45.5% more appreciation in society. Interventions directly related to psycho-

²⁹https://noe.arbeiterkammer.at/interessenvertretung/dialogforum/AKNOe_Umfrage-Arbeitsbedingungen-Dialogforum.pdf

social risk ranked lower: 40.2% wanted more health promotion at work, 26.2% better support by the organisation, 24.3% more understanding by patients, 21.8% more recognition by management, and 20.8% more support by their direct supervisor. 17.5% asked for better information and communication and 14.3% for psychological support.

Duden et al. (2023) surveyed 639 healthcare professionals in Germany and Austria in 2020 and 2021 for symptoms of depression, anxiety and other mental disorders (according to the ICD-10 symptom rating questionnaire), stress factors and help-seeking behaviour. In 2021, 55% of the surveyed reported light to medium symptoms of depression and 6.5% had severe symptoms. 26.3% contended with light to medium anxiety and 2.8% struggled with severe symptoms. Rates in 2020 were even higher.³⁰ Comparisons among nurses, physicians and paramedics showed that as expected, more nurses reported poor mental health. As significant stress factors, job insecurity (for those who felt any) and anxiety about the infection of family members increased depression and anxiety, and protective measures hindering work processes contributed to the risk of depression. Pre-existing medical conditions also increased the severity of symptoms.

Notably, despite the high incidence of symptoms in that survey, only 14% of the surveyed said they would seek psychological support. Those who did not claimed that other people that support more, they did not know adequate healthcare services, did not feel they were “distressed enough”, or lacked the time. However, this was not statistically explained by established professional-identity related concepts that measure items like a “caregiver self-image” or prosocialness. Mental well-being turned out to be centrally and directly positively influenced by the team climate:

„Both a low tendency to evaluate social comparisons of one’s own resilience with coworkers negatively (TC1) and open communication among colleagues (TC2) seem to have influence on the reported symptoms“ (Duden et al., 2023, p. 8).

Stakeholders and social partners also commissioned studies during and after the pandemic. “Offensive Gesundheit”, an alliance of healthcare unions, the Chamber of Labour and the Viennese Medical Chamber (see section 5.2) conducted an online survey among 6,969 healthcare staff in 2021 about working time, thoughts about changing jobs, and mental health, also according to the ICD-10 questionnaire (Offensive Gesundheit, 2021). 61.5% had worked longer hours than contracted in 2020, compared to 52.9% in a similar survey of 2018.

Among depressive symptoms, 71.8% reported at least “some” “lack of energy”, 67.7% suffered from at least “some” “feeling low”, 56.8% noted “some” “lack of joy” in things they liked doing, and 26.7% reported “some” low confidence and self-worth.

Masseurs, medical and dental assistants, and home carers had the highest rates of symptoms, followed by nurses and paramedics among whom still ca. 80% reported some symptoms. Doctors, psychologists and psychotherapists fared better but still around 70%, 60% and 50% of these respective groups noted symptoms. Younger workers, those in long-term care and extramural services were more affected. Indeed, those that regularly worked longer hours than contracted or had noted an increase in working longer hours, had poorer mental health. Vice versa, reliable work schedules, higher skills and higher age appeared as protective factors.

5.2 The health system and social partnership in the health sector

The Austrian healthcare system has been characterised as “both complex [...] and fragmented” (LSE Consulting, 2017, p. 26). Austria is a federal country with nine federal provinces (of which Vienna is one). The overall structure is described by OECD as follows:

³⁰ Bauer et al.

„The federal level sets the legal framework, including regulation of social health insurance (SHI), healthcare providers and most areas of care provision. The nine federal states (Länder) provide hospital care in their jurisdictions and fund capital expenditure in the hospital sector. Outside hospitals, healthcare providers are predominantly private and negotiate collective contracts with SHI funds for the provision of outpatient care“ (OECD, 2023, p. 9).

Some municipalities or associations of municipalities as well as health insurance funds also run hospitals. There are private-sector and non-profit hospitals (often run by religious orders) as well, whose care can also often be accessed through health insurance.

Long-term care became a distinct policy field in 1993 when both cash transfers and care services became the responsibility of the federal provinces. However, the largest share of long-term care is still provided by unpaid and “informal” carers. In long-term and social care, large non-profits such as the church-related Caritas and Diakonie as well as the secular Volkshilfe and Hilfswerk as well as public and private-sector providers of all sizes provide both inpatient and mobile services. Health insurance is nearly universal (with 0.1% of residents not covered, *ibid.*).

Austrians report fewer unmet medical needs than residents of other European countries, and the density of both physicians and nurses is high at 5.4 physicians and 10.6 nurses per 1000 residents, compared with 4.1 and 8.5 respectively in the EU average. Overall health expenditure was the second-highest in the EU in 2020 (OECD, 2023), with 78% of this covered by public spending. However, there are gaps in healthcare: the population is both ageing and increasing due to immigration whereas the proportion of general practitioners has been declining since 2010 and is now among the lowest in the EU. In some specialties (such as pediatrics and gynecology, and also psychiatry, especially of children and youth), doctors and therapists with health insurance contracts are hard to find, and some rural regions have difficulty filling GP positions as local doctors retire and new cohorts tend to move into private practice or work shorter hours. For these reasons, Austria spends a comparatively large share of its health budget on inpatient care.

Labour shortages in care especially are a concern: a prognosis commissioned by the Ministry for Social Affairs first in 2019 and then updated, predicts a need for an additional 51,000 careworkers by 2030 (Juraszovich et al., 2023). Up until 2050, some 7,000 additional care workers will be needed per year, of which ca. 5,800 should have nursing degrees. In 2022/2023, academic and non-academic courses in nursing had 4,543 graduates (Prammer-Waldhör, 2025, S. 31).

Due to demographic ageing and concerns over public expenditure, as in other European countries, health has become more politicised through and after the Covid-19 pandemic. In some provinces, attempts to merge or close small hospitals for reasons of cost saving and improving quality have led to political controversy and to increased shares of far-right populist votes in recent years. Policy is trying to strengthen primary care and promoting multi-disciplinary primary care centres and telemedicine but advances are slow.

On the employer side the private healthcare sector is represented in the Chamber of the Economy. Doctors, as both employers and employees are statutory members of the Medical Chamber. Public healthcare providers conduct their own collective bargaining on the provincial level, and the non-profit sector is also fragmented. Religious order hospitals have their own association and collective agreement, and a wide range of non-profit and social economy organisations, of which a majority cover social care, are represented by “Sozialwirtschaft Österreich”³¹ (Social Economy Austria).

The Chamber of the Economy also hosts the platform for health economy which aims to coordinate interests around healthcare and the health economy, and influence the legal framework, by bringing together companies from all sectors, interest groups, researchers and policy makers. The platform’s taskforce („Rethinking health”) was formed by members of Patientenanwälte, Institut für Höhere

31 <https://www.swoe.at/>

Studien, WKÖ, Vinzenz Gruppe (a hospital group), Gesundheitszentrum Erste Group (a bank's healthcare centre), MEDICON medical consulting and the Chamber of Labour of Nether Austria. In their manifesto presented in 2023, the taskforce calls for reducing waiting times for therapy for people affected by mental health conditions and for improvements in their (re-)integration in the labour market (their labour force participation rate in Austria lies below the OECD average) – arguing for the need to maintain the ability to work.

On the **employee side**, four trade unions represent workers in the Austrian health sector. In the public sector, GÖD (Gesundheitsgewerkschaft) represents health workers at the federal and federal province levels as well as in outsourced federal and state organisations, whereas Yunion represents municipal employees. For health, care and social services workers in the private and non-profit sectors, there are the white-collar union GPA and the services union vida. The trade union federation ÖGB and Chamber of Labour also influence health policy. In addition to trade unions, there are professional associations for varied health professions that do not participate in collective bargaining but advocate for professional interests.

GPA, the private sector white-collar union organises somewhat atypical employees such as freelancers and professionals in “interest groups” that also offer low-cost membership. The interest group for the health and social sector, “IG Social”, together with the other unions in the sector, ran a project “Bündnis für die Pflege” (= Alliance for Care) from 2021 to 2024 to gather and align unions’ demands and strategies for the care sector and discuss them in a series of local events with care workers and trainees (Haberl & Schwanter, 2022).³²

Health and social services are often addressed together by trade unions, thereby grouping together a wide range of occupations and professions. The unions and works councils collaborate in the working group for health and social professions (ARGE or AG Gesundheit)³³. From 2019 to 2023 the “Health campaign” (Offensive Gesundheit) started, a Vienna-based cooperation between the health trade unions (GÖD, GPA, ÖGB/ARGE, vida, yunion), the Chamber of Labour and the Medical Chamber for Vienna’s section for employed doctors (Offensive Gesundheit, 2020). However, that collaboration ended in 2023 due to political disagreements between unions and the Medical Chamber.

5.2.1 Policy

As there is a gap between staff needed and being trained and all healthcare professions have staffing shortages, policy initiatives aim to make training in healthcare professions more attractive, prevent students’ dropping out, and ensure they enter the profession. In addition, the authors of the prognosis (Juraszovich et al., 2023) recommend recruiting people returning to work after parental or educational leave, recruiting healthcare staff abroad, as well as improving staff retention, digitalisation to coordinate workflows or lighten administrative and documentation workloads, and an increased focus on prevention and health promotion at work.

After the Covid-19 pandemic, a bundle of federal policy initiatives to reform care (“Pflegerreformpaket I – III”) were implemented in 2022 - 2024. The policy process was somewhat hindered since from 2020 to 2024, the Health Ministry, held by the Green Party in a Conservative-Green coalition, had to contend with staff shortages itself and ministers changed twice.

The federal state offered extra funds to increase pay in care occupations (a “caring bonus”) which due to the provincial responsibilities were allocated in uneven ways. It also provided stipends for people in training (also retraining) for these occupations (extended to academic training in 2024), a sixth week of paid holiday to all nursing staff after age 43, and extra time-in-lieu for nightshifts in long-term care. The recognition procedure for foreign training in nursing and care was simplified, a

32 <https://www.gpa.at/die-gpa/interessengemeinschaften/ig-social/ig-social-buendnis-fuer-die-pflege>

33 <https://www.oegb.at/der-oegb/ag-gesundheits-und-sozialbetreuungsberufe>

competence centre and database for this recognition established, and skilled immigrants are allowed to work in the lower-graded caring professions until their training has been recognised. For nursing assistants and nurses with non-academic training, recognition of their training in further academic qualification has been improved.

However, the enthusiasm of unions about the outcome was limited. Pay increases outside of collective bargaining were seen as intransparent and arbitrary (cf. Haberl & Schwanter, 2022), and the additional holiday week applied to few nursing staff as the existing collectively agreed or company-specific rest periods were deducted.³⁴

5.3 Problem areas and union initiatives in healthcare: systemic risks and root causes

In the health sector as a multi-stakeholder field, experts interviewed (from the labour side as well as professional associations and OSH), researchers and policy actors tend to be well-informed about the evidence and about each other's respective views. They converge in seeing psychosocial risk in close connection with the key challenge of staff shortages, current and future labour supply. Apart from generally low staffing levels, these shortages render work schedules unpredictable as workers in often elaborate shift systems are asked to "come back in" at short notice if sudden spikes in demand or absences of workers due to illness or emergencies occur. All of this further undermines work-life balance and rest periods in a sector in which some unsocial work hours are inevitable.

Indicators such as the expectation to stay in one's job (or in the profession) until retirement or thinking about quitting are thus frequently used and interpreted both as indicators of poor working conditions and OSH risks and as warning signs of further labour turnover. Similarly, the concept of "missed nursing care" indicates both job and care quality and is likely to affect patient as well as worker outcomes. These concepts enable unionists especially to connect poor job quality with challenges to "the system" that impact the general public, patients and voters and thus to add political weight to the interests of healthcare workers.

Two unionists and works councillors cite the study by Gferer & Gferer (2021) with its 45% of nurses thinking about quitting the profession. One comments,

„If I owned a company and half of my employees say, once a month they think about quitting, I would consider that a risk“ (Intv9_health_union, Pos. 108).

Another sees that this evidence indeed has an impact in the organisation, a large province-level health provider, and in policy at large:

„And that led to an outcry, because it was said, we need to look more into that“ (Intv2_health_union, Pos. 28).

However, unionists point out that people thinking about job alternatives do not necessarily leave the profession but look for possibilities with more predictable schedules – one more reason for employers to improve working conditions:

“We don't have the sense that everybody wants to quit but they are looking for alternatives. They look for fields within nursing that are less demanding, less stressful. [...] used to be, when you went home, nursing was over for you for the day and now, it catches up with you too fast. You may have three days off, and on the second day it may happen that you get the call, can you fill in, and that for many people is the real reason to either change the field within

³⁴ <https://www.oegb.at/themen/gesundheit-und-pflege/pflege/gastkommentar--nur-halbherzige-verbesserungen-in-der-pflege>

nursing, to somewhere with more security in planning. And if they don't find an alternative, they quit the profession. We have many [colleagues] who study psychotherapy on the side, or go into education, sort of getting 'away from the bed' (Intv2_health_union, Pos. 53).

This person and their colleagues are convinced that work has become more burdened which is also mirrored in the counselling activities of the organisation's psychological support services. They summarise the issues much in line with the data presented in section 5.1.1.

"We conducted this future workshop last year [2024] [...] in a world café setting. And the recurrent subjects were, constantly being connected, constantly delaying things, the high pressure at work, especially of those working with patients, and in long-term care, pressure by relatives, because their demands have increased or have become harder to fulfil" (Intv2_health_union, Pos. 31).

5.3.1 Staffing levels and unpredictable schedules

Unionists and other sector experts see insufficient staffing levels as the central challenge in working conditions and the root cause of high workloads and time pressure, unpredictable schedules and missed nursing care, all of which amount to psycho-social risk:

"This creates psychosocial risk because you're always told, yes, you have to prioritise. Yeah, sure, only, prioritise is what I should do in an emergency. [...] But if I enter a health profession, then I want to be able to do that job in a decent way on principle. If the system doesn't offer that opportunity, then every day I have a sense I haven't done my job correctly. You don't mind that once, twice, five times, or ten times. But in the long run that has an effect, because you go into work with a high ethos and that leads to permanent psychosocial stress. This is not a peak, peaks you can usually handle. [...] it's the basic stress level that causes these impacts. The colleagues, while working, keep in mind everything else they need to be doing and are aware that it won't work out. That eats away at people." (Intv9_health_union, Pos. 25-29)

In this context, "missed nursing care" (Cartaxo et al., 2022a, 2022b) on the individual and team level arguably reveals a dark side of discretion at work, which in OSH is generally considered a resource. If time and staff are lacking to do what is deemed necessary, discretion means that frontline workers themselves must ration care against their professional sense of work well done, painfully undercutting their own professionalism. A healthcare worker in the open comments section of the PSYR-IR survey (see section 6) described such a situation in their workplace and the resulting combination of exhaustion and sense of insecurity:

"Everybody has to do anything, staff shortages, mental strain, physically hard work, many sick leaves that aren't replaced, unpredictable schedules, many varied working hours",

"exhausted after each shift, pain, feeling depleted, a sense you have forgotten something".

Notably, improving staffing levels is more difficult than increasing pay levels, which in the hospital sector has occurred in recent years:

„that happened slowly, step by step, that pay schemes were revised. But going so far as to say, we're going to hire more staff, more qualified staff? There, the forces of economy are still too strong, that someone says, let's hire extra people now because we know that next year, two or more are leaving, that doesn't happen" (Intv1_health_verband, Pos. 25).

Since training capacities have been increased and some subsidies and stipends for training and retraining have been made available, unionists point out that now worker retention is the key to

rebuilding capacities in the sector. However, in Austria there are no general staffing ratios, and developing standards (or tools to arrive at standards) is a central political demand (see section 5.3.2):

„we have a few areas where there are staffing ratios but otherwise you can do what you want here, with the effect that you don't hire staff according to criteria of care quality but according to budget criteria. And the employer can't help it much, because he gets his budget, mostly from public finance. And we're lacking standards, criteria for the structure, for quality as well" (Intv9_health_union, Pos. 83).

"How do I know if the train is late? If there's a timetable that says, 10 o'clock the train has to arrive, then I know at ten past ten it is late. If I don't have a timetable posted, the train is never late. [...] The staffing situation in a hospital is similar. I have no standard so I can't say we're short" (Intv9_health_union, Pos. 94-98).

5.3.1.1 Increasing demand

Demographic change is also noted to increase workloads and time pressures as more elderly patients have higher needs for care. In addition, relatives and informal carers put increasing demands on care workers:

„people in hospitals are getting sicker. The health system says, you have to do more treatments extramurally, in primary care. That is all right, and well and good, but it means that people in hospital tend to be more severely ill than 20-30 years ago" (Intv9_health_union, Pos. 56).

That does not just imply higher practical care needs, but also more conversation and counselling, more work with relatives and more emotional emergencies – for which to handle, there is too little time as the studies on “missing nursing care” show.

5.3.1.2 Job (in)security

One positive effect of staffing shortages could be that job insecurity, another psychosocial risk factor, is no longer noticeable to works councillors in the hospital sector:

„concerns over job security – no one has that now in the [healthcare] system. People know that they've become rare earth, to compare it like that." (Intv2_health_union, Pos. 40)

Yet, job insecurity still shows up in research. We have seen evidence (section 5.1.1 and Schönherr 2021) that the lower-skilled, women and older workers (but also those who are confident of the durability of their skills) think less about quitting or changing jobs. This shows that even in a favourable labour market, not everybody feels they can confidently access available options. In turn, a sense of lacking alternatives if working conditions are not satisfactory may add to stress and psychosocial risk.

In addition, in large healthcare organisations ongoing restructuring, mergers and consolidation of hospitals can exert similar pressure on workers:

„and it is always said that a location closure for those affected is like hearing a close relative is dying. With all the emotions, fury, grief, until acceptance – and the problem with us is that it takes years, XX [location] has been closing for 15 years now and that is a massive burden for people: Then the younger or more flexible leave and people staying are those who say, they'll stay until the end and then lock up the place" (Intv2_health_union, Pos. 32).

5.3.1.3 Digitalisation

As staff shortages and the underestimation of absences in personnel planning render working schedules more unpredictable, digitalisation plays a particular part shifting the boundaries between formal and informal coordination and undermining regular (paid) work modes such as on-call duty:

„This unpaid on-call work, always being connected, that has increased with the mobile phones. [...] We are fighting WhatsApp and these messengers somehow, because [groups] are mostly founded to celebrate a colleague's farewell, and then, let's set up a WhatsApp group, and in no time at all, this is used as a work planning tool, where the head nurse writes, who can fill in, can you do that shift? And then they write to the whole group so the pressure increases for everyone. [...] that's not supposed to happen, and that's a really urgent issue for us [works councils]” (Intv2_health_union, Pos. 42-44)

This mechanism of using (private) mobile phones for ad hoc shift planning has also been described for the cleaning sector, another short-staffed industry with real-time demand (Sardadvar & Holtgrewe, 2017). However, with ever more everyday communication running through messenger apps, it becomes more difficult to ignore such messages. Works councillors are thus trying to abolish the (informal) practice on the organisation level.

Yet, works councillors in health do see potential for digital and AI-based support of tasks, especially in documentation, a generally unpopular and time-consuming task among nurses and other careworkers. Experts give examples of specific tools and improvements that are considered helpful rather than large integrated systems: Tools that feed data directly from the patient's location into the organisation's information system are promising, such as a “digital fever curve” that is being introduced in one organisation. Replacing handwritten notes, especially by doctors notorious for their handwriting, with digital entries reduces mistakes and time spent on deciphering them.

However, documentation has been a job quality issue in health and care for a long time and the question remains why digital tools so far have brought limited gains in lowered workloads. Asked about this, one works councillor points out,

“I think a hospital in some areas is well capable of change, in others, not so much. Partly, it will be high investments. Partly, the training effort will be very high, and digitalisation isn't an immediate priority. But I can't be sure. Generally, hospitals tend to be slow to change” (Intv9_health_union, Pos. 66-67)

There may also be an incumbent bureaucracy and the multiple levels of governance and funding that multiply demands on healthcare organisations.

“[Bureaucracy:] I know, we are all suffering from that. You mustn't use fax any more to communicate diagnostic findings. Nor e-mail, and there is no system. They're sent by mail currently. So yes, the many stakeholders, no one is the bad guy, it's nobody's fault” (Intv9_health_union, Pos. 68-69).

5.3.2 Unions' demands for policy

Regarding policy, unions predominantly address staff shortages, work schedules and working time reductions as well as training and social security. They argue that these structural challenges are key in preventing psycho-social risk at work as well as attracting and retaining workers in the sector, and the demands of workers in surveys reflect this priority (see section 5.1.2). In the sector, the typical employment relationship (and as we have seen, social partnership) is multiply embedded in other, interrelated modes of funding, governance, and interactions: (1) flows of funding, especially public funding by the state and funding by social insurances, but also some private expenses that impact resources and conditions at work, (2) state and professional regulation of training,

responsibilities, and professional hierarchies that affect discretion and social recognition of working in the sector, (3) characteristics, needs, demands and challenges of patients in the respective (sub-)sector and not least the role of informal carers in managing care, bridging interfaces and filling in gaps. Hence, unions' demands cannot simply address employers as if they had full discretion over their investments, priorities, quality standards and so on or were just reacting to a market.

In cooperation with all unions in the health and social care sector and the national union federation ÖGB, white-collar union GPA Vienna in 2021 launched a consultation on ways to improve working conditions in care (Haberl & Schwanter, 2022). This outlined several demands on staffing levels, pay increases and training: Notably, working time reduction in a general sense (moving towards a 35-hour work week) was deprioritised in the light of the staffing shortage. The primary aim in relation to working time was defined as "working schedule security" with (more) predictable schedules. This was seen to require a

"timely increase of staffing levels on the basis of newly calculated, and binding staff ratios that would primarily take care effort and the professional logic of the nursing professions into account" (p. 22).

In the unions' view, current staffing ratios underestimate absence rates at typically 20%, which delays replacements and increases workloads of remaining workers. Current planning tools (implemented on the province and subsector level) do not mirror all tasks³⁵ adequately.

Pay increases were demanded across all segments of care, and the alliance suggested a "best practice model" that would integrate the range of collective agreements along the lines of the currently best pay systems and decrease pay differences between fields and employer types.

In training, financial support of training and retraining was demanded as well as improved possibilities to upgrade skill, enable retraining, and provide dedicated time resources for on-the-job instruction of trainees.

One recent political success with the new government in Austria is the recognition of frontline nursing as "heavy labour" in the pension system. This under certain conditions (still to be specified) allows for earlier than the statutory retirement without deductions of the pension.³⁶ This was demanded by unions in 2023 and taken up in the programme of the new government in 2025.

5.3.3 Addressing staffing and work schedules on the organisational level

Works councillors report that their organisations address staffing shortages and work schedules. The large regional healthcare provider of Interviewee2 is increasingly focusing on staff retention:

"Recruitment is the one thing, but the other is retention, and retention has really come into focus. Used to be they said, well, go find something else then, and now they're really trying everything to make sure people are staying" (Intv2_health_union, Pos. 32-37)

To improve the predictability of work schedules and limit requests to fill in at short notice, regional providers are introducing standby pools and some are shifting budgets for overtime into funding such positions that prevent ad-hoc overtime demands. For emergencies, hospitals have increasingly been using the instrument of hazard notifications: if care cannot be provided safely, beds or entire wards can be closed temporarily. However, general improvements in staff ratios or extra time allowances for training and management so far have not been introduced (Haberl & Schwanter, 2022).

35 That is, direct care, administration, working with patients, "emotional labour", and interdisciplinary coordination, training and supervision.

36 <https://www.youunion.at/themen/gewerkschaften-bekaempfen-benachteiligung-des-gesundheitswesens->

The organisation of Interviewee2 has also agreed on a bonus of EUR 130 for staff filling in if changes are made to the work schedule less than two weeks ahead. Healthcare unions generally agree that “filling in should cost something” (Haberl & Schwanter, 2022, p. 5):

„now, that doesn't solve the problem itself, because that's connected with the shortages of skilled staff which currently affects all of Europe. But at least we wanted that to be paid adequately” (Intv2_health_union, Pos. 5).

They confirm that addressing staffing shortages and currently implemented solutions take priority over the unions' wider ambitions regarding a general reduction of working hours.

In the healthcare sector, the calculation of working hours is different from other sectors: covering 24/7 hours is inevitable, and (depending on the collective agreement) public holidays do not always reduce the hours a worker needs to cover. If staffing levels are low, shortening contracted working hours either increases work intensity to potentially unsafe levels, or increases overtime. This increases income, but for the unionists interviewed is still a second-best option, as they generally are aware that psychosocial risk cannot simply be compensated in monetary terms.

„It's very funny I should say that. But we must move away from the financial aspect, that it is always money that solves the problem, because that has its limits. Employees themselves feel that they're receiving damage compensation, that hasn't got a long-lasting effect and then the problems you've had for years are popping up again“ (Intv2_health_union, Pos. 17).

Another works councillor insists that worker voice should not be neglected in scheduling:

„Approach people in a communicative way, take it into [...] consideration if colleagues tell you this, this schedule, I simply can't handle that. There are people who like taking a lot of night shifts, others can't do that so well. There is much more attention to that than 20 years ago“ (Intv9_health_union, Pos. 15).

Paying attention to individual needs and preferences is thus not just necessary for working climate reasons but may also mobilise capacities.

5.4 “Conventional” psychosocial risks and social partner initiatives

Work intensity, staff shortages and unpredictable work schedules are consistently perceived as the key issues in the healthcare sector and the root causes of psychosocial risk. Yet the risks that more directly impact mental health also receive attention.

5.4.1 Difficult patients and violence at work

Healthcare is one of the sectors in which third party violence became visible as an issue well before the pandemic. In long-term care in Austria, 40-50% of employees were exposed to aggression and violence by care recipients and 20% also reported sexual harassment (G. Bauer et al., 2018, S. 36). This does not just affect regular employees in contact with patients:

„something that's hardly ever explored, is violence against agency staff. These Turkish cleaners employed by a subcontractor who are affected the same way as [the hospital's] own staff. That means, they have the difficulty on top that nobody cares. The works council doesn't feel responsible, they aren't part of the ward team, and so on. That means, there's a big black hole there“ (Intv3_health_labour, Pos. 63).

One public sector healthcare provider ran a large study in 2019 on violence and aggression with some 7,000 of 30,000 potential participants, a response rate the organisation took as indicator of the size of the problem. Beyond third party violence respondents noted high pressure exerted by managers, which might escalate into verbal violence.

“So right now, we also focus on this subject inside, because we must address that collectively, together with the employer, so I’d say, it’s really come into the focus in the last 5-6 years” (Intv2_health_union, Pos. 10)

A regional Chamber of Labour is commissioning research and offering information and workshops to healthcare providers which resulted in inhouse programmes.

“And we [the Chamber] acted as accelerators, because a few things were promised to us by management, and they said this has been implemented already, and then we checked up if that was the case. Then I made works councillors aware that that wasn’t so. But slowly, it’s getting better and they are doing a bit more on their own initiative” (Intv3_health_labour, Pos. 15).

In another hospital, an emergency support was introduced through a speed dial number where workers being harassed or attacked could receive immediate intervention and help.

5.4.2 Poor communication and leadership

Although the ESENER survey showed a limited occurrence of poor communication and leadership in the Austrian healthcare sector and a supportive “team climate” appears to mitigate many pressures (see sections 2.1.1 and 4.1.1) poor communication still exists. One factor is the professional hierarchy between doctors and nursing staff which is traditionally stronger in German-speaking countries than in countries where skill upgrading and tertiary education of nurses have a longer history.

„I’d just mention one profession, also known as the „gods in white“ who still perceive us as ancillary staff and don’t want us to work autonomously and under our own responsibility. That creates a lot of conflict in working and contributes to psychosocial risk. Because you’re doing your best every day but don’t get any appreciation“ (Intv1_health_verband, Pos. 13).

In such configurations, the expansion of nurses’ competencies as foreseen in the “care reform” can be seen ambiguously: it may both add to the workload of nursing staff and smoothen workflows, but does not always fit organically into developing professional roles. A similar ambiguity was found in the introduction of return interviews after (longer) illness in one healthcare provider. The intention was for management and the worker affected to explore ways to rebuild and sustain that person’s ability to work and any adaptations that might be needed.

“That is generally well accepted but still needs some work. Very many people feel it as additional pressure to be able to work or to have to function. And that’s very much dependent on how the manager communicates that or interprets it. Because the intention is not to exert pressure. So I think the subject of leadership now is one of the big issues, because we notice, where they speak the same language and work together people like to stay, they stay longer and are a lot more resilient in the light of these risks.” (Intv2_health_union, Pos. 64)

Indeed, in spite of the general awareness in the sector that employers claimed in the ESENER survey, respondents in the PSYR-IR survey comment as well that in their workplaces

“it is up to everyone by themselves to look after their mental health”.

Another healthcare worker, most likely in mobile care, notes some disregard of workers' objections in management decisionmaking:

“overall carelessness of the employer in assigning tasks. We care for seniors under time pressure and have much expertise there. All of a sudden, we are assigned the care of a diabetic two-year-old. If we draw boundaries and show some responsibility doing so, this is regarded as timidity”.

5.4.3 Vulnerable groups

The health and care sectors are generally known to be specifically affected by psychosocial and also physical OSH risks (see section 2.2.1). Within the sector, experts and researchers agree that mobile care carries specific risks regarding difficult clients and possible violence as well as unsafe work environments where supportive equipment may be unavailable and even electricity installations and household equipment may pose dangers. Indeed, the Labour Inspectorate already ran a campaign on mobile care from 2013 to 2016 (Kloimüller, 2025). In addition, mobile workers in care by definition spend less time on-site and with colleagues and are thus less reachable by works councils. This may intersect with the size of the employer:

„If a large provider offers mobile care or domestic support or something, then of course, they have trainings, instruction and everything. But the many, many others, associations or something, these are certainly groups exposed to high risk, from physical factors with poor ergonomics in households to psychosocial risk, harassment, discrimination, exploitation” (Intv7_osh_xp, Pos. 80).

As in OSH at large, more precarious or atypical employee groups generally are likely to face higher risks, due to mobile working, agency working, outsourced functions such as cleaning, or self-employment, for example in live-in care. For them, company initiatives, risk evaluation and the responsibilities of works councils generally do not apply, and their exposure is hard to assess. Not least, these groups of workers are harder to reach by surveys and other research methods.

5.5 Addressing psycho-social risk in the sector

5.5.1 The organisation and workplace level

In large organisations in the healthcare sector, experts see improvements in the obligatory risk assessments, not least because the Labour Inspectorate set some priorities in healthcare during and after the Covid-19 pandemic. Yet, as in Austria generally, the continuous improvement logic of the law has not entirely been taken on board in the sector:

“I’m supporting many of the large providers and they’ve all been inspected, whether they do the assessment, do it properly, plus, if they’ve included the issues resulting from Covid – so control has improved and the awareness that they must do the assessments. Implementation is slower. [...] I mean, that’s subjects that take longer, it’s not just staffing shortages, it’s cultures that have taken long to develop and that persist. But the large providers all have staff assigned to the risk assessment and trained them. They conduct the assessment; but the second, third and fourth step, to get into the implementation, that takes a while (Intv7_osh_xp, Pos. 15)

According to the representative of a professional association, SME providers of nursing care also make frequent use of the free services of AUVA to assess and mitigate psychosocial risk. There are

also SMEs that explore new organisational models such as Dutch Buurtzorg which aims for participation of both care recipients and carers in organising mobile care (La Marca, 2023). Another expert sees a difference between private sector and public sector providers in one Austrian region:

“Private hospitals. There, top management had an interest. In the public sector I didn’t see so much of that from the employer side. They react to needs and demands but moving forward and taking charge of the subject, I didn’t notice that in [the region]” (Intv3_health_labour, Pos. 24)

5.5.2 Individual support

Several employers have initiatives that provide individual support by psychologists, psychotherapists or supervisors. Making this accessible generally in healthcare and ensuring anonymous access is a demand of the professional association’s representative. The reason is that

“in nursing this is often viewed negatively. And you have to take the official path. Well, and then everybody knows, oh, I have a problem, and I want supervision. This needs improving that you say, here’s a list of supervisors, you can go there anytime if there’s a problem. And that lady then invoices one [therapy] unit to the employer, and not, who it was” (Intv1_health_verband, Pos. 54).

Such a model had been implemented since 2000 by a large regional healthcare provider.

“But this was hardly known in the organisation and hardly anyone used it. So, you always heard, there’s nothing and no one for us to turn to in an emergency. [...] And then the colleagues paid a lot out of their own pockets to afford these hours [of counselling]. And we [the works council] said, let’s make this more public, and from 2019 onwards, we really put some effort in” (Intv2_health_union, Pos. 9).

This provider has both a long-established inhouse psychological service and a network of external counsellors in case employees prefer that. 20 hours of first treatment are provided and more is possible on demand. In addition, the organisation has trained workers in peer support, known as „mental health first aid“, that is, low-level interventions for stresses and emergencies. In another hospital, a similar project was launched during the Covid-19 crisis:

“We work with work psychologists and psychologists in the market where you can take a therapy anonymously. You go there with your employee ID card, and the therapists invoice the hospital anonymously. Originally that developed because in the crisis, stress factors were so high. And it was a bit – some colleagues had difficulty admitting that. Partly, you still live in a world, where ‘you just have to bear it’. So, this was a super project in the crisis, and so far, we’ve kept it getting funded. The organisation is behind it and uptake is excellent” (Intv9_health_union, Pos. 36-41).

In addition to anonymous access to counselling, the professional association would also like more informal formats sometimes along the lines of “mental health first aid”:

“in practice, for a nurse, it’s very easy if you have a person on the team that helps with that, that you don’t need to talk to the ward manager and make an application but there’s a person I can go to anytime if something’s wrong. This low-threshold approach, we’d need to develop that, for young people, maybe a chat, whatever, where you can write your question and a psychologist or other mental health professional answers, I think they could be well reached by that” (Intv1_health_verband, Pos. 54).

Although experts say that workers in healthcare have become more aware of the psychosocial risks of their work, they still observe some stigma attached to mental health issues and a habitual attitude of self-sufficiency and not seeking help for oneself as a carer. Another healthcare expert at a panel discussion on nursing organised by the private sector union vida, pointed out that this appears to be both an individual and collective obstacle to mitigating psycho-social risk:

“I’d like to teach the profession to say no and not do everything all the time” (Vida-7Apr25, Pos. 22)

5.5.3 Future agendas: participation, empathy and supportive management skills

As in the field of OSH generally, works councillors and unionists in the health sector think about ways to better involve workers directly. While awareness generally has increased and organisation-wide initiatives have been launched, Interviewee 2 aims to target more specific problem areas in their organisation such as work situations with high turnover.

Interviewee 9 explored ways to increase the hours worked by part-time workers to mitigate staff and skill shortages. The background is that in early 2025 in Austria, Conservative politicians and some economists and consultants started a debate on the “fairness” of part-time work in the light of staffing shortages, strained finances in social and health insurance and the impression that younger worker cohorts take a higher interest in work-life balance.³⁷ They suggested increased social security contributions for part-time workers who did not have care obligations, framing “work-life balance” as a personal and somewhat selfish choice rather than a right and trying to reassert full-time employment as a norm. Indeed, in healthcare, older workers (who are less likely to look for alternative employment) tend to reduce their working hours for mental or physical health reasons if they feel they can no longer handle full-time work.

While agreeing that part-time workers may offer a labour reserve to fill gaps, interviewee 9 points out:

“If ten 25-hour workers increased their working hours to 30, I’ve also gained 50 hours. That’s more than one full-time equivalent, and then they still don’t need to work fulltime” (Intv9_health_union, Pos. 123-127).

However, this would require a “*more empathetic approach*” of employers and policy than blaming part-time workers, such as actually asking people “*what do you need [to be able to work more hours]?*”.

“The well-known subject of appreciation also means that if I want someone to do something, how do I talk to them? How do we cooperate? Just increasing the pressure won’t have much effect” (Intv9_health_union, Pos. 139).

This interviewee would like units in the organisation to recover a team spirit of interdisciplinary cooperation, make sure to get rid of tasks done ineffectively with some digital support. Improving leadership to be able to listen and involve the team would also be central. This will require more support for managers as well:

“They have been trained once to take leadership positions, but I think afterwards they are left quite on their own with their challenges and hardly find any support. So, I think with ongoing training for management you can improve things, such as, how to handle difficult situations,

37 <https://www.derstandard.at/story/3000000254622/debatte-nach-sager-von-mikl-leitner-ist-teilzeit-asozial>

high rates of absences, how to look why turnover in some unit is high". (Intv2_health_union, Pos. 62)

6. The PSYR-IR survey in Austria

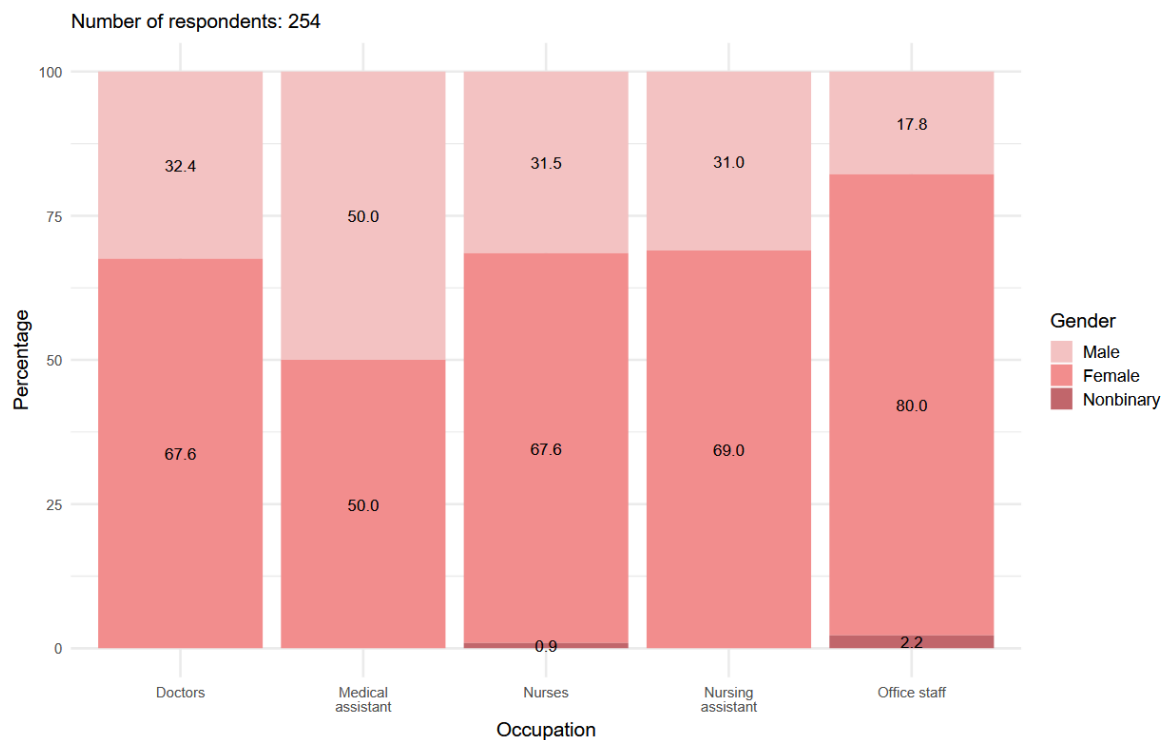
6.1 Sample Description

The PSYR-IR survey for Austria was translated into German from the English version and questions were adapted to focus on the health sector. It was distributed through interview partners from the labour side (n=187) and through the surveying company Norstat (n= 76). The total sample consists of 263 respondents who completed the survey. Of these, 183 identify as female, 76 as male, and 2 as nonbinary or other; the remainder either preferred not to say or did not provide gender information. In terms of age, 49 respondents are under 35, 74 are between 35 and 44, 80 are aged 45 to 55, and 60 are over 55. By professions, the sample includes 73 doctors, 220 nurses, 13 medical assistants, 120 nursing assistants, and 82 office staff. Organisation types varied as well: 33 participants work in the private sector, 70 in the public sector, 83 in a joint private–public organisation, and 62 in the not-for-profit or NGO sector. Any differences in totals are due to missing responses or individuals choosing not to disclose certain information.

Table 2: Sample composition of the Austrian survey

	Frequency
Gender	
Female	183
Male	76
Nonbinary	2
Age	
<35	49
35–44	74
45–54	80
55+	60
Organisation type	
private sector	33
public sector	70
joint private-public organisation	83
not-for-profit sector or NGO	62

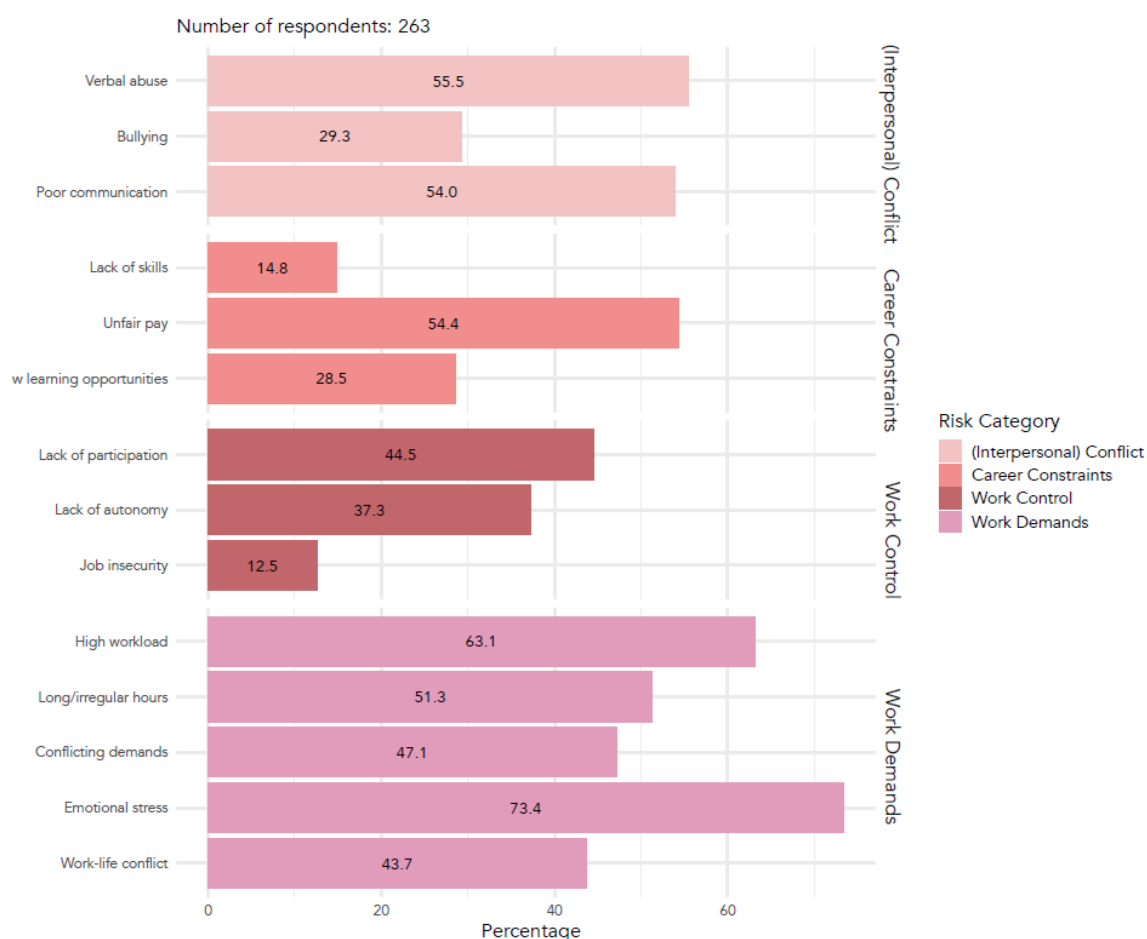
Figure 1: Occupation type by gender



The distribution of occupations differed by gender (Figure 1, n = 254). Two thirds of nursing and physician roles and four fifth of office roles were filled by women, with 67,8% of nursing assistants and 67.6% of nurses identifying as female as well as 67.6% of doctors,. The highest share of men was found among medical assistants (50%). Nonbinary and other or non-disclosed gender identities were represented in very small numbers across all job categories, limiting interpretation.

6.2 Psychosocial Health Risks

Figure 2: Exposure to various psychosocial risks



Altogether, 96% respondents were exposed to at least one psychosocial risk (see Figure 7). This is well above the data of the Austrian Labour Force Survey, where overall 74% of healthcare workers reported at least one psycho-social risk (Statistik Austria, 2022, p. 48). Exposure to psychosocial risks is highest among doctors and medical assistants, closely followed by nurses and nursing assistants (Table 3). Across any occupational group, more participants were exposed than in the Austrian Labour Force Survey (Statistik Austria, 2022). In that study, at least one psychosocial risk was reported by 89.7% of nurses, 79.8% of doctors and 71.6% of care workers, while 24.9% of workers in health and social care reported exposure to three or more risks (Statistik Austria 2022, p. 48f.).

Table 3: Participants reporting at least one PSR, by occupation

Occupation	n	%
Doctors	37	100
Medical assistant	7	100
Nurses	106	98.1
Nursing assistant	57	96.6
Office Staff	41	91.1

In our survey, among psychosocial risks (Figure 2, n = 263), the most reported issues included emotionally disturbing situations (73.4%), high workload (63.1%), and verbal abuse (55.5%). Unfair

pay (54.4%), poor communication (54%) and irregular working hours (51.3%) were also reported by more than half of respondents. The lowest exposure was reported for job insecurity (12.5%) and lack of skills (14.8%). Statistik Austria's figures were similar (ibid.): Among healthcare workers, 59,4% reported difficult situations with clients and 66.3% of nurses and 61.5% of doctors reported the risk of work overload (ibid.).

Exposure to psychosocial risks varies by both age and gender (Figure 3, n = 253). Younger respondents (under 35) reported higher exposure to irregular working hours (although the 55+ age group was also close), high workload or pressure, and inadequate pay. Poor communication affected workers under 45 more than the older cohorts. Those aged 55 or older reported higher exposure to harassment and a lack of participation or involvement more often.

Women reported greater exposure to risks than men in six out of fourteen domains, including verbal abuse, high workload, and emotionally disturbing situations (which, however, were the most reported risk among men as well). Men more often reported poor communication, long or irregular working hours and high workload.

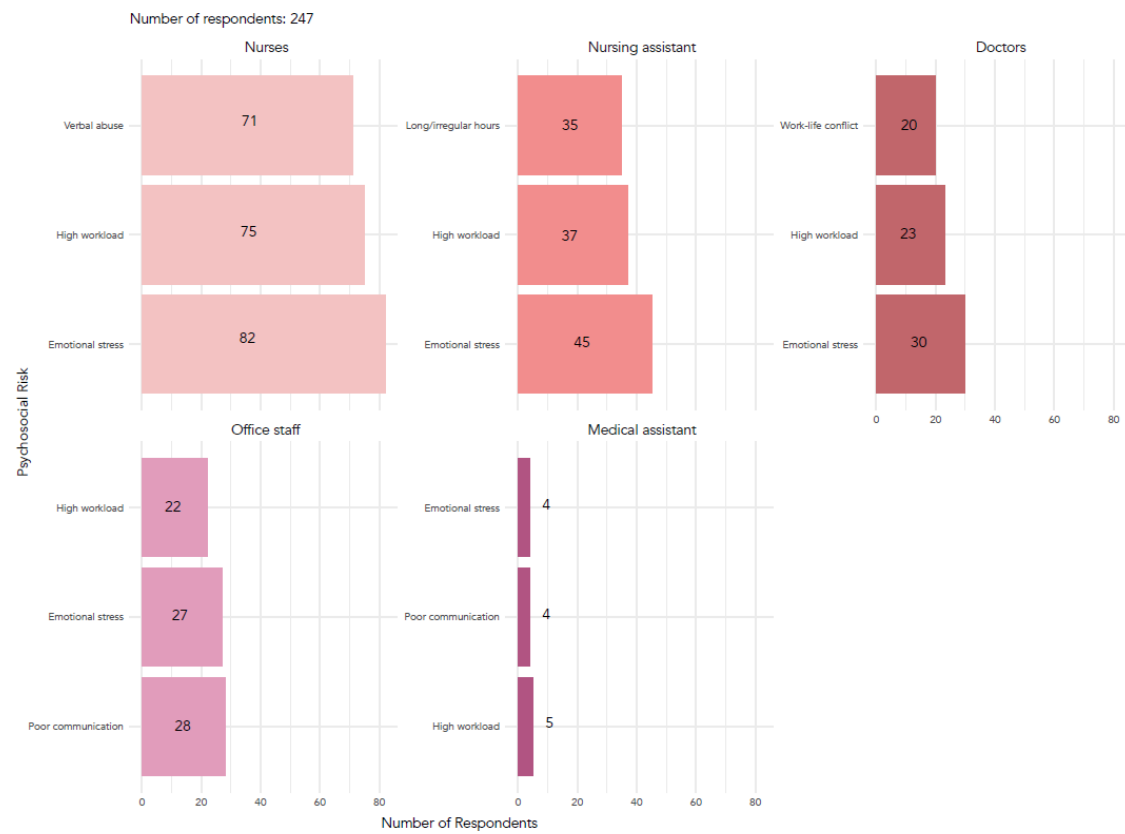
Figure 3: Exposure to psychosocial risk by age and gender

Number of respondents: 253



Looking into psychosocial risk exposure by occupation (Fout! Ongeldige bladwijzerverwijzing., n = 247), high workload and emotional stress figured among the three most-noted psychosocial risks in all occupational groups. As the third most reported risk, nurses mentioned verbal abuse, nursing assistants reported long and irregular working hours, and doctors encountered work-life conflict. For both office staff and medical assistants, poor communication was an important stressor.

Figure 4: Top-3 psychosocial risks by occupation



6.3 Health and wellbeing outcomes

6.3.1 Engagement and Exhaustion

In the survey, asking about engagement and exhaustion shifted the focus from psychosocial risks to work-related outcomes for health and well-being: engagement captures how often respondents find themselves energised, enthusiastic and immersed in their work. Exhaustion measures the frequency of mental exhaustion and emotional detachment, as well as cognitive and emotional difficulties in relation to work. Exhaustion was measured in the survey using the ultra-short version of the validated Burnout Assessment Tool (Hadžibajramović, E. et al., 2024).

Figure 5: Engagement vs exhaustion by occupation



In our survey, engagement levels were relatively high, with a mean score of 3.7 on a 5-point scale. In contrast, exhaustion appeared to be on the lower side, averaging 2.3 across all respondents. Always or regularly, 5% reported that they felt they had no control over their emotions at work, 10% struggled with concentration, and 20% reported a lack of enthusiasm. About 20% indicated they often or regularly experienced mental exhaustion. On the other hand, over half of respondents said they always or often felt energized at work, nearly 65% felt enthusiastic, and 77% reported being immersed in their work. Full results are provided in the Tables 2 to 4 in the Appendix.

Overall, engagement and exhaustion are negatively correlated, although it is individually possible to be both engaged and exhausted. Occupation was not a clear factor in reported engagement and exhaustion levels, as shown in

Figure 5 (n = 251). Yet, nurses and nursing assistants exhibited above-average levels of exhaustion with a mean exhaustion index of around 2.5.

6.3.2 Self-Reported Health

Overall self-reported general health offers insight into the health impacts of psychosocially challenging work, also allowing for the psychosomatic aspect in other health conditions such as

musculoskeletal disorders. On average, self-reported health was 3.6 on a 5-point scale, where 5 indicates very good and 1 indicates very bad. Most respondents said their health was good (roughly 40%) or fair (36.1%). When looking at mental and physical health separately, 66, 5% of respondents reported stress, depression, anxiety or sleeping problems, and 89% of respondents reported infectious diseases, bone or muscle pain, headache or eye strain, exhaustion. More details on self-reported health are shown in Table 5 in the Appendix.

As illustrated in Figure 6, self-reported health ratings differed only slightly across gender and age groups. Women were somewhat more likely to rate their health as “good” or “fair,” while men were slightly more likely to report “bad” health. Age-related differences were modest: respondents under 35 were the most likely to report their health as “very good,” whereas those aged 55 and older more often described their health as “fair.” However, these variations were small.

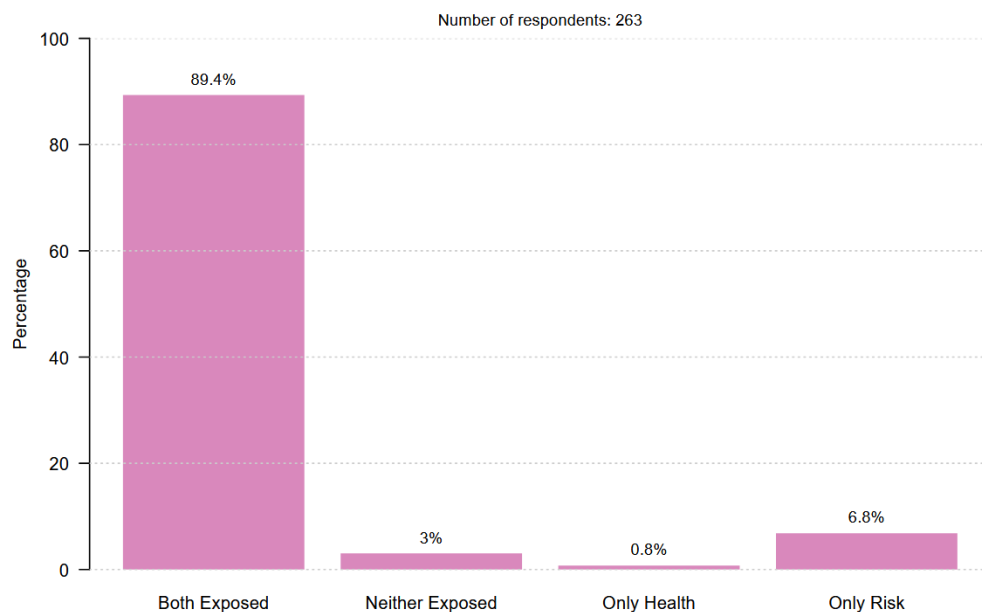
Figure 6: Self-reported health by gender and age



Nevertheless, 90.2% of respondents reported at least one work-related health problem. This is a high share compared with Statistik Austria data (2022) where in the health sector, only 15.2% were affected. In the nursing and care occupation, this rate was 20.7%. In the present survey (

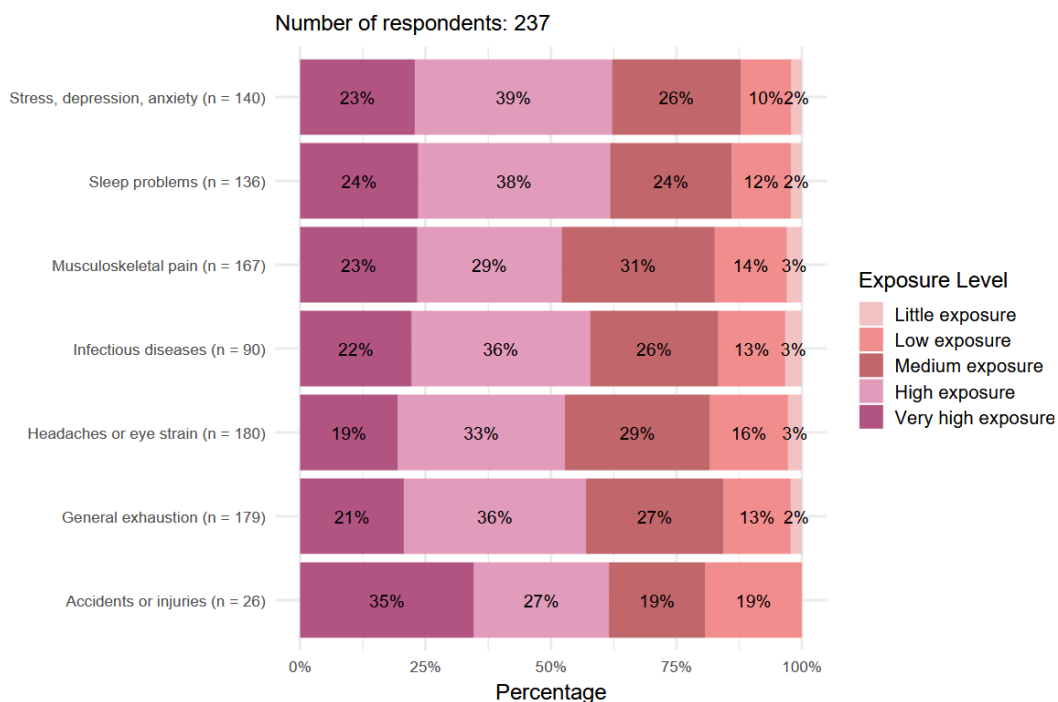
Figure 7, n = 263), the majority of respondents (89.4%) experienced both risk exposure and actual health problems. Only 3% reported neither risks nor health issues. A very small proportion (0.8%) reported health problems without associated psychosocial risks, while 6.8% indicated exposure to psychosocial risks but no resulting health complaints.

Figure 7: Exposure to psychosocial risk and health problems



When looking in more detail at work-related health problems (Figure 8, n=237), more than half of respondents who report to experience any type of these problems also indicate a very high or high exposure to psychosocial risks. Accidents or injuries stand out as the only type of work-related health problem associated with the majority of respondents reporting a very high exposure to psychosocial risks.

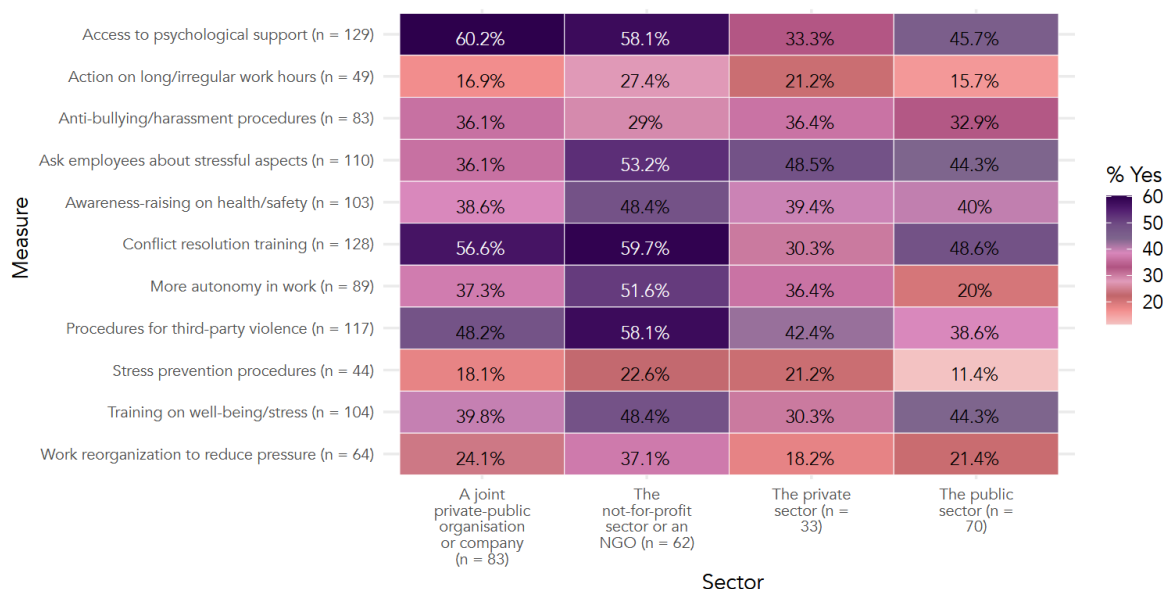
Figure 8: Work-related health problems by level of psychosocial risks



6.4 Organisational initiatives and cultures

6.4.1 Measures implemented in respondents' organisations

Figure 9: Preventive measures by subsector



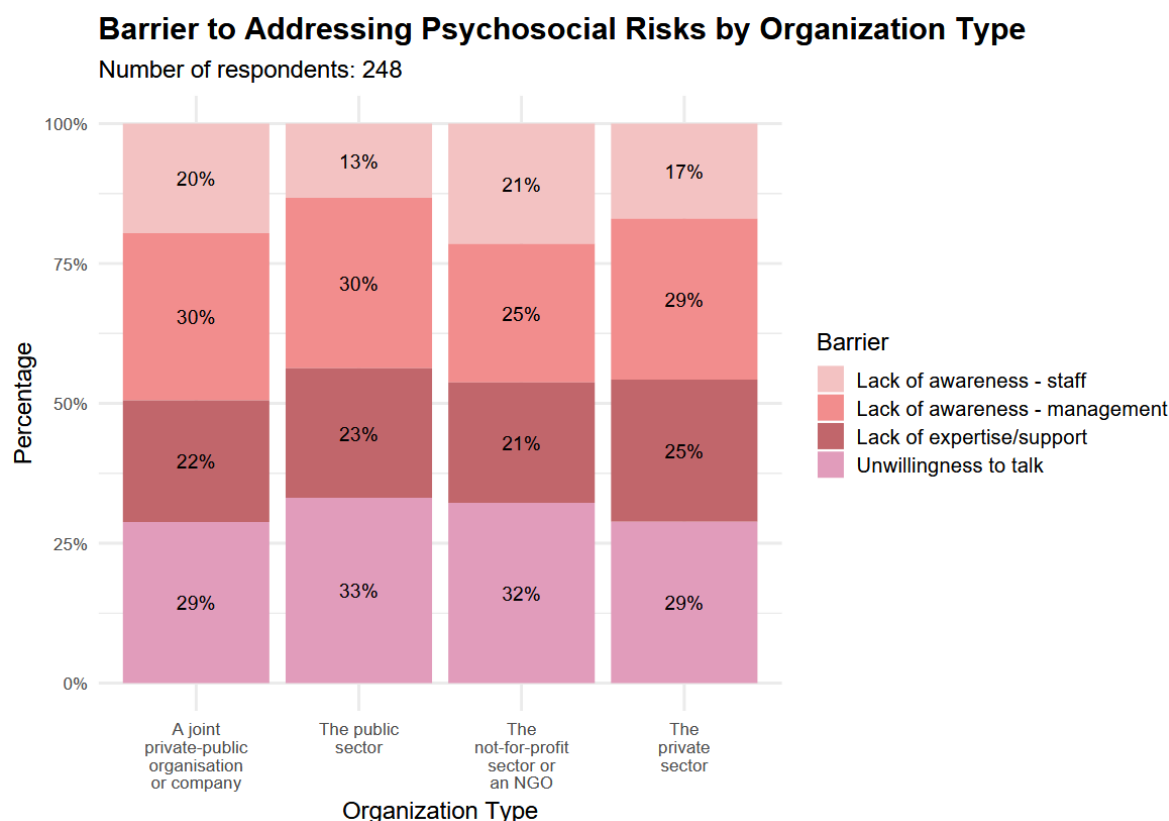
The implementation of psychosocial risk prevention measures in respondents' organisations varied across segments of the health sector (Figure 99). So, for instance, while 117 respondents reported the existence of procedures in their organisation in case of third-party violence, when looking at the distribution of this answer across subsectors, it ranges from 58.1% in the not-for-profit sector to 38.6% in the public sector. In general, employees of not-for-profit organisations and to a lesser extent joint private-public bodies were the most likely to report procedures in place, with the highest rates for access to psychological support (60.2% in private-public organisations, 58.1% in not-for-profit organisations) and conflict resolution training (56.6% in private-public organisations, 59.7% in not-for-profit organisations). In neither the public nor the private sector did more than half of respondents report any particular initiative in place in their organisation. Across the board, the least reported measures were stress prevention procedures, work reorganisation to reduce pressure, and action against long or irregular work hours. These interventions are more preventive and "systemic" than others in addressing the organisational causes of psychosocial risks but may require wider organisational changes.

Comparing these figures on organisational measures and initiatives reported by healthcare workers with those reported by Austrian employers in the sector in ESENER (see section 2.1.2) shows a notable gap in perceptions of employers and workers. Austrian healthcare employers appear to perceive more measures to be in place compared to what employees say. For instance, in ESENER 80.2 % of healthcare employers report initiatives addressing 3rd party violence, 73.7% measures to reorganise work to mitigate stress, and 62% interventions against overly long working hours.

This disparity may have several reasons: Firstly, the PSYR-IR survey is not representative and respondents, recruited through union channels, may have higher than average awareness of psychosocial risk and take a critical view of their employers' (lacking) efforts. Yet their places of employment are unlikely to have especially low adoption of prevention measures. Vice versa, employers in ESENER may have overrated their own engagement in psychosocial risk prevention, or our survey may capture that some employers are unsuccessful in making employees aware of ongoing initiatives. Also, employees' persistent workplace stresses and frustrations may overshadow

employer efforts. Both may hint at a prevention paradox: preventive measures may be in place (or not), but many individuals see little improvement of their own situation.

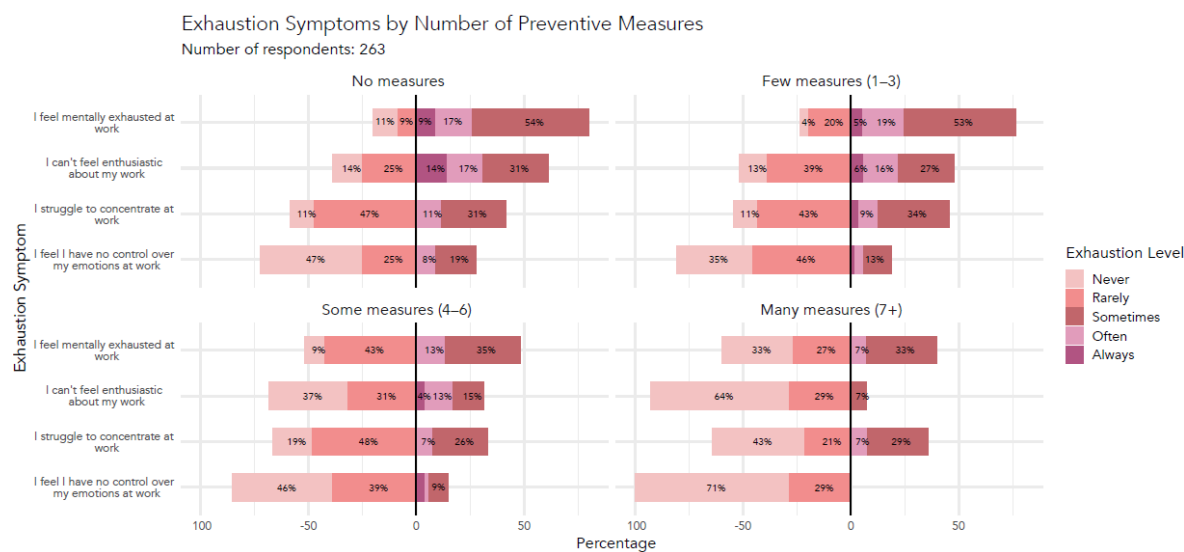
Figure 10: Perceived barriers by organisation type



Respondents (n = 248) were also asked about barriers to implementing psychosocial risk measures, with slight differences by sector, as shown in Figure 1010. The most reported barriers across all organisation types included a general unwillingness to discuss the issues in the organisation and a lack of awareness among management. Lack of awareness among staff was the least reported, between 13% and 21%, with the highest figures in not-for-profit (21%) and lowest in the public sector (13%). It is followed by lack of expertise or support, which was reported by between 21% and 25% of respondents.

Measures implemented in organisations do have a notable impact on health outcomes: The number of preventive measures in a workplace reported by respondents showed a strong inverse relationship with exhaustion symptoms (Figure 111, n = 263). Respondents in workplaces with many preventive measures (7 or more) reported substantially lower levels of mental exhaustion, emotional strain, and lack of enthusiasm than those with fewer or no measures. Only difficulty in concentrating did not decrease much with measures in place. In contrast, workplaces with few or no preventive measures had the highest prevalence of frequent or constant exhaustion symptoms. Notably, in workplaces with no or few preventive measures, more than half of respondents reported sometimes or often feeling mentally exhausted.

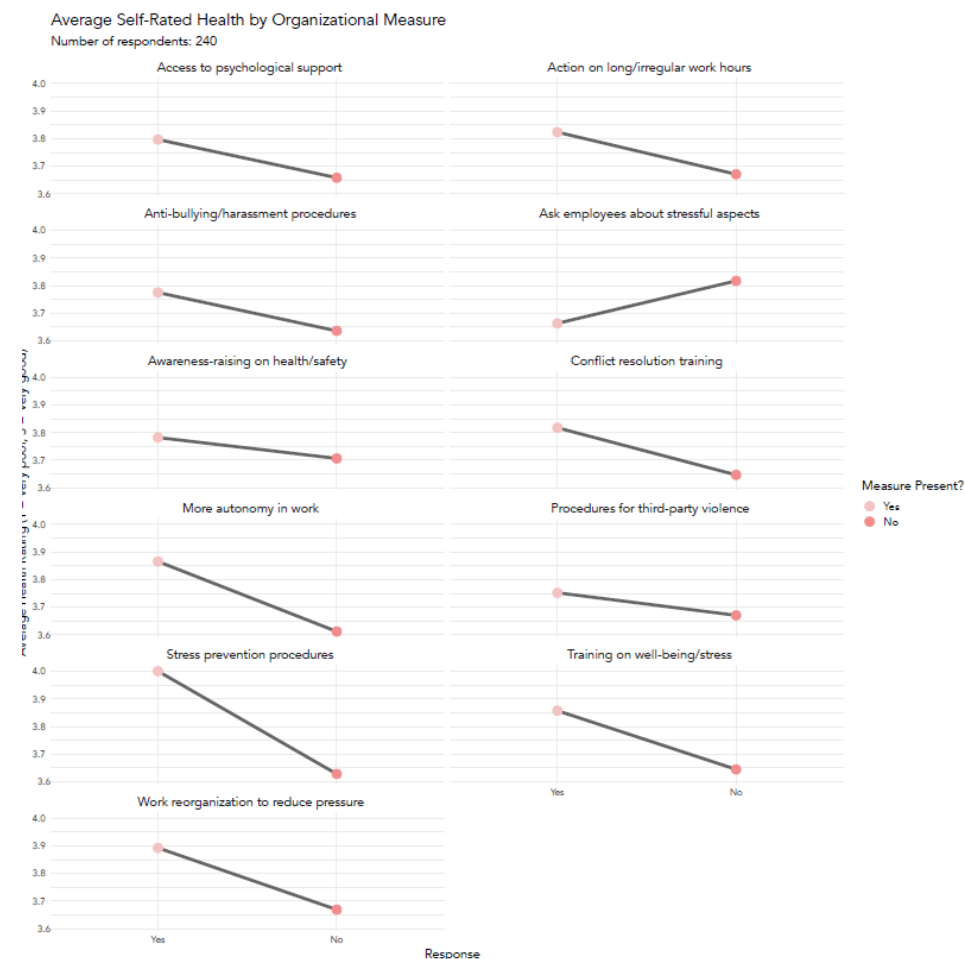
Figure 11: Exhaustion symptoms by number of preventive measures in the organisation



Self-rated health was also generally better among respondents in workplaces where psychosocial risk prevention measures were in place, shown in Figure 122 (n = 240). In the presence of nearly each intervention, respondents reported average health ratings between 3.8 and 4.0 (on a 5-point scale), compared to 3.6 to 3.8 in workplaces without those measures. Measures with more of a preventive focus such as stress prevention, work reorganisation to reduce pressure or increase autonomy in work have a stronger impact on reported health (above 3.8) compared with more reactive measures that tackle problems once they arise.

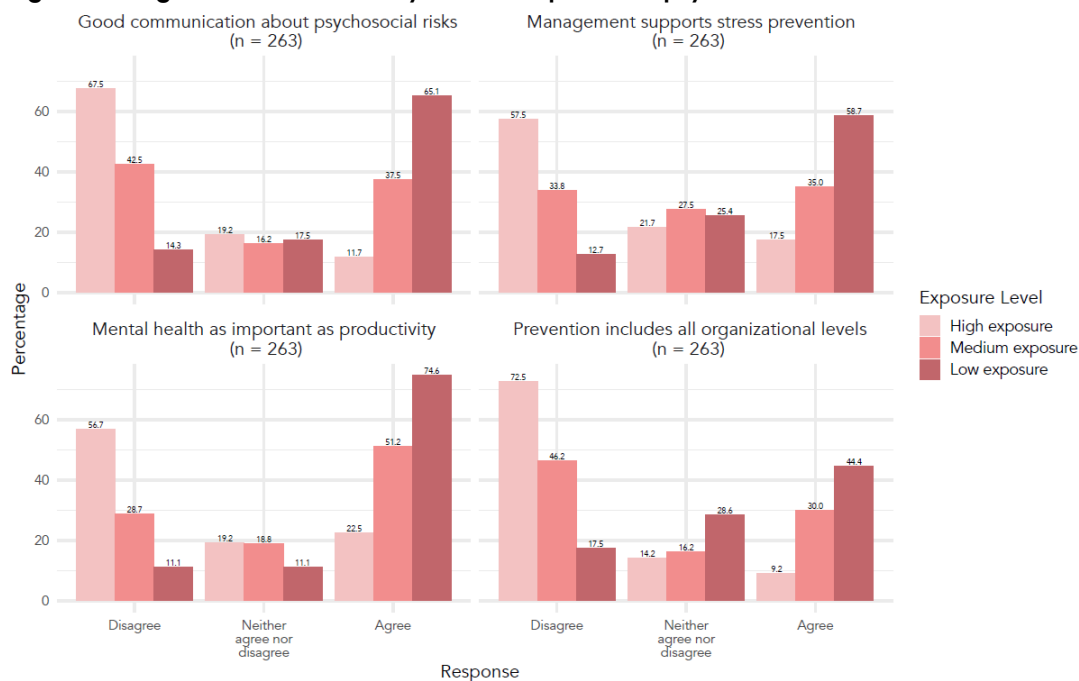
However, one notable exception was the measure to “ask employees about stressful aspects”: in the absence of this measure respondents reported slightly better average health than in workplaces places where feedback had been gathered. This exception could reflect a reverse relationship: since it is unlikely that asking employees about their well-being leads to poorer health outcomes, it is possible that organisations with higher levels of stress or poorer employee well-being are more likely to inquire about stress – but may not have implemented measures that improve employee health.

Figure 12: Average self-rated health by organisational measures



6.4.2 Organisational cultures

Figure 13: Organisational culture by level of exposure to psychosocial risks

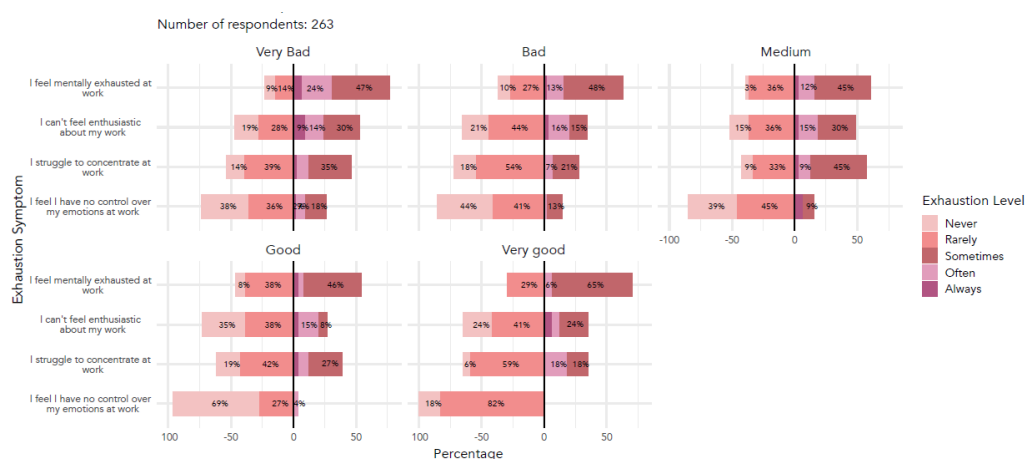


The survey also asked healthcare workers about their perception of the organisation's culture in paying attention to psychosocial health and psychosocial safety, captured by questions about the psychosocial safety climate in the organisation (cf. Dollard et al., 2019). Respondents were asked whether they agreed or not that 'their' organisation considers employees' mental health as important as productivity, that prevention involves all organisational levels, and/or that there is good communication about psychosocial risks in the organisation.

Our survey suggests that exposure to psychosocial risk and perceptions of organisational culture are associated (Figure 133, n = 263). Consistently, respondents who saw the organisational culture as supportive reported lower exposure to psychosocial risks. Conversely, those who did not perceive the organisation as supportive were more likely to report higher exposure. We cannot distinguish cause and effect here as those with higher risk exposure may well take a dimmer view of their organisation's culture, but there is clearly a strong inverse relationship between perceived organisational support and perceived risk exposure.

Exhaustion symptoms also varied substantially with the perceived organisational culture (**Fout! Ongeldige bladwijzerverwijzing.4**, n = 263). Far fewer respondents who "strongly agreed" that their organisation has a psychosocially supportive (i.e. "very good") culture reported exhaustion symptoms than among those who disagreed or disagreed strongly. Again, difficulty in concentrating was less affected. Indeed, of the group who felt unsupported (i.e. in organisations with a "very bad" culture towards psychosocial risks) more than half indicated they "often" or "always" felt mentally exhausted or lacked enthusiasm about their work.

Figure 14: Exhaustion symptoms by organisational culture

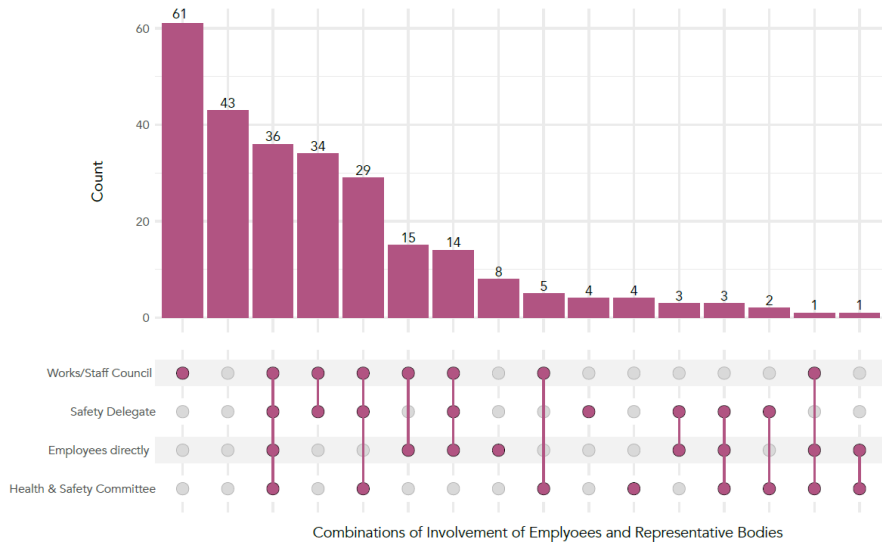


6.5 Worker representation and voice

Finally, we explore the influence of workers' representative bodies and direct worker participation on psychosocial risk exposure, organisations' measures of psychosocial risk management, and on outcomes for engagement and exhaustion. Figure 155 shows the reported involvement of employees themselves and of varied representative bodies in psychosocial risk management – notably not the existence of these bodies in the organisation (n = 263). 195 respondents reported that only the works council was involved, 125 a safety delegate, and 81 had an active health & safety committee in their

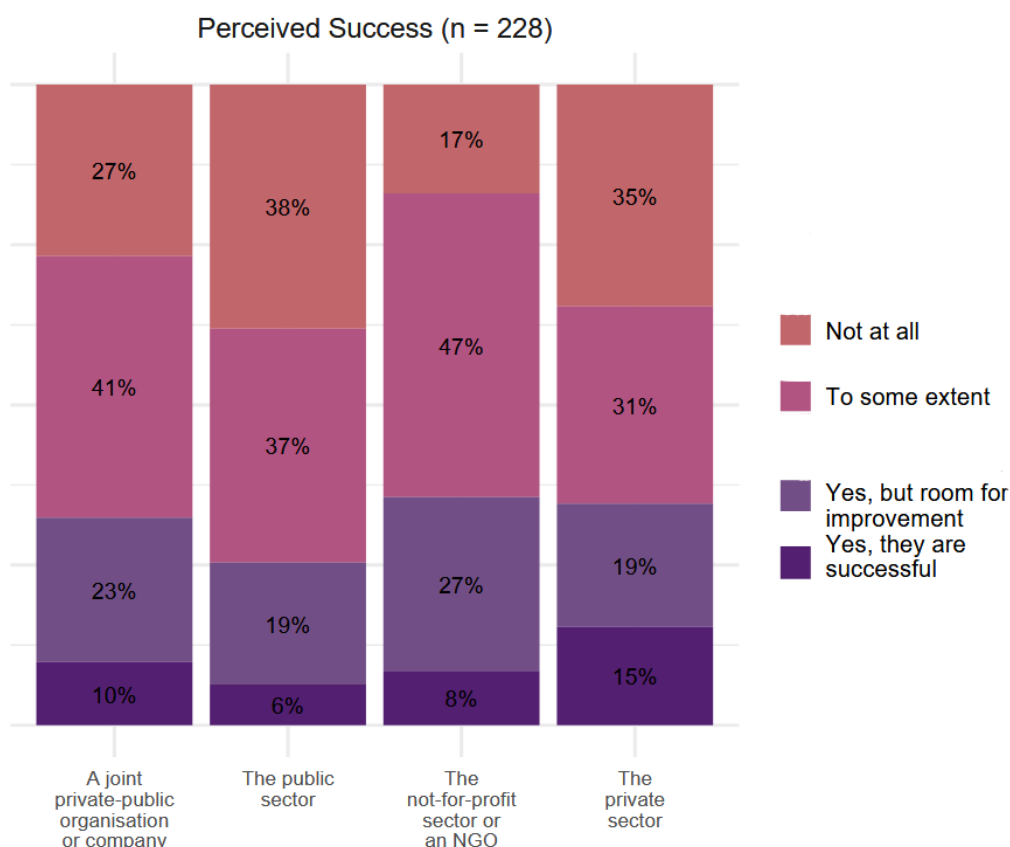
organisation.³⁸ 81 respondents said employees themselves actively influenced psychosocial risk management in their organisation. 43 respondents noted no type of worker voice active on psychosocial risks management (i.e. 16,4% of the total sample).

Figure 15: Presence of representative bodies and employee participation



38 The survey also asked about the involvement of union representatives. However, since union representatives have no statutory role in OSH in Austria, we could not interpret what respondents meant in assigning them a role. Hence, we are not reporting these figures which were close to those for works councils and may suggest that – in line with the sampling through trade unions – unions were generally present in the works councils.

Figure 16: Perceived success of worker voice by organisation type



Perceptions of the effectiveness of that involvement by workers and representative bodies (6, n = 228) vary across subsectors, but respondents generally are somewhat unenthusiastic. In non-profit (27%) and private-public (23%) organisations, roughly a quarter of respondents see success with room for improvement or full success. In the public and private sectors this share is notably lower at 19%, and both sectors also have the highest share of respondents reporting no success of workers' voice at all.

Figure 177 (n = 222) explores the relationship between worker voice in psychosocial risk management and the prevalence of reported psychosocial risks. For each representative body and for employees' direct participation, the chart shows the percentage of respondents who reported exposure to one or more risk in the key groups of psychosocial risks. Overall, the differences between bodies involved were modest, suggesting that worker involvement may not substantially alter the exposure to most risks – which may explain the skepticism about representative bodies' success found in Figure 16.

Figure 17: Psychosocial risk exposure by involvement of employees and representative bodies



However, one notable exception appears in interpersonal conflict: only 64.2% of respondents reported this risk when employees were directly involved, compared to higher shares when safety delegates (76%), health & safety committees (77.8%) or works councils (81%) were involved in psychosocial risk management. This may suggest that direct employee participation is associated with a perception of a more positive interpersonal environment, or that representative bodies have a part in raising awareness of interpersonal conflict as a psychosocial risk rather than a clash of personalities.

Representative bodies and direct worker participation make more of a difference in the presence of organisational measures to address these risks (Figure 18, n = 222) – and in this way, may have more impact than employees acknowledge or note.

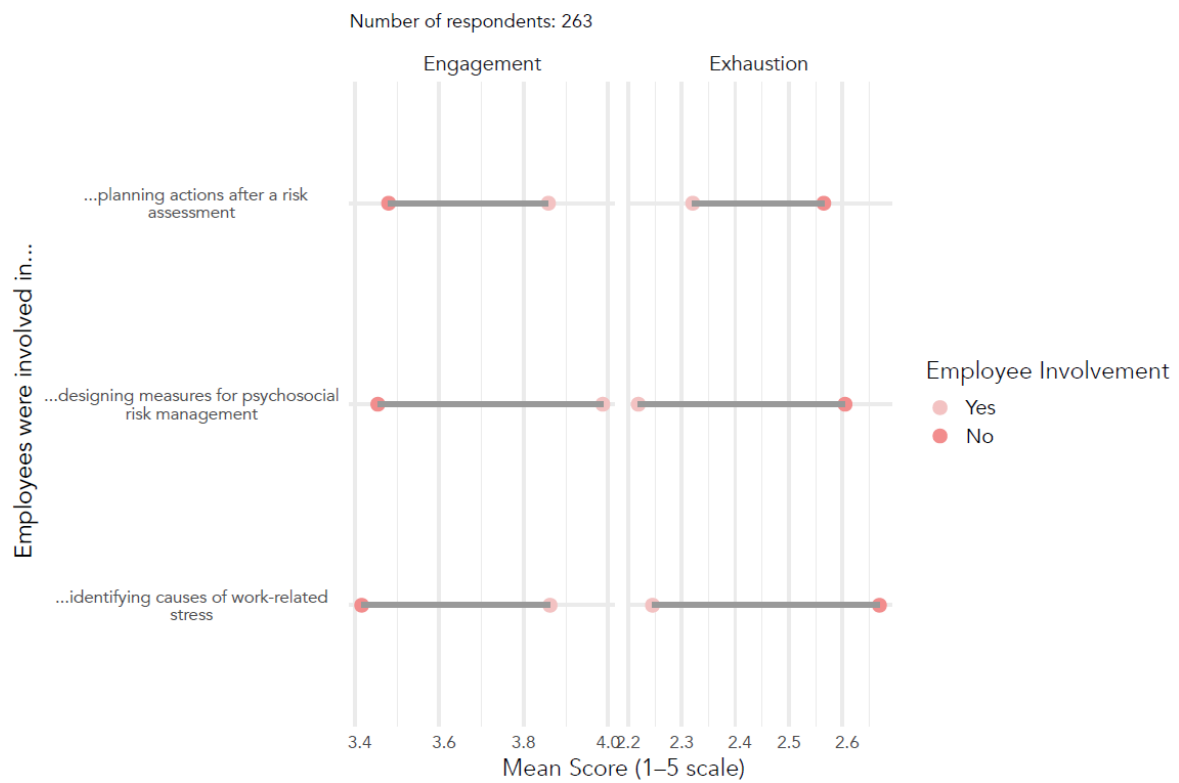
Figure 18: Reported organisational measures by involvement of employees and representative bodies



Notably, especially workers' direct participation was associated with high proportions of employer initiatives, largely on a par with an active health & safety committee. Indeed, in promoting the most preventive measures (i.e. work design and addressing working hours) and in training and education, raising awareness, and promoting further participation, direct participation took the lead. Active Health & Safety committees were associated with the most frequent policies and procedures. Compared with direct participation and with dedicated OSH bodies, works or staff councils' involvement led to fewer company initiatives (with the important exception of work design).

Workers' direct participation in all phases of devising measures to prevent and mitigate psychosocial risk was also associated with higher engagement and lower exhaustion (Figure 199, n = 263). The planning of actions had a lower effect than involvement in the design of measures or in identifying causes of stress. Generally, this suggests that direct participation, in addition to getting more measures implemented, may have an intrinsically invigorating effect on employees, especially when they contribute to actual problem-solving. This may of course be short-term but may also provide a pathway towards virtuous circles of participation bringing improvements in working conditions, raising awareness of them, and leading to higher commitment of all stakeholders to mental health at work.

Figure 19: Engagement and exhaustion by employee involvement



7. Conclusions

7.1 Addressing psychosocial risk in Austria

In sum, in Austria psychosocial risks appear to be well integrated into OSH regulation, social partnership and dedicated authorities and bodies of expertise. Experts agree that the institutional side is well aligned with the European state of the art, with information flowing in both ways. Social partners and OSH actors offer ample information and support to companies, workers and workers' representatives, and general awareness and destigmatisation of mental health issues is also, slowly, improving.

Clearly, the gaps lie in the general enforcement of OSH legislation and specifically in employers' adoption of its philosophy, which involves not just risk assessment, but a cycle of continuous improvement involving prevention and mitigation measures, the assessment of these measures' effectiveness, and further improvement. Experts note that companies have a lot of leeway for pro forma risk assessments, which leads to shelves full of documents to show to labour inspectors.

However, the interest of social partners and their political counterparts in psycho-social risk and prevention is somewhat asymmetrical: for workers and their representatives, the issues of OSH and psychosocial risk are increasingly vital as they affect working people's whole lives. Employers, as caring as they may be, adopt the idea of OSH as a win-win-configuration with increased job satisfaction, labour retention and productivity somewhat tentatively. Their representatives tend to interpret their legal responsibility in the light of managerial prerogative and remain somewhat averse to mandatory procedures that are considered burdensome.

Consequently, in the light of social partner compromise between conflicting interests, the gaps in implementation and enforcement of the law can be considered an expression of that very compromise. The labour inspectorate sets annual priorities in sectors and issues, emphasises advice over sanctions and takes a generally measured and didactic approach to companies. Their staffing levels and the resources of AUVA have been limited by political decisions in recent decades.

While this compromise offers ample information, support and advice in tailoring measures to the willing, and good and very good practices and initiatives can certainly be found in Austria, the gaps in enforcement affect some groups of workers more than others. Vulnerable groups at large are defined by the intersection of sociodemographic characteristics and employment status. Migrants, women, young workers, mobile workers, and the precariously employed all carry particular risks, are likely to lack workplace resources to mitigate them, perceive few alternative options when exposed to poor working conditions, and in precarious employment and mobile working, are harder to reach by unions and OSH bodies offering information and advice.

7.2 Psychosocial risk in healthcare

As we have seen, in the healthcare sector, unionists and experts focus on staff and skills shortages, high work intensity and unpredictable work schedules as "root causes" of psychosocial risk. They prioritise addressing these systemic risks, which exacerbate psychosocial risk configurations. Indeed, workers responding to the PSYR-IR survey reported that such preventive measures are less present in their workplaces than those providing support. In addition, staff and skills shortages may undermine more specific efforts targeted at psychosocial risks in a narrower sense. There is evidence

of vicious circles, where the impacts of understaffing drive up both illness-related absences and labour turnover, with further pressure on remaining workers. Or, if workers miss tasks under pressure, this impacts their own wellbeing as well as quality of care and support for patients and informal carers, and may increase disease burdens, workloads and the cost of healthcare in the long run. Political impacts are not negligible either as the experience of gaps in healthcare (with still an overall high standard) contributes to a widespread sense of insecurity and institutional failure among Austrian voters. As the government formed in early 2025 prioritises limitations in public and social security spending at the same time as post-pandemic awareness of the needs for investment in health and social care persists, it remains to be seen how these tensions play out.

Notably, for unions, this awareness and the visibility of staff and skills shortages present opportunities. As workers find a more favourable labour market, employers feel the pressure of possible exits, and the public appreciates the needs and demands of workers – although workers' exit options vary along the lines of age and skill level.

Given the complex, fragmented, multi-level and multi-stakeholder environment of the Austrian healthcare system, it is not surprising that no catch-all solutions are available, and nobody expects any. Apparently, unions and policy actors approach the issues in a piecemeal way and explore incremental improvements both in national policy and on the organisational, regional, or sub-sectoral level. In this way, compromises and some disappointments are inevitable, but unionists retain a sense of direction in which they pursue direct improvements within a wider framework of demands and increasingly coordinate activities and demands. They have also developed a sense of processual quality in terms of making changes, with consideration for context and worker participation.

The downside is that compared with hospitals the smaller-scale and less organised segments of the sector, especially mobile or social care, have fewer capacities to address their own specific configurations of staff shortages, work intensity and fragmented or unpredictable work schedules. The same applies to subcontracted workers in the sector – whose employers and managers face similar challenges of recruitment and retention of workers with higher cost pressure. The challenge to policy, research and collective action is familiar in questions of work and employment quality: how to extend advances and good practices, not least those of continuous improvement in the sense of the OSH law, beyond the large and well-organised flagships of large healthcare providers.

Despite the specificities of the health sector, some insights may also be applicable to other sectors and functions. For example, teachers, the police, social workers or prison staff are similarly likely to encounter persistent situations of “missed care”, where they are unable to fulfil or complete tasks that they deem to be professionally necessary due to time, staff or skills constraints. This is one mechanism that enrolls workers in “essential services” in dismantling their own professional standards and rationing services on their own and against their sense of responsibility.

7.3 Psycho-social risk and mental health at work in the view of healthcare workers

While the survey conducted by the PSYR-IR project is not entirely comparable with representative surveys such as the Labour Force Survey or the surveys commissioned by EU-OSHA, it offers a picture of workers' views on psychosocial risk, organisational initiatives and health outcomes.

Firstly, it confirms that healthcare workers are a population with high overall exposure to psychosocial risk at work. Emotional stress, high workload and/or time pressure and verbal abuse or “difficult” patients are common, and more than half of respondents note poor communication in the organisation and unfair pay respectively. In the present survey, a high proportion of respondents also have a work-related health problem.

Healthcare organisations do implement measures that prevent and mitigate psychosocial risk, but implementation is uneven across subsectors. Notably, both public and private sector health providers are lagging behind. Only in the non-profit sector and in public-private organisations do we find measures reported by more than half of respondents: psychological support and conflict resolution training in both types, and procedures against 3rd party violence in non-profits. Across all organization types, more preventive measures were the least reported, including measures for stress prevention, work reorganisation to reduce pressure, and against long or irregular work hours. A potential reason why these actions are lacking is that to address the organisational causes of psychosocial risks they necessitate broader organisational changes. However, such measures influence reported health outcomes: The presence of measures improves self-reported health and reduces symptoms of exhaustion. Self-reported health is better when preventive measures are in place. Exhaustion is experienced less frequently the more measures are adopted. Employees who perceive their organisations' cultures as supportive to mental health report notably less exposure to psychosocial risk and less exhaustion as well.

Importantly, the survey shows that worker voice clearly supports psychosocial risk mitigation. On risk exposure, the influence is small, but especially health & safety committees and direct participation make a difference in measures addressing psychosocial risk and in some health outcomes. Workers' direct involvement is even primarily associated with preventive measures such as improving work design and working time as well as in raising awareness, promoting further participation, and providing training. Works councils have less of an impact in the field, apart from influence on work design. Direct participation also reduces exhaustion and increases engagement of workers.

Thus, ambitious participation clearly appears as a key factor in improving mental health at work on multiple levels. Firstly, it naturally raises awareness that something is being done. Secondly, workers provide their own expertise and insight into their needs and challenges, may contribute good and workable ideas, and may well save companies misdirected investments by providing feedback on the functioning of initiatives. In the process, participation in itself may improve engagement at work. However, turning this into a virtuous cycle of improved working conditions, engagement and performance will require real, knowledgeable and sustained commitment by management as well and leave little space for the pro forma assessments that are often conducted in Austria.

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9. Appendix

Appendix 1

Number of psychosocial risks	n	%
0	10	3,8
1	12	4,6
2	18	6,8
>3	223	84,8

Appendix 2

Scale	label	Gender	Mean score	n
Engagement	Energy	Male	3,38	76
		Female	3,48	177
	Enthusiasm	Male	3,55	76
		Female	3,77	177
	Immersion	Male	3,79	76
		Female	3,99	177
Exhaustion	Concentration issues	Male	2,39	76
		Female	2,38	177
	Emotional control	Male	1,86	76
		Female	1,84	177
	Exhaustion	Male	2,84	76
		Female	2,85	177
	No enthusiasm	Male	2,68	76
		Female	2,41	177

Appendix 3

Scale	Label	Age group	Mean score	n
Engagement	Energy	<35	3,33	49
		35–44	3,23	70
		45–54	3,71	76
		55+	3,48	58
	Enthusiasm	<35	3,8	49
		35–44	3,5	70
		45–54	3,88	76
		55+	3,64	58
Immersion		<35	3,86	49

Exhaustion	Concentration issues	35–44	3,87	70
		45–54	4,04	76
		55+	3,91	58
		<35	2,51	49
	Emotional control	35–44	2,39	70
		45–54	2,42	76
		55+	2,24	58
		<35	1,8	49
	Exhaustion	35–44	1,87	70
		45–54	1,79	76
		55+	1,93	58
		<35	3,12	49
	No enthusiasm	35–44	2,89	70
		45–54	2,72	76
		55+	2,74	58
		<35	2,57	49

Appendix 4

Exhaustion	Agreement	n	%
I can't feel enthusiastic about my work	Never	55	21
	Seldom	91	34,7
	Sometimes	62	23,7
	Regularly	38	14,5
	Always	16	6,1
I feel I have no control over my emotions at work	Never	108	41,2
	Seldom	106	40,5
	Sometimes	33	12,6
	Regularly	11	4,2
	Always	4	1,5
I feel mentally exhausted at work	Never	20	7,6
	Seldom	61	23,2
	Sometimes	126	48,1
	Regularly	44	16,8
	Always	11	4,2
I struggle to concentrate at work	Never	38	14,5
	Seldom	114	43,5
	Sometimes	82	31,3
	Regularly	23	8,8
	Always	5	1,9
Engagement	Agreement	n	%
I feel full of energy at work	Never	4	1,5

	Seldom	36	13,8
	Sometimes	83	31,8
	Regularly	114	43,7
	Always	24	9,2
I am enthusiastic about my work	Never	6	2,3
	Seldom	26	9,9
	Sometimes	64	24,4
	Regularly	108	41,2
	Always	58	22,1
I am immersed in my work	Never	3	1,2
	Seldom	12	4,6
	Sometimes	45	17,3
	Regularly	139	53,5
	Always	61	23,5

Appendix 5

Self-reported health		
status	n	%
Very good	38	14,4
Good	107	40,7
Fair	95	36,1
Bad	21	8
Very bad	2	0,8

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Deliverable 3.1

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1. Introduction

1.1 Background

This report presents a case study on Belgium, developed as part of the PSYR-IR project on “*The opportunities for industrial relations to prevent and manage psychosocial risks in post-pandemic workplaces*”. It is part of a series of national case studies, highlighting the current situation when it comes to psychosocial risks and workers’ mental health and well-being, as well as the regulatory and policy framework around these issues, and the role of the social partners and social dialogue. Besides Belgium, the PSYR-IR project offers case studies for Austria, Denmark, Estonia and Italy. This report also draws on the research conducted as part of the InCreMental project (Lenaerts et al., 2025) as well as recent EU-OSHA work (2025), in which the research team was also involved.

When it comes to work-related psychosocial risks and workers’ mental health and well-being, the Belgian case is particularly interesting since the **country has long prioritised the issue of work-related psychosocial risks and mental health in its labour policies**. As early as 1992, a royal decree was introduced to protect workers from psychosocial risks, which focused on addressing sexual harassment in the workplace. This commitment to tackling work-related psychosocial risks was further formalised in 1996 through the Act on the well-being of workers in the performance of their work, which remains the cornerstone of Belgium’s occupational safety and health (OSH) legislation. Although the 1996 act did not include a definition of the concept ‘psychosocial risks’, a 2014 amendment to the Act did introduce a clear definition, framing **psychosocial risks** as the likelihood of psychological harm, which is potentially accompanied by physical harm, resulting from various work-related factors such as job content, the work organisation, working conditions, employment terms, and interpersonal relations, all of which fall under the employer’s influence. These factors are commonly referred to as the five A’s in the Belgian context, and are a red threat in legislation and policy action around the topic.

Psychosocial risks are characterised by a **wide variety of symptoms**. These symptoms are often classified as emotional, behavioural and/or physical symptoms. Emotional symptoms of exposure to psychosocial risks are stress, burn-out, depression, nervous breakdowns or suddenly bursting into tears, and others. Behavioural symptoms include conflicts, bullying, violence, inappropriate behaviour, substance abuse,... Examples of physical symptoms include muscle pain, headaches, sleep disturbances, digestive problems, (repeated) infections, increased blood pressure,... Psychosocial risks experienced at work may also have an impact on the social level (deterioration of relations with family and friends) (FPS Employment, Labour and Social Dialogue, no date). At the organisational level, psychosocial risks can affect the work climate in a negative manner. Absenteeism levels might rise and there might be a higher degree of turn-over, lower productivity, a decline in the quality of work,... (FPS Employment, Labour and Social Dialogue, no date).

Within the European Union (EU), Belgium stands out among the EU Member States for having **specific legislation targeting psychosocial risks at work**. In addition, Belgian policymakers and social partners are **actively promoting greater attention to mental health and workers’ well-being at the European level**. This advocacy was particularly evident during Belgium’s

recent Presidency of the Council of the European Union from January to June 2024. One of the Presidency's key priorities was to **strengthen the EU's social and health agenda**, aiming to foster a more inclusive, gender-equal, and fair society. Within the framework of the EU Strategic Framework on Health and Safety at Work (2021-2027), Belgium pushed for a **more holistic approach to mental health, addressing workplace stress, burnout, and other mental health challenges, while also promoting prevention, risk reduction, and support for returning to work after illness, including for the self-employed.**

As part of its Presidency, Belgium hosted a **High-Level Conference on Mental Health and Work** in January 2024. This high-level conference focused on both primary prevention and the creation of healthy workplaces, as well as secondary and tertiary prevention strategies. It explored key issues such as job quality, precarious employment, the impact of digitalisation, and the legal and regulatory frameworks governing psychosocial risks at both the national and EU levels. Another important event held under the Presidency took place in June 2024, when the Belgian Federal Public Service (FPS) for Employment, Labour and Social Dialogue organised a **Peer Review on legislative and enforcement approaches to psychosocial risks at work**, with support of the European Commission. This event set out to exchange best practices and discuss how to improve legal and enforcement mechanisms to better protect workers from psychosocial risks. Within this peer review, Belgium served as the host country (see ICF, 2024 and European Commission, 2024 for more details).

Turning the **supranational level**, EU policymakers have consistently worked to promote the well-being of EU citizens, which includes key efforts to protect workers' rights and ensure safe and fair working conditions. OSH is central to this mission, being enshrined in EU treaties, the Charter of Fundamental Rights, and the European Pillar of Social Rights (EPSR). While physical risks have traditionally received more attention, the importance of psychosocial risks has grown significantly recently, especially since the pandemic. The pandemic intensified existing mental health issues, prompting the EU to address these concerns more directly in its 2021-2027 Strategic Framework on Health and Safety at Work (OSH Strategic Framework), which includes a dedicated focus on psychosocial risks and outlines measures for improvement. Against this background, this report zooms in on recent developments in Belgium.

1.2 Methodology of this case study

Methodologically, this case study relies on a combination of **desk research** and **fieldwork**. Desk research involved the search, identification, and analysis of academic and grey literature in Dutch, French and English on topics relating to psychosocial risks and workers' mental health and well-being, available data sources capturing these issues, the current legal and regulatory framework around occupational safety and health (and psychosocial risks and well-being in particular), the industrial relations system and the positions and roles of the social partners, as well as specific sources referring to the situation in the healthcare, manufacturing and construction sectors.

The fieldwork relied on a combination of **semi-structured interviews** with representatives from academia, government agencies, social partner organisations, and other relevant actors, at the national and sectoral levels (16 in total; 5 with government representatives; 2 with academics or experts, and 9 with representatives from the social partners' organisations). All interviews were conducted in the national languages (Dutch or French) and took place online. The participants received an information sheet explaining the aim of the interview, and were asked for their consent prior to participation in the interview. Interviews addressed topics such as the general prevalence

of psychosocial risk factors, the evolution in policymaking regarding psychosocial risks and main actors involved, and related topics. The full interview guide is available upon request. Interviews lasted between 30 and 90 minutes and took place between June 2024 and June 2025.

Furthermore, an **online survey** was conducted among workers in healthcare, construction and manufacturing in Belgium. Data were collected using the survey panel from Norstat as well as via circulation of the survey based on an open link (with the support of representative organisations in the respective sectors). Data collection took place between April and July 2025. Panel members fitting the targeted respondent group were invited to participate in the study through the Norstat platform, after which they were redirected to the survey platform, programmed in LimeSurvey. The survey was provided in Dutch and English. In total 202 respondents completed the survey for the construction and manufacturing sectors (of which 185 were recruited through Norstat, while 17 were collected via the open link), while 249 respondents completed it for healthcare (of which 100 were recruited through Norstat, while 149 were collected via circulation with the open link). The full questionnaire is available upon request. The aim of the study was to gain in-depth insights into employees' views on work-related matters, with a particular focus on psychosocial risk factors and how these risks are managed in the workplace.

The table below provides more details on the socio-demographic characteristics of the survey respondents. As the table shows, the healthcare and the construction and manufacturing sectors differ significantly in their socio-demographic profiles, reflecting the nature of the work, institutional structures, and historical labour patterns.

Gender is one of the most striking differences between the sectors. Healthcare is a predominantly female profession, with women making up 86% of the workforce. This is consistent with the caregiving and service-oriented nature of healthcare roles, which have traditionally attracted more women. In contrast, the construction and manufacturing sector is heavily male dominated, with 67% of workers being men. This reflects the physical demands and technical nature of the work, which has historically been associated with male labour.

In terms of **age**, both sectors are largely composed of individuals aged 25 to 54, representing the core working population. Healthcare has 71% of its workforce in this age group, while construction and manufacturing have a similar proportion at 68%. However, healthcare has a notably older workforce overall, with 24% aged 55 and above, compared to 17.33% in construction and manufacturing. Younger workers aged 16 to 24 are more prevalent in construction and manufacturing (14%) than in healthcare (6%), possibly due to lower entry barriers and earlier career starts in the former.

The **functions performed within organisations** also vary widely. In healthcare, the majority of workers are in technical occupations and associate professional roles (58%), which include nurses, technicians, and other specialised staff. Service occupations are also significant (16%), reflecting roles such as caregiving and patient support. In contrast, construction and manufacturing are characterized by a high proportion of skilled workers (29%), along with notable shares of semi-skilled (10%) and unskilled workers (8%). Professional and technical roles are less common in this sector, each accounting for only 10%, indicating a more manual and labour-intensive workforce.

Employment contracts show a clear divide in job stability. Healthcare workers are overwhelmingly employed on permanent contracts (92%), suggesting a stable and institutionalized employment environment. Temporary contracts and self-employment are rare in

healthcare, each at 3%. In contrast, construction and manufacturing exhibit more flexible and varied employment arrangements. Only 74% of workers have permanent contracts, while 10.15% are on temporary contracts and 9% are self-employed. This reflects the project-based nature of construction work and the prevalence of subcontracting in manufacturing.

The **sectoral affiliation** of workers also differs. Healthcare workers are spread across various sectors, with 44.96% in the private sector, 29% in the public sector, and a significant 21% in non-profit or NGO organisations. This diversity reflects the broad institutional landscape of healthcare services. In contrast, construction and manufacturing are predominantly situated in the private sector (72%), with limited representation in the public (22%) and non-profit sectors (0.75%), consistent with their commercial and industrial orientation.

Company size further distinguishes the two sectors. Healthcare workers are more likely to be employed in large organisations, with 57.14% working in companies with 250 or more employees. This aligns with the structure of hospitals and large healthcare institutions. Smaller companies are less common in healthcare. On the other hand, construction and manufacturing workers are more evenly distributed across company sizes. While 31% work in medium-sized companies (50-249 employees), a significant portion (30.08%) are in small firms (10-49 employees), and 13% in micro-enterprises (1-9 employees). Only 26% work in large companies, reflecting the fragmented and varied nature of the industry.

Finally, **trade union membership** is relatively high across all sectors. In healthcare, 57.55% of workers are members of a trade union, likely due to the strong presence of public and non-profit institutions and the tradition of collective bargaining in the sector. In construction and manufacturing, trade union membership is even higher at 66%, possibly reflecting the historical strength of trade unions in industrial sectors and the need for collective representation in physically demanding and sometimes hazardous work environments.

Table 1. Descriptive statistics of the survey respondents

	Socio demographic variable	% Healthcare	% Construction & manufacturing
Gender	Men	13.65%	66.67%
	Women	86.35%	33.33%
Age	16-24 years	5.62%	14.36%
	25-54 years	70.68%	68.32%
	55+ years	23.69%	17.33%
Function in organisation	Professional occupations	14.94%	9.64%
	Technical occupations and associate professionals	57.68%	9.64%
	Higher administrative occupations	2.90%	9.14%
	Clerical occupations	4.98%	11.17%
	Sales occupations	0.41%	8.63%
	Service occupations	15.77%	3.05%
	Skilled worker	1.66%	28.93%
	Semi-skilled worker	1.24%	10.15%
	Unskilled worker	0.41%	8.12%
	Farm worker	0%	1.52%
Contract	Self-employed	2.85%	9.14%
	Employee with a permanent contract	91.87%	74.11%
	Employee with a temporary contract	2.85%	10.15%
	Without a professional activity	1.63%	5.08%
	Other	0.81%	1.52%
Sector	Private sector	44.96%	72.18%
	Public sector	29.41%	21.8%
	Joint private-public company	4.20%	5.26%
	Non-profit sector or NGO	21.43%	0.75%
Company size	1-9 people	3.90%	12.78%
	10-49 people	10.82%	30.08%
	50-249 people	28.14%	30.83%
	250 people and over	57.14%	26.32%
Members of a trade union	Yes	57.55%	65.93%
	No	42.45%	34.07%

Source Own calculations, survey data collected among healthcare workers (N=249) and workers in construction and manufacturing (N=202) in Belgium

2. Context

This section explores the **current state of knowledge on work-related psychosocial risks and mental health**, with a **particular focus on the Belgian context**. Special attention is given to the impact of the COVID-19 crisis, which significantly altered the working conditions and exacerbated existing psychosocial challenges. By examining these issues, the section lays the foundation for understanding the specific drivers and consequences of psychosocial risks in Belgium and sets the stage for the empirical analyses presented in the remainder of the report.

2.1 State of play of psychosocial risks and mental health

In Belgium, the prevalence and management of psychosocial risks in the workplace are shaped by sectoral dynamics and organisational practices. Building on the work of Heylen et al. (2024) and several EU-wide surveys that cover the Belgian situation, we highlight key issues below.

According to the ESENER 2019 survey, 67% of Belgian establishments recognised the challenge of **dealing with difficult customers, patients, or pupils, which is one of the highest rates** in the EU. This issue is particularly relevant in the health and social care sector, where emotional demands are prevalent. Closely related to this point, data from the EWCS 2015 and EWCTS 2021 show that 34% of Belgian healthcare workers were at risk of **high work intensity** in 2021, and 57% reported working **atypical hours** such as work during evenings and weekends, or in shifts. These figures underscore the demanding nature of care work and its implications for worker well-being.

More generally, **work intensity** is a significant concern in Belgium. According to data from the EWCS 2015 and EWCTS 2021, the share of Belgian workers at risk of high work intensity rose from 27% in 2015 to 35% in 2021. In the industrial sector, this figure increased from 30% to 37%. Complementing this view based on the EWCS data, the OSH Pulse 2022 survey found that 47% of Belgian workers reported exposure to severe **time pressure or work overload**, slightly above the EU average. The **use of digital technologies** further contributes to this issue: 91% of Belgian workers use digital devices in their main job, and 39% report that such technologies increase their workload. However, only 14% feel that digitalisation reduces their autonomy. This percentage is lower than in most other countries.

Autonomy at work appears relatively well protected in Belgium. According to the 2022 OSH Pulse Survey, only 17% of Belgian workers reported a lack of autonomy or influence over their work pace and processes, which is just below the EU average of 18%. This suggests that Belgian organisations may be more successful in implementing measures that enhance employee control over their tasks. The ESENER 2019 data show that 77% of Belgian organisations implemented measures to increase employee autonomy, which is among the highest in the EU.

Interpersonal relationships at work present mixed results. The OSH Pulse 2022 indicates that 20% of Belgian workers reported exposure to violence or verbal abuse from clients or patients,

while 8% experienced harassment or bullying. These figures are higher than the EU averages and indicate persistent challenges in ensuring respectful workplace interactions. Additionally, the EWCS 2015 and 2021 data show that 8% of Belgian workers reported a lack of support from colleagues, and 53% of organisations evaluated supervisor-employee relationships, suggesting room for improvement in managerial support structures.

Career development indicators show both progress and setbacks. Based on EWCS 2015 and 2021, the share of Belgian workers reporting a lack of career opportunities decreased significantly over this time period. However, the percentage of workers experiencing a lack of recognition rose sharply from 3% to 18% during the same period. This increase may reflect growing dissatisfaction with how contributions are acknowledged in the workplace.

Occupational insecurity has declined in Belgium. The EWCS 2015 and 2021 data show that the share of workers reporting job insecurity fell, and financial worries also decreased. However, 31% of Belgian workers still reported a lack of appropriate pay in 2021, with higher rates in the health sector, especially among women. These findings suggest that while job stability may have improved, perceptions of fair compensation remain a concern.

Work-life balance also remains a notable issue. According to the EWCS 2015 and 2021 data, 12% of Belgian workers reported work-life interference in 2021, which is the highest among the countries studied. This issue is particularly pronounced among women and workers aged 25–54, reflecting the pressures of balancing professional and personal responsibilities.

Belgium also stands out in terms of organisational measures. While only 20% of organisations intervened to address long or irregular working hours, which is below the EU average, according to ESENER 2019, Belgium performs well in other areas. For example, 83% of organisations had procedures to address bullying and harassment, and 71% had procedures to deal with threats, abuse, or assault. Additionally, 52% offered access to confidential counselling, and 39% provided training on conflict resolution.

Finally, Belgian workers report relatively **high levels of comfort in discussing mental health issues**. The OSH Pulse 2022 found that 72% of Belgian workers felt comfortable speaking to their manager or supervisor about stress or mental health concerns. 47% of workers believed that disclosing a mental health condition could negatively impact their career, which is below the EU average of 50%.

Taking all these findings together, Belgium demonstrates a **strong awareness of psychosocial risks and mental health issues** and has implemented several measures to address them (at the policy as well as the organisational levels; see Heylen et al., 2024; ICF, 2024; EU-OSHA, 2025 for further details). However, important **challenges remain in several areas**, such as recognition, interpersonal relationships, and work-life balance. These are elaborated on below.

2.2 Impact of the COVID-19 pandemic

Although psychosocial risks and mental health were already recognised as important policy issues in Belgium before the COVID-19 pandemic, the **pandemic heightened both public and institutional awareness** (ICF, 2024; European Commission, 2024; EU-OSHA, 2025). Although the COVID-19 pandemic did not lead to major legislative changes, which according to interviewed

stakeholders is due to Belgium's already extensive OSH framework, it had a substantial influence on how mental health is addressed in practice.

The pandemic exacerbated mental health challenges, particularly among essential workers who faced increased exposure and limited ability to isolate. At the same time, it **helped break taboos around mental health and psychosocial risks**, leading to increased reporting and a broader societal understanding that these issues can affect anyone (Heylen et al; 2024; EU-OSHA, 2025). This shift in awareness prompted the government to invest more in mental health support and develop comprehensive strategies beyond the workplace. The crisis also underscored the need for further **intergovernmental collaboration**, particularly at the federal level, and accelerated the implementation of the Federal Action Plan on Mental Well-being at Work (EU-OSHA, 2025). The pandemic created momentum for advancing mental health initiatives and improving coordination across institutions.

In response to the crisis, the Federal Public Service Employment, Labour and Social Dialogue launched the "Let's go for it together!" campaign in March 2021 (EU-OSHA, 2025). This social media initiative aimed to raise awareness of psychosocial risks and promote available tools for prevention and support. The campaign, supported by the website voeljegoodophetwerk.be, provided resources on stress, violence, loneliness, and teleworking, and reminded employers of their responsibilities under the well-being legislation, even in remote work settings.

3. Regulatory framework on psychosocial risks and workers' health and well-being

3.1 Legislation and policy

3.1.1 Legal framework on OSH and psychosocial risks

Belgium's legal framework on occupational safety and health is anchored in **the Act of 4 August 1996 concerning the well-being of workers in the performance of their work** (Belgian Official Gazette, 18/09/1996) (Lenaerts et al., 2024; ICF, 2024; EU-OSHA, 2025). This Act transposes the European Framework Council Directive 89/391/EEC of 12 June 1989, which aims to promote improvements in the safety and health of workers at work. It adopts a **broad definition of well-being at work**, encompassing physical safety, health protection, psychosocial aspects, ergonomics, and occupational hygiene. This legislation serves as a foundational framework from which implementing royal decrees are derived, which are codified in the **Codex on Well-being at Work** (EU-OSHA, 2025). This legal structure is reinforced by **collective labour agreements at national, sectoral, and company levels**, as well as by **recommendations from advisory bodies such as the National Labour Council (NLC) and the High Council for Prevention and Protection at Work**. The Act sets out general principles and objectives, allowing companies flexibility to tailor their well-being policies to specific organisational needs.

The Act of 1996 stipulates that every employer in Belgium is obliged to pay attention to a number of specific domains of wellbeing at work (Lamberts, 2019). Wellbeing is defined as a set of factors relating to the working conditions in which the work is performed. The following domains are defined: occupational safety and the investigation of workplace accidents; protection of workers' health at work; psychosocial aspects of work; ergonomics; occupational hygiene; improvement of workplaces (Lamberts, 2019). In addition, under this legal framework, all Belgian employers must implement a policy on occupational health and safety at work including, among other aspects, the prevention of psychosocial risks (primary prevention); the prevention of harm resulting from psychosocial risks (secondary prevention); and the mitigation of harmful effects of psychosocial risks (tertiary prevention) (Lamberts, 2019). Employers are required to conduct a comprehensive psychosocial risk assessment every five years, which informs a global prevention plan. This plan is operationalised through annual action plans, allowing for ongoing monitoring and adjustment of measures (Lamberts, 2019; EU-OSHA, 2025).

The Act of 1996 foresees an important role for (internal or external) services for the prevention and protection at work, which are responsible for the detection of health and wellbeing risks that employees might be confronted with. Another central role is foreseen for the Committee for the Prevention and Protection at Work (health and safety committee). This committee embeds trade union representation on this matter at the company level (FPS Employment, Labour and Social Dialogue, no date).

A major development occurred in **2014**, when the **Act was amended to formally incorporate the concept and definition of psychosocial risks** (Lenaerts et al., 2024; ICF, 2024; EU-OSHA, 2025). Psychosocial risks are **defined as the likelihood that one or more workers may suffer psychological harm, potentially accompanied by physical harm, due to exposure to elements of work organisation, job content, working and employment conditions, and interpersonal relationships at work**. The definition identifies five key domains as sources of psychosocial risks, in that way offering a comprehensive framework for analysis and intervention.

There are two elements that need to be taken into account when speaking of psychosocial risks at work. First, it must **relate to a situation that is objectively dangerous**. It is an objective risk if it can lead to health damage in the average employee, under similar circumstances. Secondly, **psychosocial risks at work concern only those elements an employer has an impact on**. As an illustration; the employer of an emergency centre has no impact on the fact that its employees experience emotional strain when answering emergency calls as this emotional strain is inherent to the nature of the job. However, the employer can take measures to minimise this strain and prevent it from causing health damage by means of providing psychosocial support... (FPS Employment, Labour and Social Dialogue, n.d.; Lamberts, 2019).

The 2014 amendment of the legislation also introduced formal and informal procedures for psychosocial interventions. With the amendment, employers are legally required to conduct **risk assessments and implement preventive measures targeting psychosocial risks**. The roles of two key actors in the Belgian framework, more specifically confidential counsellors and prevention advisors for psychosocial risks, were also clarified (EU-OSHA, 2025). Confidential counsellors manage informal procedures, offering confidential support and mediation, but do not have a formal legal status and cannot handle formal intervention requests. Prevention advisors, by contrast, play a formal role in overseeing psychosocial risk management. They conduct risk analyses, advise on preventive strategies, and handle informal as well as formal requests for intervention. These advisors benefit from legal protection and must meet specific qualifications in terms of education and experience.

Since its adoption, the legal framework has **undergone multiple revisions**, each adding further detail and expanding its scope. These updates have enriched the regulatory landscape but also introduced complexity, which may hinder understanding and practical application among workers, employers, and other stakeholders (Lenaerts et al., 2024; ICF, 2024; EU-OSHA, 2025). The current legislation applies universally to all employers and employees in both public and private sectors. It obliges employers to promote worker well-being through structured risk assessments and preventive measures. While it prioritises collective prevention strategies, it also provides for individual psychosocial interventions when collective approaches prove insufficient.

Belgium has recently introduced two other key legislative acts that strengthen its OSH framework, especially regarding work-related psychosocial risks and mental health. The first is the **Act of 26 March 2018 on strengthening economic and social cohesion**, which includes provisions for burnout prevention and digital disconnection. Section 1 of Chapter 2 enables government-funded burnout prevention projects, submitted by joint committees, following advice from the National Labour Council. Section 2 mandates regular consultations within the Committee for Prevention and Protection at Work on the use of digital communication tools and disconnection from work, aiming to protect rest periods and work-life balance. These consultations can lead to company-level agreements or amendments to work regulations.

The **Act of 3 October 2022 containing various labour provisions** introduces a formal **right to disconnect** for employees in companies with more than 20 workers. Employers must establish agreements—either through collective agreements or work regulations—on how this right is applied, including guidelines for digital tool usage and awareness-raising measures. The Act also mandates the **appointment of a confidential counsellor** in organisations with more than 50 employees. At least one counsellor must be part of the internal staff, and while training is required, it can be completed within two years of appointment.

Despite its strengths, **the evolving legal framework has become complex, which may hinder its practical application and enforcement**. Stakeholders interviewed for the study noted that while individual-level interventions are well established, collective approaches, though potentially more impactful, are underutilised (also see EU-OSHA, 2025, where similar findings emerged). Unions have been particularly active in advocating for stronger collective prevention strategies.

3.1.2 Recent policies on OSH and psychosocial risks

In Belgium, psychosocial risks and workers' mental health have gained significant attention from policymakers and social partners, particularly in recent years. Burnout prevention is considered a major societal challenge, driven by the rising number of individuals on long-term sick leave due to mental health conditions (also see EU-OSHA, 2025; FPS Employment, Labour and Social Dialogue, no date). This concern led to the inclusion of stress and burnout in the occupational safety and health legal framework in 2014. That same year, a national awareness campaign was launched targeting employers, HR managers, and union representatives to help identify burnout symptoms (EU-OSHA, 2025).

Despite these efforts, Belgium continues to face **high rates of long-term illness and disability**. According to the National Institute for Health and Disability Insurance (2024), and a report by the High Council for Prevention and Protection at Work, the number of workers unfit for work for over a year increased by more than 150% between 2000 and 2021. The rise is particularly pronounced among women, attributed to demographic shifts such as increased retirement age and labour market feminisation. Belgium ranks among the worst-performing EU countries in this area, making reintegration and mental health a top policy priority.

At the national level, Belgium's **Action Plan for Worker Well-being 2022–2027** translates the EU OSH Strategic Framework into domestic policy. It builds on the previous 2016–2020 plan and reflects priorities jointly defined by social partners. The plan is reviewed annually together with stakeholders to ensure responsiveness to emerging challenges. Key focus areas include the prevention of psychosocial risks, and exposure to hazardous substances. It promotes a 'vision zero' approach to workplace accidents and supports vulnerable workers and reintegration efforts. The plan addresses evolving work organisation, including telework, and calls on the National Labour Council to refine the legal framework for **remote work**. This includes ensuring work-life balance, disconnection rights, and protections against isolation-related psychosocial risks. The government supports these efforts by disseminating tools and best practices via official platforms.

Specifically on psychosocial risks, the plan outlines four priorities. A first priority is the **Federal Action Plan on Mental Well-being at Work**: Developed in collaboration with all relevant actors, including social partners. A second priority is the **focus on health and care workers**, recognising high stress levels in these sectors, the government supports sectoral agreements to reduce work pressure. A third priority is the **monitoring of 2014 legislation**. As part of the initiative, networking sessions with confidential counsellors and prevention advisors are organised, case law is

analysed, and overlaps with anti-discrimination laws are examined. The ratification of ILO Convention No. 190 in 2023 further strengthens protections against workplace violence and harassment. A final priority involved **pilot projects** on burnout prevention and innovative work organisation are being rolled out and closely monitored (also see below, as these were guided by the National Labour Council).

Together, the developments reflect Belgian policymakers' commitment to a proactive, inclusive, and evidence-based approach to managing psychosocial risks and improving mental well-being.

3.2 Key actors

In Belgium, OSH policy is shaped and implemented by a **broad network of stakeholders** across the **government, social dialogue institutions, and prevention services**. Note that the different actors involved from a social dialogue perspective are described in the following section.

The Federal Public Service (FPS) Employment, Labour and Social Dialogue plays a central role, under the authority of the Federal Minister for Work. Within the FPS, two key directorates are involved: the Directorate-General for the Humanisation of Work, which develops and promotes well-being policies, and the Directorate-General for the Control of Well-being at Work, which acts as the labour inspectorate (EU-OSHA, 2025; FPS Employment, Labour, and Social Dialogue, no date). The Federal Agency for Occupational Risks is responsible for managing occupational accidents and diseases, primarily in the private sector. It plays a key role in secondary prevention and operates under a management committee that includes representatives from trade unions and employers' organisations. For tertiary prevention, the National Institute for Health and Disability Insurance oversees disability benefits and health insurance, while a similar role is fulfilled for the self-employed by the National Institute for Social Insurance of the Self-Employed (FPS Employment, Labour, and Social Dialogue, no date).

Turning to the organisation level, besides the employer, there are numerous actors that play an important role in OSH. These include members of the hierarchy at the company (management); a confidential counsellor (as part of the company); the Committee for Prevention and Protection at Work; the prevention advisor psychosocial aspects (as part of the company or as affiliated with an external service); and other actors (e.g.; the occupational physician, prevention advisors who are not specialised in psychosocial risks, etc.) (FPS Employment, Labour, and Social Dialogue, no date; Lamberts, 2019).

Members of the hierarchy are those persons, from high to low in the company, who are authorised to give orders to employees. The members of the hierarchical chain are the ones who implement the prevention policy regarding psychosocial risks in everyday practice. Based on their daily experiences, they can propose the employer preventive measures that could be beneficial to the employees they supervise. Due to their close contact with employees, they have a responsibility to identify problems of a psychosocial nature associated with work. In case of a problem at the level of an individual employee, it is their duty to inform this person about the possible options that exist in order to solve the problem. In case of collective problems, e.g. the emergence of a psychosocial risk within a particular shift, members of the hierarchy should ask the employer to carry out a (new) risk assessment (FPS Employment, Labour, and Social Dialogue, no date).

Whether or not a confidential counsellor is obliged, depends on the number of employees (FPS Employment, Labour, and Social Dialogue, no date). When there are at least 50 employees in the

company, at least one counsellor must be appointed. Employees confronted with or worried about psychosocial risks can consult this person.

The Committee for Prevention and Protection at Work (also see below) is a consultative body that ensures the employee participation on issues related to well-being, including psychosocial risks, at work. It consists out of the head of the company and a delegation of employer representatives (members of the hierarchy, those with a managerial function). Employees are also represented. The members of the Committee that represent the employees are put forward by the trade unions and chosen based on works council elections (FPS Employment, Labour and Social Dialogue, no date). The Committee is tasked with contributing to the (further) development and promotion of well-being at work. More specifically, it gives advice on these matters, develops proposals for concrete measures that can be taken, etc.

Having a prevention advisor on psychosocial aspects is an obligation for every employer. A prevention advisor on psychosocial aspects can either be someone who works at the organisation or someone who is affiliated to an external service provider for prevention and protection at work. Whether or not the prevention advisor psychosocial aspects is part of the organisation or affiliated to an external service, is dependent on the number of employees. When an organisation has less than 50 employees it is obliged to engage an advisor who is externally affiliated. Whereas there are more than 50 employees, the choice is given to the organisation. The prevention advisor psychosocial aspects has a crucial role in everything that has to do with psychosocial risks: from assisting the employer with a risk analysis, the evaluation of the risk analysis, providing advice for the development and adjustment of prevention measures, the handling of formal and informal interventions, (FPS Employment, Labour, and Social Dialogue, no date).

When examining people, the occupational physician also explicitly takes the psychosocial risks into account. At least once a year, the occupational physician gives feedback on the psychosocial aspects that arose during medical examinations and workplace visits. This is useful information that helps the employer with the evaluation of the prevention policy and measures. Occupational physicians also inform employees suffering from psychosocial harm at work what actions they could take (e.g. (in)formal intervention, contacting the prevention advisor on psychosocial risks or confidant,) (FPS Employment, Labour, and Social Dialogue, no date).

4. Industrial relations system and regulatory framework on social dialogue

4.1 Industrial relations system and its key actors

Belgium has a well-established and multi-level social dialogue system that plays a central role in shaping OSH policies (Vangeel and Lenaerts, 2024; Lenaerts et al., 2024). Social dialogue is widely recognised as a mechanism for improving job quality, safety, and health, and complements legislation through collective bargaining agreements at national, sectoral, and company levels.

The **institutionalisation of social dialogue in Belgium** began in **1944** with the **Social Pact**, a landmark agreement between employers and trade unions that marked mutual recognition and a commitment to social peace (Vangeel and Lenaerts, 2024; Lenaerts et al., 2024). This pact laid the foundation for Belgium's **social security system** and **dialogue institutions**, contributing to post-war economic and social development. By 2018, trade union membership totaled 3.4 million, though only 2 million were part of the active labour force (Vangeel and Lenaerts, 2024). This suggests that one in three members is inactive (e.g., retirees, students, unemployed).

Belgium's union landscape is notable for its **low fragmentation** between public and private sectors (only 1.6% difference in union density), **high union density**: 49.1% in 2019 (lowest since 1990), with 52.8% among men and 46.9% among women, **consistent unionisation across company sizes and age groups**, and **targeted outreach** to migrant workers (since the 1960s), women (since the 1970s), and youth (since the 1980s) (Lenaerts et al., 2024).

Belgium's relatively high union density can be partly attributed to its use of the partial Ghent system (Vangeel and Lenaerts, 2024). In this system, while unemployment insurance is mandatory, unions play a central role in administering and distributing unemployment benefits. Unemployed individuals can turn to one of four payout institutions for information and payment of benefits: the three major trade union confederations and the Auxiliary Fund for Unemployment Benefits (HVW/CAPAC). This close involvement creates regular contact between unemployed workers and union officials, which strongly incentivises union membership. The system not only facilitates access to benefits but also reinforces the relevance and visibility of trade unions in workers' lives. This dynamic was particularly evident during the COVID-19 crisis, when many workers joined unions to expedite the processing of their temporary unemployment benefits. The Ghent system thus contributes significantly to sustaining high union membership rates in Belgium by intertwining social protection with union engagement.

Collective bargaining in Belgium operates at three distinct levels (Vangeel and Lenaerts, 2024; Lenaerts et al., 2024). At the highest level, national negotiations take place between employers' organisations and trade unions to establish intersectoral agreements that apply across the entire economy. These centralised agreements set the framework for employment conditions and labour relations nationwide. Beneath this, the intermediate level, which is the dominant level of collective bargaining, focuses on sector-specific negotiations conducted within joint committees

and subcommittees. These sectoral agreements tailor employment conditions to the particular needs and dynamics of each industry. Finally, collective bargaining occurs at the company level, where agreements are negotiated to address the specific circumstances of individual enterprises.

The system is **hierarchical**, meaning that agreements reached at lower levels can only improve upon the conditions set at higher levels; they cannot derogate from them. This structure ensures that minimum standards established nationally or sectorally are upheld across all workplaces. Moreover, any collective bargaining agreement (CBA) automatically applies to all enterprises that are members of the joint (sub)committee that negotiated it. This mechanism effectively extends the coverage of intersectoral CBAs to all Belgian employees, contributing to the country's high collective bargaining coverage rate (Vangeel and Lenaerts, 2024;).

At the **national level**, key social dialogue institutions include the **National Labour Council** (NAR/CNT), which can conclude binding collective agreements across all sectors, and the **Central Economic Council** (CRB/CCE), which provides economic and social policy advice. The **Group of Ten**, which is composed of high-level representatives from trade unions and employers' organisations, negotiates interprofessional agreements (IPAs), which serve as strategic frameworks but are not legally binding unless translated into formal agreements by the NAR/CNT.

At the national level, the High Council for Prevention and Protection at Work is another influential body. Composed of social partner representatives, it advises the federal Minister of Employment on issues relating to well-being at work. While its advice is not binding, it is typically followed, especially when a consensus is reached among social partners. The Council issued a joint priority note for 2024–2029, calling for improvements in prevention services, legislation clarity, and awareness-raising among workers (EU-OSHA, 2025).

At the **intermediate level** of Belgium's collective bargaining system, negotiations take place within approximately 170 joint committees and subcommittees (Vangeel and Lenaerts, 2024; Lenaerts et al., 2024). These bodies are organised by sector and are responsible for implementing the overarching framework established at the interprofessional level. Within these committees, employers and trade unions negotiate specific aspects of working conditions, including pay scales, working-time arrangements, and training opportunities. Sectoral social funds also support prevention initiatives and distribute benefits.

Every **company** in Belgium is assigned to a sectoral joint committee as soon as it applies for a social security number (Vangeel and Lenaerts, 2024). Consequently, all employees registered with that company are automatically linked to the same joint committee. This system ensures that sector-specific agreements are consistently applied across enterprises and that workers benefit from the protections and standards negotiated within their respective sectors.

In Belgium, **employee representation at the workplace level** is structured around three main forms, each with specific conditions and roles (Vangeel and Lenaerts, 2024; Lenaerts et al., 2024). First, companies with more than 50 employees are legally required to establish a **health and safety committee**. This committee includes delegates from both unions and the employer, and its primary function is to advise the company on matters related to worker health and safety. Secondly, when a company exceeds 100 employees, it must also set up a **works council**. This body is composed of an equal number of employer and employee representatives and holds rights to information, consultation, and advice. Although its decision-making power is limited, it plays a significant role in workplace governance. Thirdly, a **trade union delegation** can be formed at any

time upon request by one of the three recognised unions, regardless of the number of employees in the company. This makes it a flexible and potentially early form of representation.

Importantly, Belgium does not provide for employee representation at the board level. The legitimacy and representativeness of collective bargaining are maintained through **social elections**, held every four years. These elections determine the employee representatives who will serve on both the health and safety committees and the works councils. Only members of the recognised trade unions are eligible to stand for election, reinforcing the central role of unions in workplace representation (Vangeel and Lenaerts, 2024; Lenaerts et al., 2024).

4.2 Social partners' involvement in the prevention and management of psychosocial risks

Belgium's tradition of social dialogue is widely regarded as a key strength in its labour relations system. This tradition has enabled constructive collaboration between employers, employees, and social partners, particularly in addressing psychosocial risks such as stress and harassment. Since the 1990s, social dialogue has facilitated proactive negotiations on these issues. However, **while awareness of psychosocial risks is generally high at the interprofessional level, there remains a significant gap in training and understanding at the company level**. Workers and employers often lack the necessary expertise (Lenaerts et al., 2024; EU-OSHA, 2025).

Despite the challenges, Belgian social partners are actively engaged in promoting mental health and managing psychosocial risks. Nevertheless, approaches differ: **employers' organisations tend to focus on individual responsibility and adopt a cautious stance toward legislation**, whereas **trade unions advocate for collective solutions** and seek to **reinforce their role as intermediaries in workplace relations** (Lenaerts et al., 2024; EU-OSHA, 2025).

A central institution in this context is the National Labour Council, which plays a pivotal role in shaping national policy on psychosocial risks. The NLC issues non-binding advice and opinions on social matters, often at the request of the government or parliament. When consensus is reached among social partners, the government typically adopts these recommendations. The NLC also concludes collective bargaining agreements with national and interprofessional scope, which are made universally applicable through Royal Decree.

One of the most significant initiatives of the NLC was the adoption of **Collective Agreement No. 72 in 1999** (FPS Employment, Labour and Social Dialogue, no date). This agreement defined stress in the workplace and outlined the responsibilities of employers and employees in implementing a stress prevention policy. Although many of its provisions were later incorporated into Title 3 of Book I of the Codex on Well-being at Work, which has a broader and more binding scope, the agreement remains in force. It focuses on collective-level interventions and applies only to the private sector, while the Codex covers both private and public sectors and includes individual-level measures and tertiary prevention strategies.

In recent years, the NLC has also led efforts to prevent burnout through organisational-level policies aimed at promoting sustainable employability. Mandated by the interprofessional agreement of February 2017, the Council developed a collective approach to burnout prevention, which was outlined in 2018. This approach involves multiple stakeholders at the company level—employees, management, HR, prevention advisers, and consultation bodies—and is implemented through pilot projects. These projects aim to create meaningful, high-quality work

environments that reduce psychosocial strain and prevent burnout, reflecting the social partners' commitment to collective, preventive action.

Between 2019 and 2021, the National Labour Council (NLC) tested its approach to burnout prevention through a series of pilot projects across various companies and sectors. These projects, subsidised to include expert project supervisors, were evaluated in 2021 and 2022 in collaboration with academic experts. The findings, published in Advice No. 2.218 and Advice No. 2.330, revealed that most participating companies viewed the interventions positively and considered them good practices for preventing burnout and psychosocial risks.

Following these pilots, the NLC issued **Recommendation No. 30** in November 2023, offering six key recommendations to companies and sectors for improving psychosocial well-being and preventing burnout. These include adopting an integrated and multidisciplinary approach that addresses both individual and organisational factors; fostering internal support by raising awareness and cultivating a workplace culture where well-being can be openly discussed; conducting tailored situation analyses to identify strengths and areas for improvement; embedding these efforts into long-term strategic policy; ensuring a bottom-up, participatory process that values worker input; and translating awareness into action by leveraging sectoral expertise and resources.

These initiatives form part of a broader federal policy framework aimed at reducing psychosocial risks and preventing work-related stress and burnout. In addition to the burnout prevention pilots, the NLC launched another series of pilot projects in 2020 focused on innovative work organisation, which ran until March 2024. Of note here is also **NLC Recommendation 31**, on the prevention and reintegration of persons with health issues/

The NLC has also issued **several other important advices related to psychosocial risks**. These include Advice No. 2.265 (2021) on anti-discrimination and protection against harmful measures, which proposed amendments to existing laws and regulations; Advice No. 1.851 (2013) and Advice No. 1.808 (2012) on the prevention of psychosocial strain, including harassment and sexual harassment; Advice No. 241 (2021) on protection against reprisals within internal procedures; and Advice No. 178 (2014) on a draft Royal Decree concerning the prevention of psychosocial risks at work. Together, these initiatives reflect the NLC's sustained commitment to improving psychosocial well-being in the workplace through collaborative, evidence-based policy development (FPS Employment, Labour and Social Dialogue, no date; EU-OSHA, 2025).

As previously discussed, social partners at both the sectoral and company levels in Belgium are actively engaged in addressing psychosocial risks and promoting mental health in the workplace. Their involvement goes beyond participation in national initiatives and includes a range of practical efforts.

5. Sectoral deep dives: Industrial relations and psychosocial risks in the healthcare sector and in the construction and manufacturing sectors

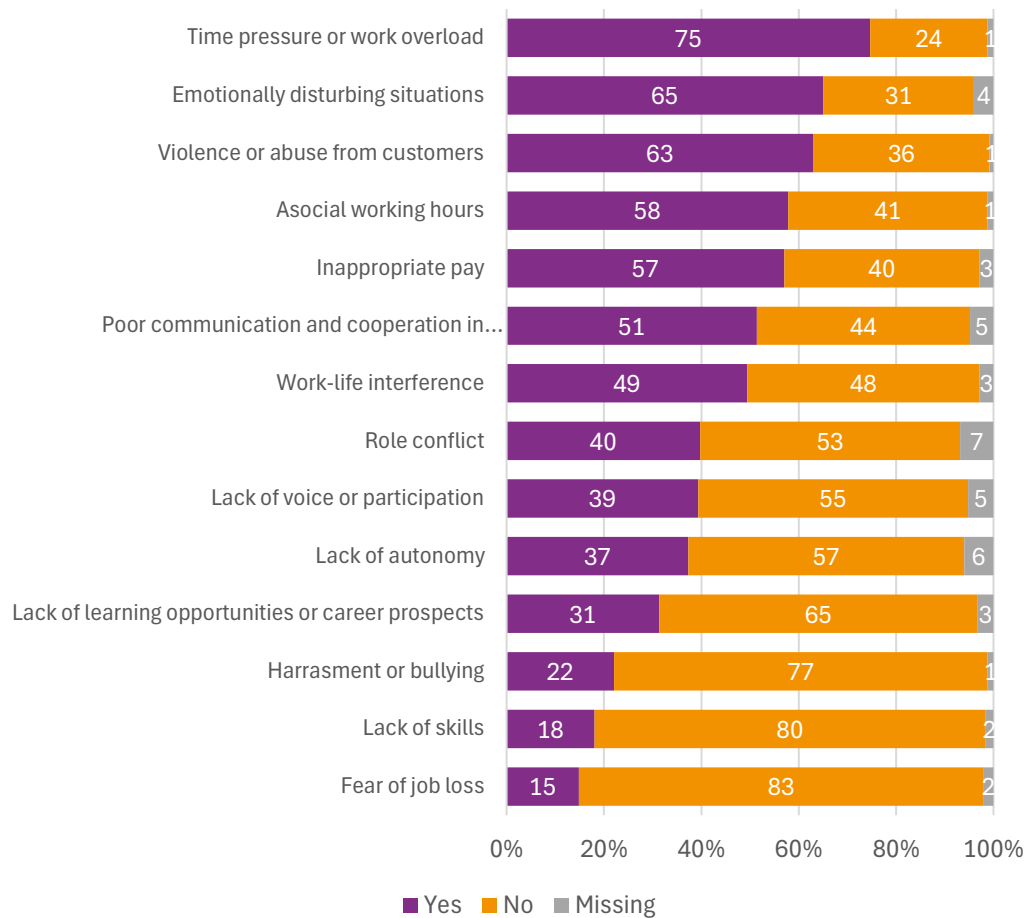
This section offers a deep-dive into two important sectors: (i) healthcare (female-dominated), and (ii) construction and manufacturing (male-dominated). These deep-dives rely on a combination of desk research, stakeholder interviews (with sectoral and company-level representatives of trade unions as well as employers' organisations) and a survey among workers, focusing on exposure to psychosocial risks, the measures taken to address those, as well as health outcomes. More specifically, the results examine workers' perceptions of targeted measures, safety voice, and the overall quality of psychosocial risk management, including the psychosocial safety climate. The extent to which employees participate in the development and implementation of strategies is also investigated, making a distinction between direct and indirect involvement.

5.1 Healthcare

Healthcare workplaces have among the highest psychosocial and physical risks. In recent years **staff shortages and burnout** have been major issues in the sector, which have intensified during the COVID-19 pandemic. The Belgian national action plan to improve the well-being of workers in the performance of their work for 2022-2027 explicitly supports healthcare workers' well-being: it supports sectoral agreements for the reduction of work pressure and foresees targeted actions such as awareness-raising and training, as well as the ratification of ILO Convention No. 190. At the time of the COVID-19 pandemic, Belgian health authorities issued special prevention guides and tested rapid workplace adjustments. Trade unions have raised the issue of rising stress in the sector and have called for enforced psychosocial risk analysis, mandatory worker training on stress prevention, and stronger inspection powers, as mentioned in the stakeholder interviews.

5.1.1 Exposure to psychosocial risks

Figure 1. Percentage of workers reporting they have been exposed to these psychosocial risks



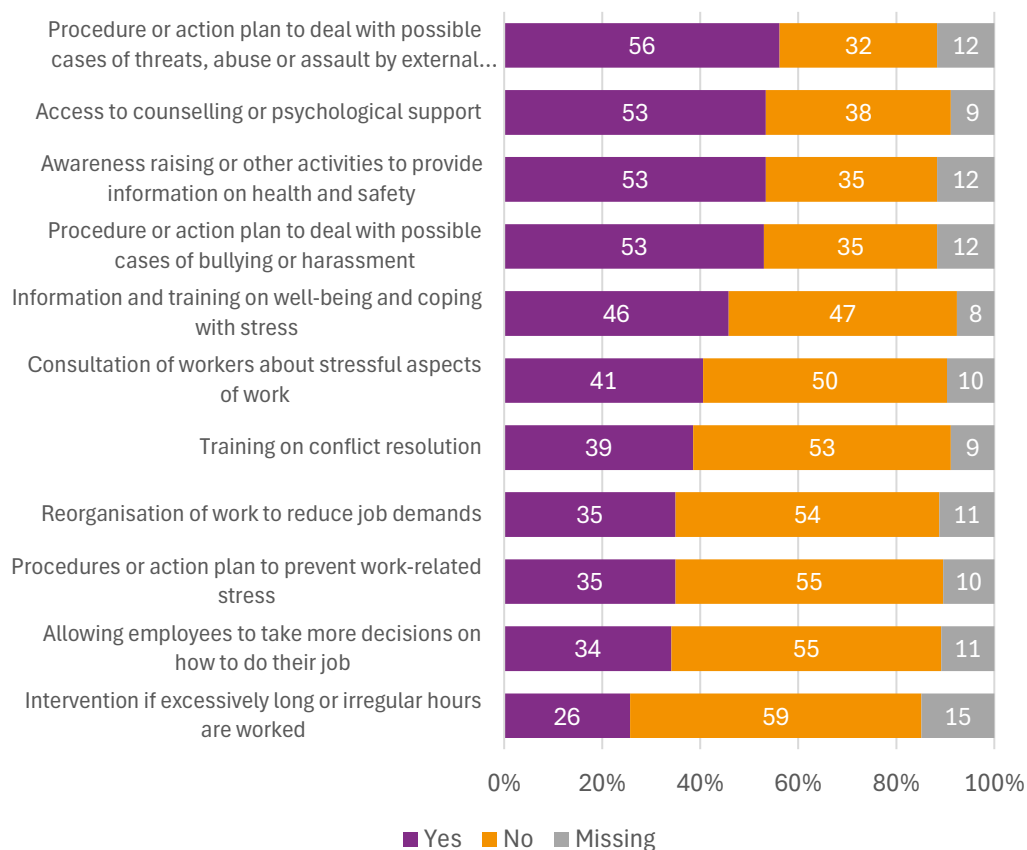
Source Own calculations, survey data collected among Belgian healthcare workers (N=249)

As a starting point for the analyses, we first consider the **prevalence of psychosocial risks at work** in healthcare. As illustrated in the above figure, the most commonly reported psychosocial risk is time pressure or work overload, with 75% of workers affected. Other frequently reported risk factors in the sector are emotionally disturbing situations (65%), violence or abuse from customers (patients) (63%), asocial working hours (58%) and inappropriate pay (57%). Emotional demands and patient aggression are strikingly high compared to most other sectors in Belgium, for example, in manufacturing, fewer than 30% report such risks. At the other end, only 15% fear job loss. This suggests that healthcare jobs are secure but extremely demanding, both emotionally and physically, and characterised by multiple overlapping risk factors. These findings are aligned with stakeholder interviews, in which the impact of having to interact with patients, their families or other third parties, on workers' well-being was highlighted.

5.1.2 Management of psychosocial risks

Turning to how psychosocial risks are managed within the workplace, we first assess the specific measures that are provided within the organisation.

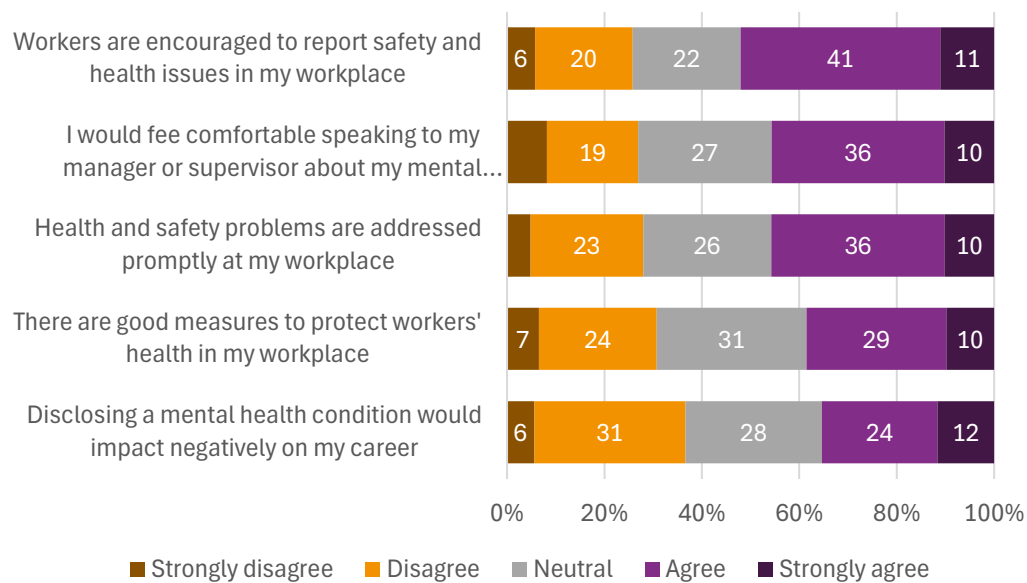
Figure 2. Percentage of workers indicating these measures were used in their organisation in the past three years



Source Own calculations, survey data collected among Belgian healthcare workers (N=249)

The most common measures that are implemented in organisations to address psychosocial risks are **reactive**: more than half of healthcare workplaces have procedures for patient aggression (56%) and provide access to counselling or psychological support (53%). However, **proactive measures** such as redesigning work, training staff on stress prevention, or conflict management are present in fewer than one in three organisations. Worryingly, 16% of workplaces offer **no measures at all**, while only 6% provide the full set. On average, workplaces implement fewer than 5 out of 11 possible measures. This shows a big gap between **responding to external threats** (like violence) and **preventing internal risks** (like chronic stress). The latter point came up in the interview with trade union representatives as well.

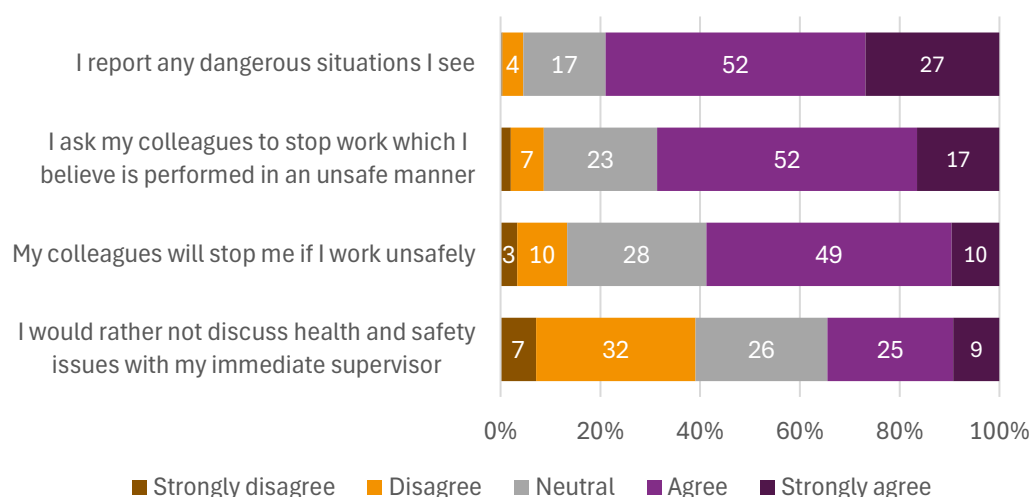
Figure 3. Extent to which workers agree that these techniques for psychosocial risk management are used within their organisations (%)



Source Own calculations, survey data collected among Belgian healthcare workers (N=249)

Healthcare workers were then asked about **the extent to which specific techniques are used within their own organisation**. 52% of the respondents indicated that workers **are encouraged to report safety and health issues** in their workplace, while 26% disagreed with this point. In addition, while 46% of workers stated that **health and safety issues are promptly addressed** in their workplace, 23% did not agree with this statement. 36% of workers indicated that disclosing a mental health condition would hamper their career. 19% does not feel comfortable speaking with their manager or supervisor about their mental health. **These findings highlight the stigma that still exists around mental health issues, as well as the fact that many workers do not feel that psychosocial risks are not appropriately managed within their workplace.**

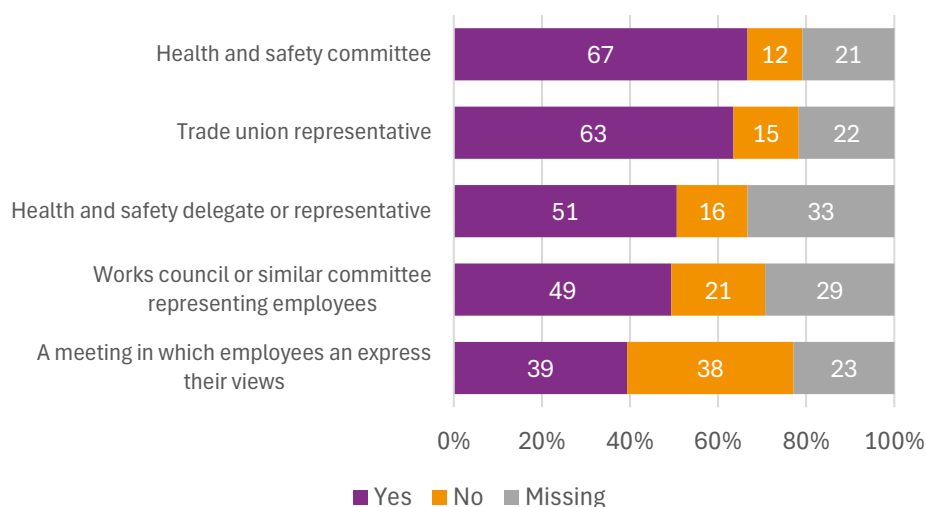
Figure 4. Extent to which workers agree to different aspects of safety voice (%)



Source Own calculations, survey data collected among Belgian healthcare workers (N=249)

Furthermore, workers were asked to evaluate to which extent they themselves have ‘*safety voice*’. Safety voice is the **believe and willingness that one can speak up for him/herself or someone else about safety-related risks and issues at the workplace** (Paul et al., 2025). Concerning psychosocial risks, this could include raising concerns about mental health, stress, workload, or interpersonal conflicts. The survey among healthcare workers in Belgium suggests that 79% of them would **report any dangerous situation they see**, while 69% would **ask their colleagues to stop work which they believe is performed in an unsafe manner**. In addition, 59% states that their colleagues would stop them when working unsafely. One-third of the surveyed workers would rather not discuss health and safety issues with their immediate supervisor, which is rather concerning and highlights the importance of strengthening social relations at work.

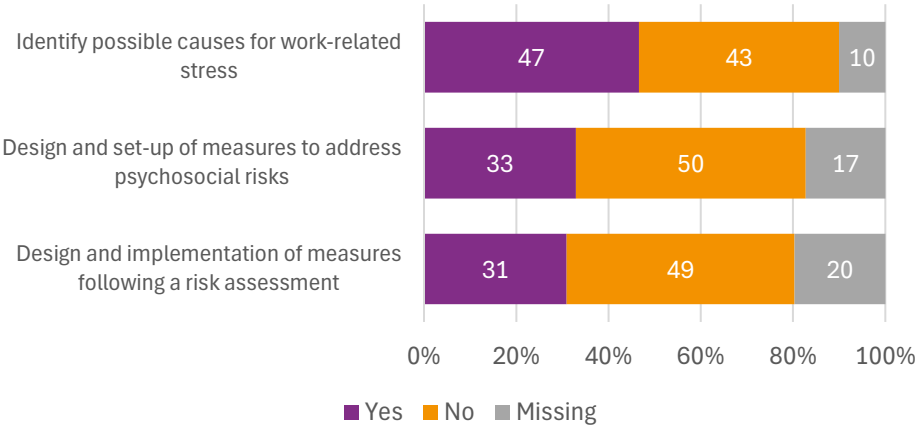
Figure 5. Percentage of workers indicating these representatives or groups are involved in discussions concerning psychosocial risks and mental well-being of workers



Source Own calculations, survey data collected among Belgian healthcare workers (N=249)

The survey further zoomed in on the different actors involved in psychosocial risk management. As the above figure shows, two-thirds of healthcare workers (67%) report their organisation has a **formal health and safety committee**, reflecting Belgian legislation requiring the establishment of such committees in larger institutions. About half of the survey respondents mention there is a trade union delegation, but only 39% say their workplace organises **direct staff meetings** where they can share views. This shows a clear difference: while **formal structures exist**, direct voice opportunities are less common.

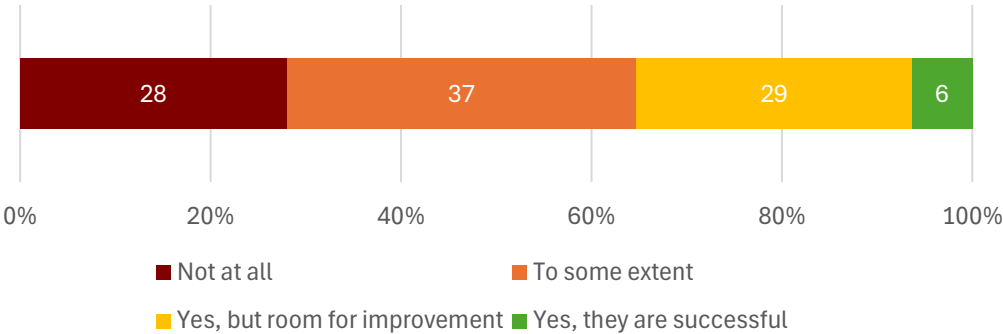
Figure 6. Percentage of workers reporting that employees have been involved in these psychosocial risk management activities



Source Own calculations, survey data collected among Belgian healthcare workers (N=249)

Almost half of healthcare workers (47%) are involved in **identifying work-related stress factors**, but far fewer help design or implement solutions. Strikingly, nearly half report **no involvement at all**. This suggests that consultation often stops at problem recognition, without engaging workers in solutions, an issue that was a common theme in the interviews with academic experts, government representatives, and social partner representatives as well. In practice, this weakens the effectiveness of prevention because frontline staff, who best understand daily pressures, are not fully engaged.

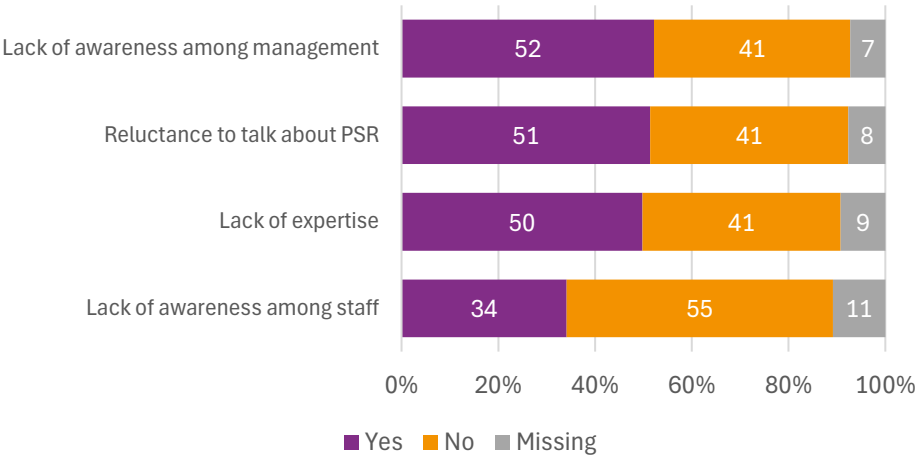
Figure 7. Evaluation of the success of actors and initiatives in the organisation to reduce stress and psychosocial risks (%)



Source Own calculations, survey data collected among Belgian healthcare workers (N=249)

When asked about how successful the measures implemented within their organisation are to reduce stress and psychosocial risks, only **6% of workers** think the initiatives are fully successful, which is a very small minority. Most (65%) say they are partly successful, and over one in four workers (28%) see them as failing. This means that even when measures exist, they often **do not meet workers' expectations**. Compared to construction workers (where 12% rated initiatives as fully successful), healthcare staff are **less convinced** about the effectiveness. This underlines that having measures is not enough: implementation quality and visible results matter. This gap between existence of measures and their perceived success suggests trust issues in the sector.

Figure 8. Percentage of workers reporting these obstacles to dealing with psychosocial risks in their organisation



Source Own calculations, survey data collected among Belgian healthcare workers (N=249)

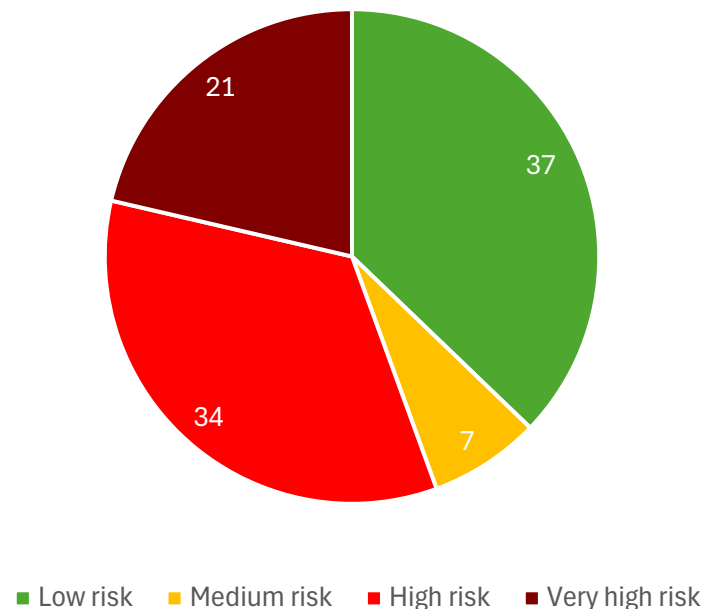
When asked about the perceived obstacles to dealing with psychosocial risks in the organisation, more than half of the surveyed healthcare workers (52%) highlight a lack of awareness among management, as well as a reluctance to talk about psychosocial risks (51%). 50% of the workers in the healthcare sector, moreover, point to a lack of expertise within the organisation. In contract, only 34% points to a lack of awareness about psychosocial risks among the staff.

As outlined in the theoretical and empirical work that is part of the PSYR-IR project (D2.1, Heylen et al., 2024), the concept of **Psychosocial Safety Climate** (PSC) is highly relevant for managing psychosocial risks in the workplace. Psychosocial Safety Climate refers to the **organisational framework through which employees perceive their employer’s commitment to safeguarding psychological health**. The concept captures the degree to which workplace policies, practices, and procedures prioritise stress prevention over productivity, address psychosocial risks, ensure open communication about concerns, and actively involve all organisational levels, including employees, management, and representatives, in promoting mental well-being, with a strong emphasis on leadership engagement (Dollard & Bakker, 2010).

For the purposes of this study, PSC was assessed using the PSC-4 scale (REF). Benchmarking against standards established by Bailey and Dollard (2019) enabled the evaluation of organisational PSC levels among respondents. A **low-risk PSC** indicates strong PSR management, with managers performing effectively and visible improvements underway. A **medium-risk PSC** suggests the situation is manageable but requires stronger implementation of

PSC principles. A **high-risk PSC** points to significant shortcomings that call for targeted improvements across the four PSC dimensions. Finally, a **very high-risk PSC** signals an urgent need for immediate action to prevent escalating psychosocial risks and associated mental health issues.

Figure 9. Percentage of respondents by PSC risk group*



* Risk group cut off values based on Bailey & Dollard (2019)

Source Own calculations, survey data collected among Belgian healthcare workers (N=249)

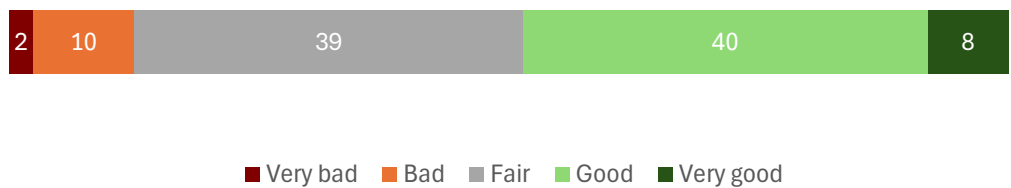
Only about one in three healthcare workers (37%) experience a **supportive psychosocial safety climate**, meaning their organisation actively manages stress and mental health. By contrast, nearly half (45%) fall into the **high or very high risk** categories. This means that in healthcare, **the majority work in settings where management is perceived as insufficiently committed to well-being**, which strongly predicts burnout and absenteeism.

Workers in organisations with a **low PSC risk** tend to do better: they report higher engagement scores and lower burnout risk. For example, burn-out scores are significantly higher in PSC groups 3 and 4 than in group 1. Similarly, general health and number of health problems worsen progressively as PSC risk rises. This result demonstrates that **organisational climate is decisive**: when management prioritises psychosocial well-being, workers are healthier and more resilient. Conversely, in poor climates, risks translate into measurable declines in health. This mirrors EU research (Dollard & Bakker, 2010) confirming PSC as a core predictor of well-being.

5.1.3 Health of workers in the sector

In a final part of the survey, respondents were asked to reflect on their health (see figures below).

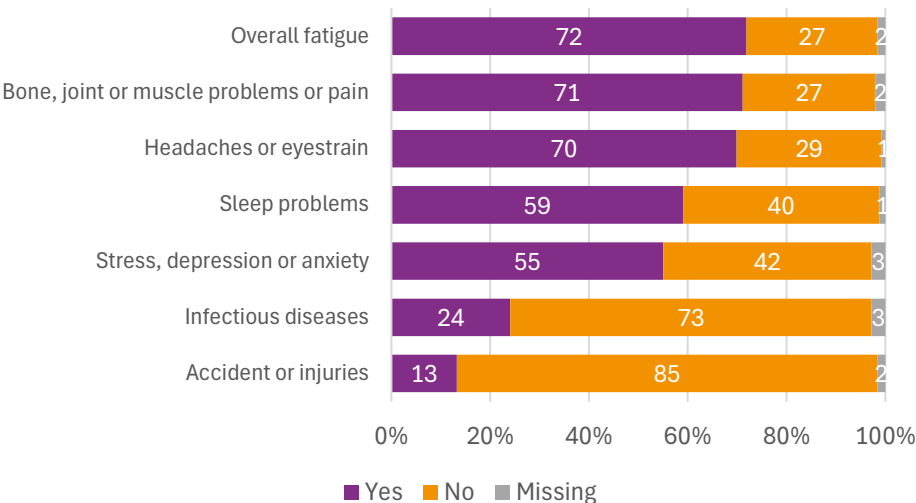
Figure 10. Workers' assessment of their health in general, percentages



Source Own calculations, survey data collected among Belgian healthcare workers (N=249)

Most healthcare workers rate their health as “good” (40%), but only 8% say “very good”. At the other end, about 12% report poor health.

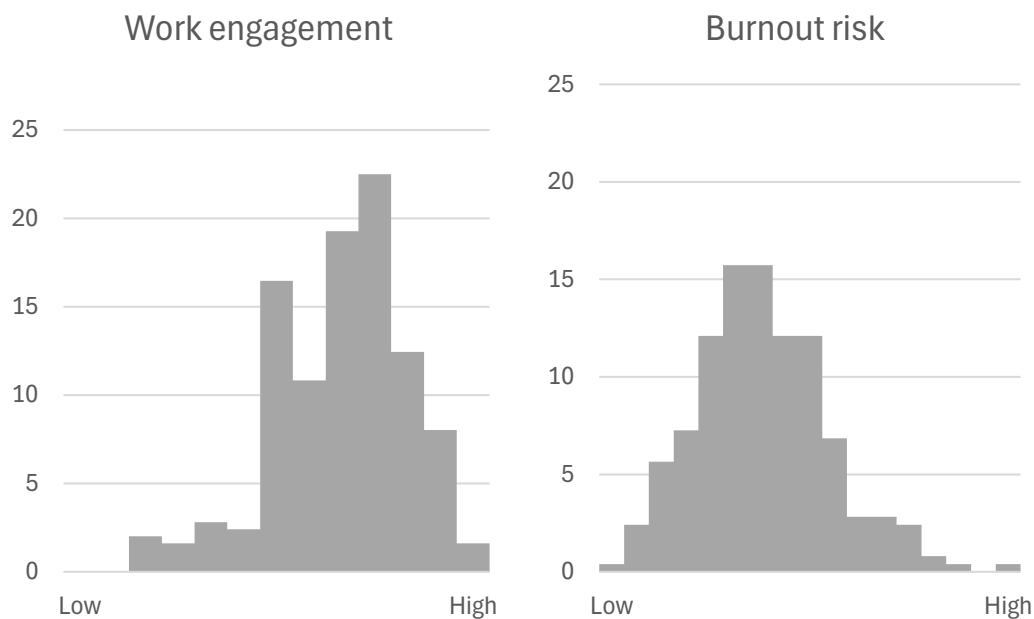
Figure 11. Percentages of workers reporting these health issues, cause or made worse by their work, in the past 12 months



Source Own calculations, survey data collected among Belgian healthcare workers (N=249)

Among healthcare workers, overall **fatigue** is the dominant health issue, reported by nearly three-quarters of workers (72%). Stress, depression and anxiety are also quite high (about 55%), while almost 60% have sleep problems. Musculoskeletal pain affects 71% of workers, reflecting the physical strain of patient handling. This confirms healthcare as a **high-risk sector** for both mental and physical complaints, with multiple overlapping conditions, as was also recalled in the stakeholder interviews.

Figure 12. Work engagement and burnout risk



Source Own calculations, survey data collected among Belgian healthcare workers (N=249)

Healthcare workers report relatively **high levels of work engagement** (3.7/5), showing they are motivated and find meaning in their work. At the same time, their **burnout risk is moderate** (2.5/5). This reflects the “engagement-burnout paradox”: staff are committed but also exhausted. Compared to construction and manufacturing workers (who report lower engagement and similar burnout), healthcare workers show that passion for the job does not shield against exhaustion when workloads remain high.

5.2 Construction and manufacturing

Following the deep-dive for the healthcare sector, we now turn our attention to the manufacturing and construction sectors, which are both male-dominated. In Belgium, the manufacturing sector remains a large employer (notably the metal, machinery and food industries). Traditional physical risks (such as machinery-related hazards, chemical exposures, MSK risk factors) still occur, but overall accidents have trended downward along with employment shifts. Many companies in the sector have internal and/or external prevention advisors. Trade unions in manufacturing (e.g., ACV-Metea) highlight concerns like repetitive strain and mental stress from automation, pressing for job rotation and ergonomic improvements. The employers’ federations (e.g., Agoria) generally emphasise compliance with risk analysis and training. The national OSH plan also notes that SMEs need extra support and guidance (tools, visits) to implement OSH policies, reflecting that many manufacturing firms are small- and medium-sized organisations. Turning to construction, this sector has historically had high injury rates, but more recently accident rates are declining (according to employers’ organisation *Embuild*). Safety culture has been improving. The 2022 national action plan calls for updates to temporary/mobile construction site regulations and fire prevention rules. Also, an “internal service for prevention” is required on major sites: committees with worker representatives (including a prevention adviser and psychosocial advisor) meet regularly about well-being issues. Trade unions in construction participate in these committees and national campaigns. Unions have also advocated for stricter enforcement of safety laws.

Note that the findings for the manufacturing and construction sectors have many missing values. The reporting of results accounts for this issue.

5.2.1 Exposure to psychosocial risks

Figure 13. Exposure to PSR



Source Own calculations, survey data collected among Belgian construction and manufacturing workers (N=202)

Among workers in the manufacturing and construction sectors; **time pressure or work overload**, again emergers as the most common risk. This is followed by irregular or unsocial hours, reflecting shift work and overtime patterns typical of manufacturing and construction. Poor communication and cooperation in the organisation, inappropriate pay, and a lack of autonomy rank high as well. Emotional strain and violence are less frequent than in healthcare, since direct customer contact is more limited. Overall, risks are more linked to **job insecurity, work schedules, and workload** than to emotional demands. These points were confirmed during the interviews with stakeholders as well, in addition to the often strong focus on workers’ safety and physical aspects of the work.

5.2.2 Management of psychosocial risks

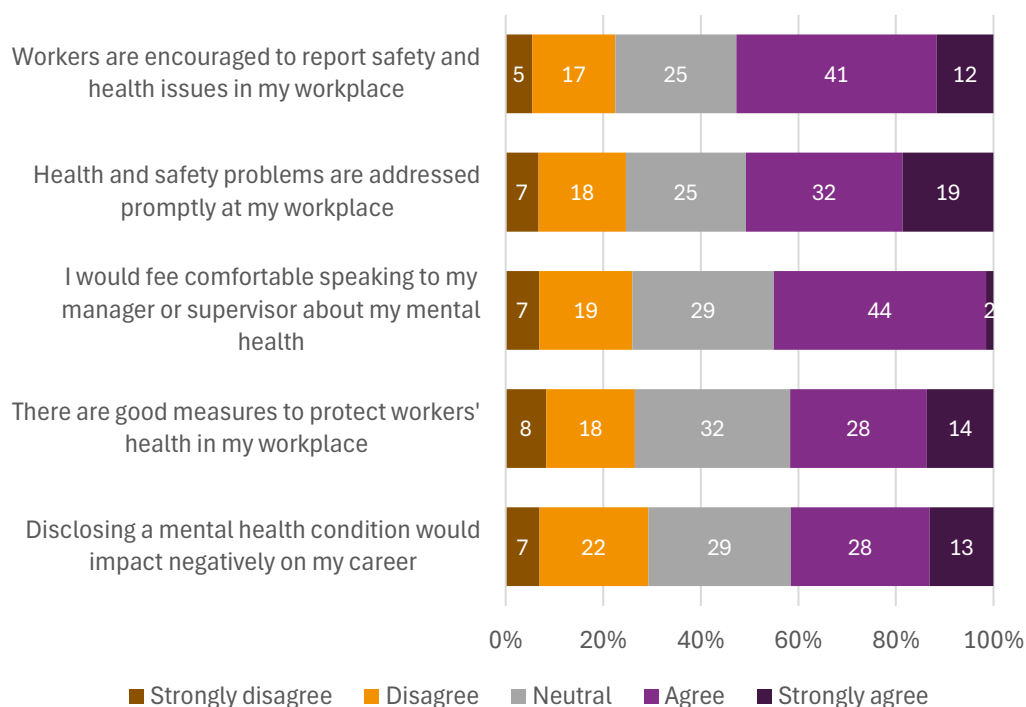
Figure 14. Percentage of workers indicating these measures were used in their organisation in the past three years



Source Own calculations, survey data collected among Belgian construction and manufacturing workers (N=202)

This figure lists measures implemented to prevent PSRs. The most common measures include access to counselling (30%) and awareness raising activities (31%). However, many measures are reported by relatively few respondents, suggesting limited implementation across workplaces. Measures appear less widespread in the construction and manufacturing sectors than in the healthcare sector, for example when it comes to procedures for dealing with aggression. Training and workload redesign are rare. Worryingly, again a substantial share of the workplaces in the manufacturing and construction sectors provide **no measures at all**. On average, workplaces offer just 3 out of 11 measures, compared to nearly 5 in healthcare. This shows that psychosocial risk management in these sectors is still **underdeveloped and reactive**. This issue was highlighted across all interviews.

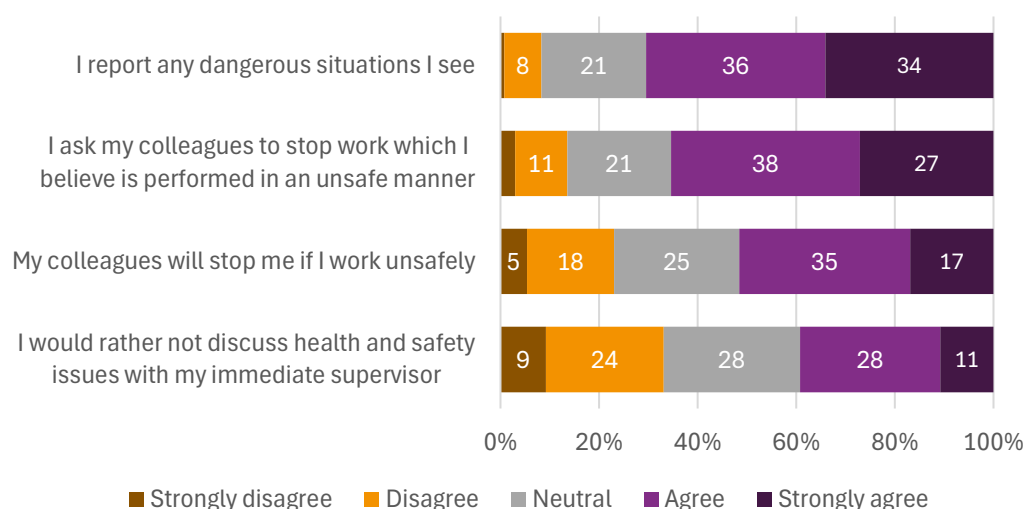
Figure 15. Extent to which workers agree that these techniques for psychosocial risk management are used within their organisations (%)



Source Own calculations, survey data collected among Belgian construction and manufacturing workers (N=202)

When it comes to the specific techniques for psychosocial risk management, 53% of the workers in the manufacturing and construction sectors report that workers are encouraged to report safety and health issues in their workplace. 51% of the workers stated that health and safety problems are promptly addressed at their workplace. 46% is comfortable speaking to their manager about mental health issues, while 42% finds that there are good measures in place to protect workers' health. Finally, 41% is afraid that disclosing a mental health condition would negatively impact on their career.

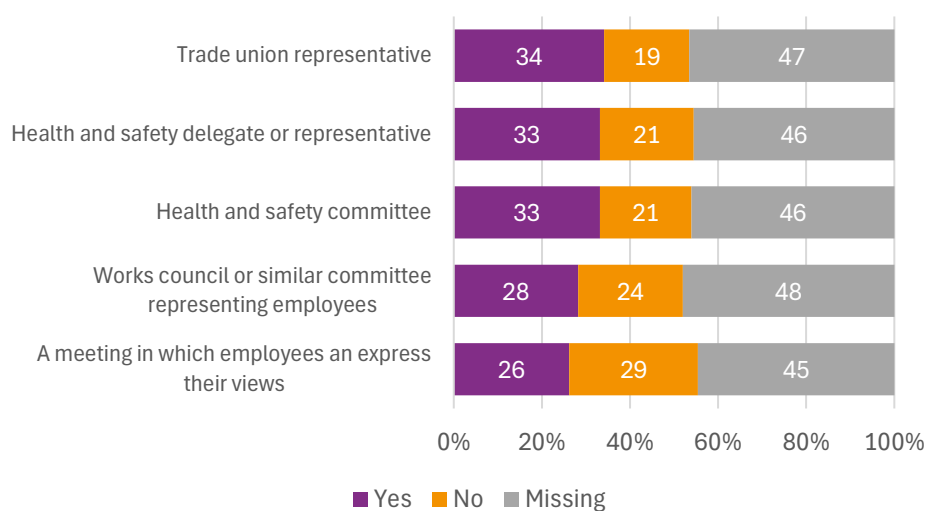
Figure 16. Extent to which workers agree to different aspects of safety voice (%)



Source Own calculations, survey data collected among Belgian construction and manufacturing workers (N=202)

Turning to safety voice in the above figure, a substantial number of respondents in manufacturing and construction will report dangerous situations (70%) and ask colleagues to stop working when doing so in an unsafe manner (65%). 52% of workers believe that their colleagues will stop them from working unsafely.

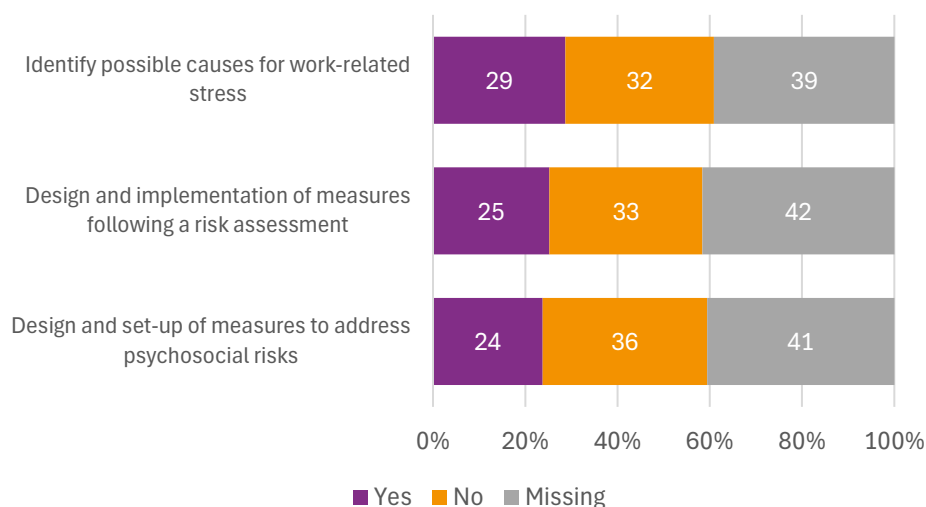
Figure 17. Percentage of workers indicating these representatives or groups are involved in discussions concerning psychosocial risks and mental well-being of workers



Source Own calculations, survey data collected among Belgian construction and manufacturing workers (N=202)

Formal health and safety committees are present in many workplaces in the manufacturing and construction sectors, as is trade union representation.

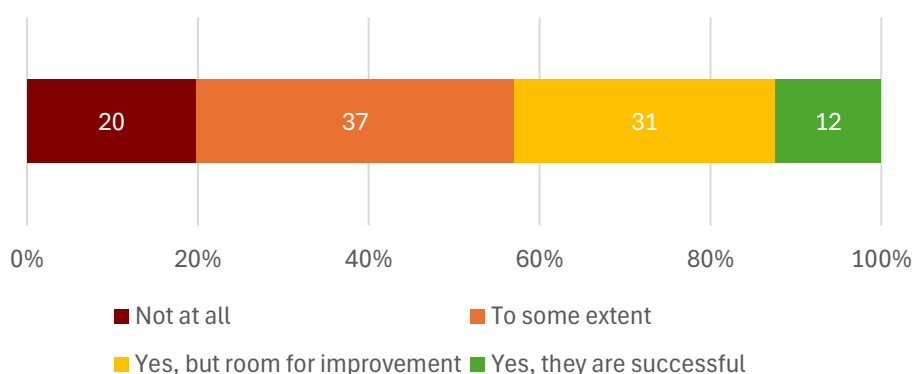
Figure 18. Percentage of workers reporting that employees have been involved in these psychosocial risk management activities



Source Own calculations, survey data collected among Belgian construction and manufacturing workers (N=202)

Of the respondents who answered the questions, less than half indicated to be consulted about stress causes, and involvement drops further for designing and implementing solutions. Many say they are **not involved at all**. This indicates that construction and manufacturing workers are even more **excluded from prevention processes**.

Figure 19. Evaluation of the success of actors and initiatives in the organisation to reduce stress and psychosocial risks (%)

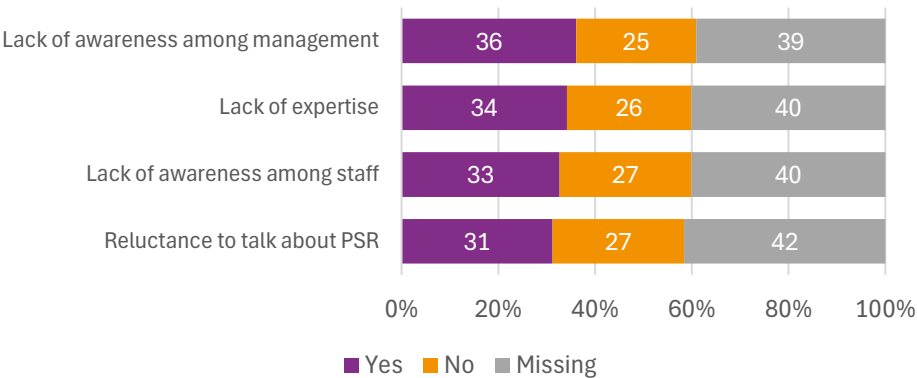


Source Own calculations, survey data collected among Belgian construction and manufacturing workers (N=202)

Only 12% of workers in construction and manufacturing view psychosocial initiatives as fully successful, which is double the share in healthcare (6%) but still a small minority. Almost six in ten (59%) see them as partly successful, while 29% consider them failures. This shows that even when measures are present, their impact is often limited. Compared with healthcare, workers here are **slightly more positive**, possibly because expectations are lower or because problems

are less acute than in healthcare. Still, nearly one-third finding initiatives unsuccessful reflects a significant **trust and effectiveness gap**.

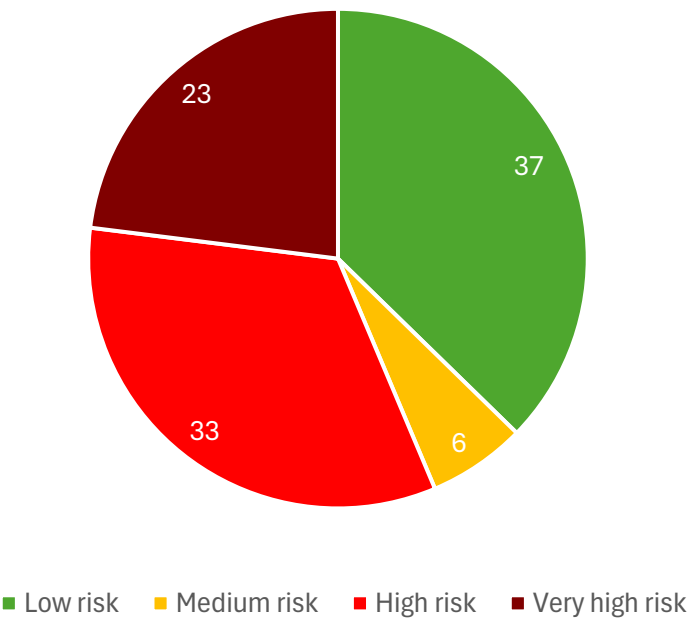
Figure 20. Percentage of workers reporting these obstacles to dealing with psychosocial risks in their organisation



Source Own calculations, survey data collected among Belgian construction and manufacturing workers (N=202)

This figure identifies obstacles to addressing psychosocial risk factors. The main barriers are lack of awareness among management and a lack of expertise. These findings highlight the need for improved training and awareness at all organisational levels, which was highlighted in interviews with government representatives and academic experts.

Figure 21. Percentage of respondents by PSC risk group*



* Risk group cut off values based on Bailey & Dollard (2019)

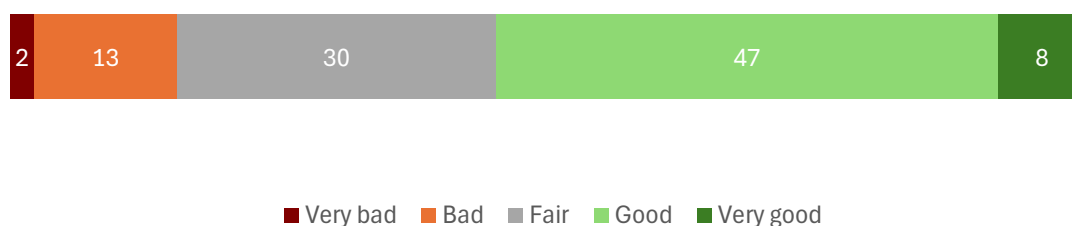
Source Own calculations, survey data collected among Belgian construction and manufacturing workers (N=202)

About one in three workers (37%) in manufacturing and construction experience a **supportive climate**, similar to healthcare. However, nearly half (47%) of them fall into the **high or very high risk groups**. This pattern is very close to healthcare, but with slightly more workers in the “very high” risk group (23% vs. 21%). In other words, around **one out of every four workers** feels their organisation makes little to no effort to manage psychosocial risks. Compared to the healthcare sector, the distribution is almost identical, but the **drivers differ**: here it is insecurity and pay; in healthcare, it is emotional strain.

The same pattern as in healthcare is confirmed: **workers in supportive climates (low PSC risk) report better health, higher engagement, and lower burnout**. Those in poor climates (high PSC risk) show the opposite. For example, burnout scores in groups 3 and 4 are significantly higher than in group 1. This reinforces that organisational climate is a critical factor across all sectors. While physical risks dominate in construction and manufacturing, the data show that psychosocial climate also shapes outcomes strongly, just as in healthcare.

5.2.3 Health of workers in the sector

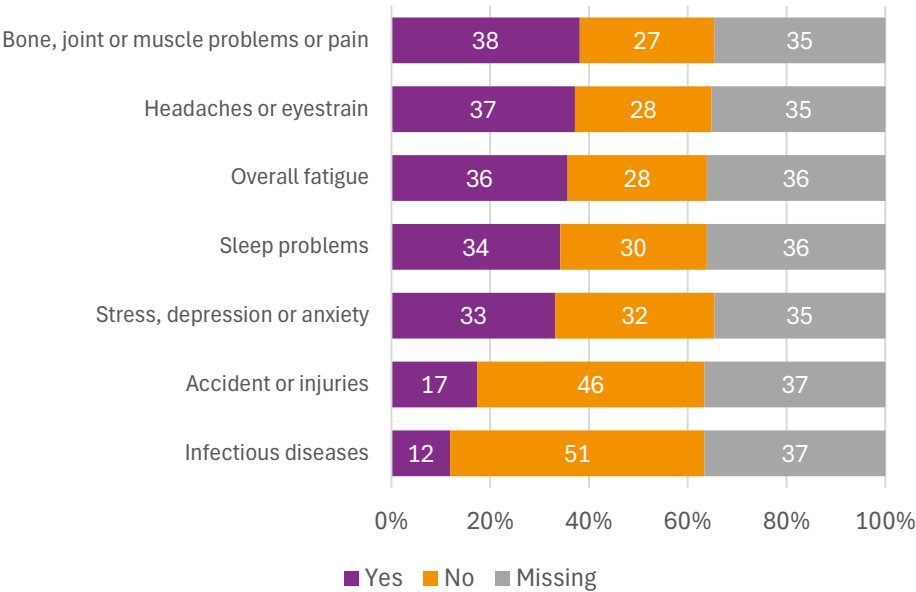
Figure 22. Workers' assessment of their health in general, percentages



Source Own calculations, survey data collected among Belgian construction and manufacturing workers (N=202)

8% of workers in construction and manufacturing rate their health as “very good”. At the same time, 15% report poor health. This suggests a significant minority struggle with bad health, often linked to fatigue and physical workload. This result was confirmed in the interviews and is aligned with previous research focusing on blue-collar work.

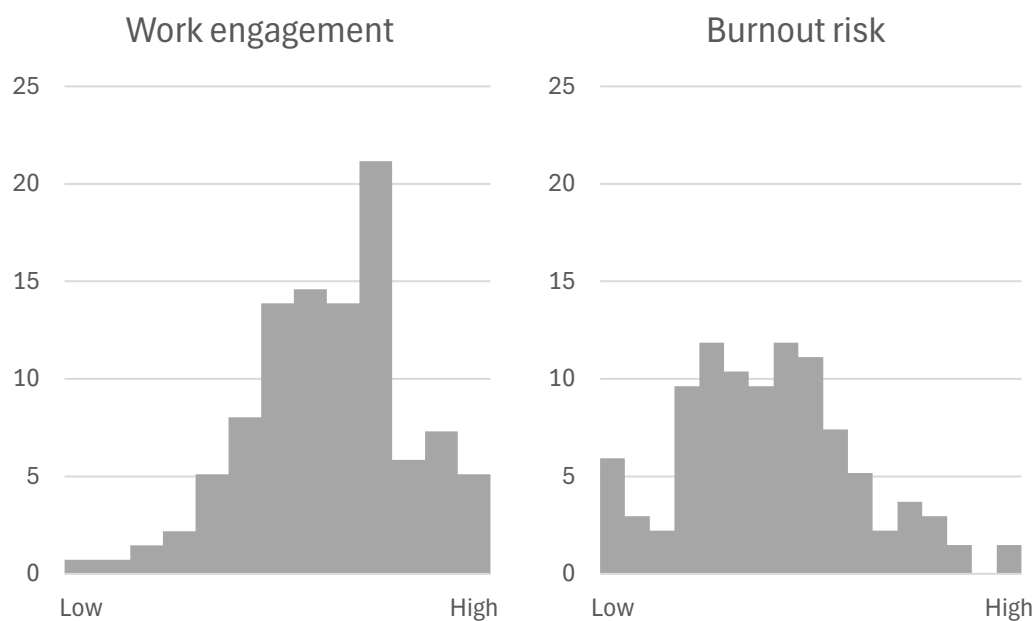
Figure 23. Percentages of workers reporting these health issues, cause or made worse by their work, in the past 12 months



Source Own calculations, survey data collected among Belgian construction and manufacturing workers (N=202)

Among workers in the manufacturing and construction sectors, bone, joint or muscle problems or pain are the most frequently reported health issue, followed by headaches or eyestrain, overall fatigue, and sleep problems. While the emotional strain is less severe than in healthcare, physical strain and fatigue are widespread in construction and manufacturing.

Figure 24. Work engagement and burnout risk



Source Own calculations, survey data collected among Belgian construction and manufacturing workers (N=202)

Work engagement (3.5/5) is moderately high, though slightly lower than in healthcare (3.7/5). Burnout risk (2.3/5) is also a bit lower than healthcare (2.5/5). This indicates that while workers are engaged, they face fewer emotional demands than healthcare workers, which may explain the lower burnout scores. Compared with healthcare, construction and manufacturing show a less extreme “engagement–burnout paradox.”

6. Conclusions

The Belgian case study reveals a comprehensive and mature framework for addressing psychosocial risks and promoting mental health in the workplace. Belgium has long been a pioneer in this domain, with legislation dating back to the 1990s and a robust institutional infrastructure that includes both legal mandates and active social dialogue. The 1996 Act on the well-being of workers, along with its 2014 amendment, laid the foundation for a holistic approach to occupational safety and health, explicitly incorporating psychosocial risks into the national agenda. These efforts have been reinforced by subsequent legislation, such as the 2018 and 2022 Acts, which introduced measures for burnout prevention and the right to disconnect.

The COVID-19 pandemic served as a catalyst for further action, intensifying public awareness and prompting new initiatives like the Federal Action Plan on Mental Well-being at Work. Belgium's Presidency of the Council of the European Union in 2024 further underscored its commitment to mental health, with high-level conferences and peer reviews aimed at sharing best practices and enhancing enforcement mechanisms. Despite these advancements, challenges remain. Implementation gaps are particularly evident in small and medium-sized enterprises, where resource constraints and limited awareness hinder effective psychosocial risk management. Moreover, physical risks continue to dominate the occupational safety discourse, often overshadowing the less visible but equally impactful psychosocial hazards.

Sectoral analyses of healthcare and construction/manufacturing highlight the nuanced nature of these challenges. Healthcare workers face high emotional demands, time pressure, and exposure to violence, while construction workers contend with fragmented worksites, subcontracting complexities, and limited access to preventive measures. In both sectors, employee involvement in psychosocial risk management is modest, and existing interventions are perceived as only moderately effective. These findings point to the need for more participatory approaches and tailored strategies that address sector-specific realities.

Social dialogue remains a cornerstone of Belgium's approach, with trade unions and employer organisations playing a pivotal role in shaping policy and implementing workplace initiatives. The National Labour Council has been instrumental in advancing collective prevention strategies, including pilot projects on burnout and innovative work organisation. These efforts reflect a broader commitment to embedding mental health into strategic policy and fostering a culture of well-being at work.

Overall, Belgium's experience offers valuable insights into the opportunities and limitations of current approaches to psychosocial risk management. While the legal and institutional frameworks are well-developed, their effectiveness hinges on practical implementation, continuous monitoring, and the active engagement of all stakeholders. As Belgium continues to refine its policies and practices, it sets a strong example for other EU Member States seeking to enhance mental health and well-being in the workplace.

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Deliverable 3.1

National Case Study Report - Denmark

Szekér Lise & Lenaerts Karolien

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1. Introduction

This national case report for Denmark is part of deliverable D3.1 'National case reports' of the PSYR-IR project. The main findings and recommendations following from this case report are discussed in the national policy brief for Denmark, available in English and Danish.

Over the past two decades, Denmark has witnessed a growing awareness of psychosocial risks (PSRs) in the workplace. This national case study explores the evolving landscape of PSRs in Denmark, focusing on the construction sector. Denmark's regulatory framework has undergone significant transformation, notably with the revision of the Working Environment Act and the introduction of Executive Order no. 1406, which explicitly addresses psychosocial risks. These legislative developments have helped legitimise PSRs as a critical occupational health concern and have fostered greater involvement of social partners in shaping preventive strategies. However, implementation remains uneven across sectors and company sizes.

The construction sector presents unique PSR challenges due to its project-based nature, interdependent workflows, and diverse workforce, including a significant proportion of migrant workers. These workers often face precarious employment conditions, limited social integration, and heightened emotional strain. The sector also grapples with the taboo to open discussion of mental health, especially among older workers. Despite these challenges, promising initiatives - such as sectoral campaigns - are emerging, signalling a shift towards more inclusive and proactive approaches to PSR management.

This national case report analyses the prevention and management of psychosocial risks in Denmark and focusses more specifically on the Danish construction sector. This report brings together insights from desk research of academic and grey literature, as well as consultation of key websites; stakeholder interviews and an employee survey among 250 Danish construction workers. This report first discussed the state of play of psychosocial risk and mental health in Denmark. Next the legislative framework on OSH and PSR in Denmark is discussed, as well as the key actors, important measures, guidelines and initiatives. Further the report discusses the Danish labour market model, and the role of the social partner in OSH and PSR management and prevention. Finally, the report presents the findings from the survey among Danish construction workers.

1.1 Methodology of this case study

By consulting dedicated websites and relevant academic and grey literature, insights were collected of the state of play of psychosocial risks in Denmark, the regulatory framework and important stakeholders. Thanks to the use of AI allowing for automatic translation to English, also information from website only available in Danish could be included in this information search.

Table 1. Overview of the interviewees

Interview code	Type of stakeholder
IA	Research institute
IB	Research institute
IC	Research institute
ID	Trade union
IE	Trade union
IF	Trade union
IG	Private prevention company
IH	Government body

Note Names and details of the interviews are pseudonymised to ensure anonymity of the interviewee.

To gain better understanding of the construction sector in Denmark, eight qualitative semi-structured interviews were conducted, with researchers, representatives from trade unions, a government body and a private prevention company¹. All interviews except for one were done in English, one interview took place in Danish, and transcripts were translated to English afterwards for analysis using Copilot. All interviews took place through online, in an Ms Teams meeting, and were recorded and transcribed automatically. Participants received an information sheet explaining the aim of the interview, signed an informed consent form before the start of the interview², and agreed that the interview would be recorded and transcribed. Table 1 gives an overview of stakeholders interviewed. The interview addressed topics such as the general prevalence of PSR, the evolution in policy making regarding PSR and main actors, future needs, influence of new technologies and good practices of PSR management³. Interviews lasted between 51 minutes and 1h20 minutes. All interviews took place between 1 April and 15 September 2025.

Further, an online survey was conducted among construction workers in Denmark. The data were collected using the survey panel from Norstat. Data collection took place in June 2025. Panel members fitting the targeted respondent group were invited to participate in the study through the Norstat platform, after which they were redirected to the survey platform, programmed in LimeSurvey. The survey was provided in Danish and English. Completion of the survey on average took 10,5 minutes for Danish construction workers. In total 250 respondents completed the survey for Denmark⁴.

Table 2 provides more information on the socio-demographic characteristics of the respondents. Most of the respondents is male (86%), which is not surprising for the construction sector. Only 6% of the respondents was younger than 24 years. On the other hand, nearly half of the respondents were older than 55 years. The average age was 50.8 years old, with the youngest respondent being 19 years old, and the oldest at 78 years old. Hence older construction workers might be overrepresented in this survey. Although all respondents were active in the construction sector, the survey still captures a diversity of functions. A significant share of the respondents are skilled workers (42%). %).

1 Despite numerous efforts, we did not manage to get an interview with a representative from the employers' organisation, or with researchers from the National Research Centre for the Working Environment (NRCWE).

2 The informed consent form is part of D2.5, materials and documents, developed in the PSYR-IR project. The document can be requested from the authors.

3 The full interview guide is part of D2.5, materials and documents, developed in the PSYR-IR project. The document can be requested from the authors.

4 The Danish questionnaire is part of D2.5, materials and documents, developed in the PSYR-IR project. The document can be requested from the authors.

Table 2. Descriptive statistics of the survey respondents

	Socio demographic variable	% of respondents
Gender	Men	86.40%
	Women	13.60%
Age	16-24 years	6.00%
	25-54 years	44.40%
	55+ years	49.60%
Function in organisation	Professional occupations	7.88%
	Technical occupations and associate pro	6.64%
	Higher administrative occupations	2.49%
	Clerical occupations	6.22%
	Sales occupations	2.49%
	Service occupations	1.24%
	Skilled worker	41.49%
	Semi-skilled worker	7.88%
	Unskilled worker	6.64%
	Farm worker	2.49%
Contract	Self-employed	8.91%
	Employee with a permanent contract	74.49%
	Employee with a temporary contract	6.07%
	Without a professional activity	6.88%
	Without a contract	1.62%
	Retired	2.02%
Sector	Private sector	89.43%
	Public sector	6.50%
	Joint private-public company	4.07%
Company size	1-9 people	23.87%
	10-49 people	26.75%
	50-249 people	24.69%
	250 people and over	24.69%
Members of a trade union	Yes	78.95%
	No	21.05%

Source Own calculations, survey data collected among Danish construction workers (N=250)

However, the sample also includes quite some workers active in professional occupations (8%), semi-skilled workers (8%), unskilled workers (7%) and clerical occupations (6%), as well as other functions. Nearly three out of four works as employee with a permanent contract, and almost all of them are working in the private sector (89%). Further, the sample shows a good division of respondents across company size, with nearly one quarter working in very small companies (up to 9 employees), a quarter working in small companies (10-49 employees), another quarter working in medium sized companies (50-249 employees) and the last quarter working in big companies with more than 250 employees. Finally the majority of the respondents indicated that they are members of a trade union (79%).

2. Context

Over the past two decades, Denmark has experienced a notable increase in mental health problems and psychosocial risks (PSRs). Despite this upward trend, Denmark continues to report levels of mental health issues that remain below the EU average (Eurofound, 2021). This report will first focus on a description of the state of play of psychosocial risks in Denmark. Then more insights will be provided on the mental health of employees in Denmark. Finally, the impact of the Covid-19 pandemic on PSR and mental health of workers will be discussed.

2.1 State of play of psychosocial risks and mental health in Denmark

2.1.1 Psychosocial risks in Denmark

To get a better insight in the state of play of psychosocial risk, in Denmark, we apply our conceptual framework on psychosocial risks (Heylen et al., 2024), assessing psychosocial risks across the broad categories of psychosocial risks. Deliverable 2.1 of the PSYR-IR (Heylen et al., 2024) provides a more comprehensive overview of the state of affairs of psychosocial risks in Europe in the past decade, focussing on the countries and sectors that are in the scope of the research project.

A first group of psychosocial risks are concerned with the **job content**. Emotional demands and lack of task significance are not considered major PSRs in Denmark's industrial sector, though both saw a marginal increase in 2021 (EWCS, 2015; EWCTS, 2021). Denmark stands out in the EU for using work reorganisation as a strategy to manage PSRs (EU-OSHA, 2022c).

A second group are psychosocial risks related to **work intensity**. Denmark ranks high in recognising work intensity as a PSR (73%), alongside Finland and Sweden, compared to the EU average of 45% (EU-OSHA, 2022c). Significant increases in work intensity were observed across sectors, especially in industry and construction (EWCS, 2015; EWCTS, 2021; Heylen et al., 2024). The risk of technology overload is rising, with 90% of Danish workers using digital devices, impacting work pace (EU-OSHA, 2022b, 2022c).

Considering psychosocial risks related to the **work schedule**, recent data show that Long and irregular working hours are widely acknowledged as PSRs in Denmark (44%) (EU-OSHA, 2022c). Post-pandemic data shows increased working hours, with 25% of workers reporting longer hours, similar to the EU average (Eurofound, 2022). In Denmark a higher share (44%) of organisations reports to intervene when employees worked extended or irregular working hours. Compared to the EU average of 30% (EU-OSHA, 2022c).

With regard to psychosocial risks concern the **lack of control and autonomy**, around 80% of Danish organisations enable employees to make decisions about task execution to address work stress, which is above the EU average of 68% (EU-OSHA, 2022c). However, Denmark saw an increase in workers reporting lack of autonomy (from 16% to 25%), contrary to the decreasing EU trend (EWCS, 2015; EWCTS, 2021; Heylen et al., 2024). One in five of Danish workers report lack of autonomy (EU-OSHA, 2022c, 2022b).

Further psychosocial risks related to **interpersonal relationships** at work receive considerable attention in Denmark. Danish workplaces more frequently recognise dealing with difficult clients as a PSR (68% vs EU average of 59%) (EU-OSHA, 2022c). This is less prevalent in construction (9%) than in health and social care (30%) (EU-OSHA, 2022c, 2022b). Exposure to violence or verbal abuse is slightly lower in Denmark (14%) than the EU average (16%). Harassment and bullying are reported by 7%, matching the EU average. Denmark shows a decline in inappropriate behaviours in general (from 25% to 20%) and in industry/construction (from 15% to 9%) (EWCS, 2015; EWCTS, 2021; Heylen et al., 2024). Discrimination remains stable at 7%. Poor communication is less acknowledged as a psychosocial risk EU-wide (17%), but in Denmark this is more often identified as a psychosocial risk (37%) (EU-OSHA, 2022b). Denmark also leads in having procedures to address harassment (64%) and threats (78%), well above EU averages (46% and 54% respectively) (ESENER 2019, EU-OSHA, 2022a). Supervisor-employee evaluations are more common in Denmark (76% vs EU average of 56%). Further, the lack of supervisor support is lower in Denmark (10% vs EU average of 15%), and only 5% report lack of colleague support (EWCS, 2015; EWCTS, 2021; Heylen et al., 2024).

Denmark performs better than the EU in **career opportunities**, though it saw a slight increase in workers reporting lack of opportunities (from 23% to 25%) (EWCS, 2015; EWCTS, 2021; Heylen et al., 2024). Between 2015 and 2023 there was a strong increase in workers reporting to experience a lack of recognition (from 3% to 14%). Further, the lack of skill utilisation is at 10%, matching the EU average, while training opportunities improved for Danish workers (EWCS, 2015; EWCTS, 2021; Heylen et al., 2024).

Job insecurity is more recognised as a psychosocial risk in Denmark (23%) than the EU average (11%) (EU-OSHA, 2022c). Lack of appropriate pay affects 27% of Danish workers, below the EU average of 31%, with sectoral differences (EWCS, 2015; EWCTS, 2021; Heylen et al., 2024).

Work-life interference doubled in the EU between 2015 and 2021 (from 5% to 10%), but remains low in Denmark (5%), with similar rates in industry (EWCS, 2015; EWCTS, 2021; Heylen et al., 2024). Surveys reveal that while Denmark generally performs better than the EU average on work-life balance indicators, a significant proportion of employees report difficulties separating work and private life (EU-OSHA, 2022a). Teleworking, which expanded rapidly during the COVID-19 pandemic, has blurred temporal boundaries, leading to evening and weekend work intrusions (EU-OSHA, 2024a). Between 2015 and 2022, reports of work-life conflict have increased moderately, particularly among teleworkers. Work-life balance challenges persist despite Denmark's flexible work arrangements.

Finally concerning **organisational culture and psychosocial safety climate**, nearly 70% of Danish organisations report they possess the necessary knowledge to identify PSRs, slightly above the EU average (64%) (EU-OSHA, 2022c). This is linked to high recognition of PSRs and action plans. Employee involvement in risk assessment is also high (76%) (EU-OSHA, 2022c). Only 18% of the workers report a lack of participation, compared to 28% EU-wide, and the lack of voice is also lower (EWCS, 2015; EWCTS, 2021; Heylen et al., 2024). Denmark leads in having action plans for work-related stress (65% vs EU average of 34%) and preventive measures (42% vs 34%). Further unionisation is high in Denmark, and 52% of organisations have union representatives, the highest share in the EU (EU average: 18%) (EU-OSHA, 2022c). Through collective bargaining, Denmark also benefits from collective agreements promoting psychosocial wellbeing, prioritising open communication, a proactive approach and employee involvement (EU-OSHA, 2022a).

2.1.2 Mental wellbeing of employees in Denmark (in relation to PSR)

The burden of PSRs is reflected in widespread mental health problems. Approximately 25% of Danish employees report experiencing **work-related stress**, slightly higher than the EU average of

22% (EU-OSHA, 2025a). Stress prevalence has shown an upward trend in Denmark over the past decades, increasing from 11.1% in 2000 to 24.4% in 2021 (Nielsen et al., n.d.; Rosenkilde et al., 2023), reflecting growing concerns about time pressure and work overload.

Furthermore, 24% of Danish workers report **symptoms** of depression, anxiety, or stress, a figure aligned with the European average (EU-OSHA, 2022b). Emotional exhaustion, indicative of clinical burnout, affects 21% of Danish workers, again mirroring the EU-27 average. A recent report of the National Institute of Public Health in Denmark adds to the evidence for this trend. They find a significant rise in self-reported symptoms between 2013 and 2021, including depression (from 25.5% to 33.8%), anxiety (from 21.2% to 28.8%), sleep difficulties (from 36% to 46.1%), and stress (from 16.4% to 24.5%) (Rosenkilde et al., 2023).

PSRs also contribute significantly to **physical health problems** (EU-OSHA, 2021). Musculoskeletal disorders (MSDs) remain highly prevalent: 45% of Danish workers reported back pain and 58% reported pain in the shoulders, neck, or upper limbs in 2015, compared to 43% and 41% respectively in the EU-28 (EU-OSHA, 2019). Recent data suggest that these figures have remained largely stable, despite interventions to promote ergonomic working conditions. Moreover, general fatigue is a critical concern. In 2020, 37% of Danish workers reported work-related fatigue, higher than the EU average of 30% (EU-OSHA, 2025a). Sleep disturbances, including insomnia and fragmented sleep, affect between 68–78% of Danish workers, a persistently high proportion that has shown little improvement over the past decade (EU-OSHA, 2019). These data illustrate the somatic embodiment of psychosocial strain and point to chronic deficits in recovery.

2.1.3 Vulnerable groups

PSR exposure is **unevenly distributed across demographic groups**. Workers with low socioeconomic status (SES) are more likely to experience time pressure, low job control, financial worries, and job insecurity, resulting in elevated rates of mental health problems such as depression and anxiety (EU-OSHA, 2023). Migrant workers, particularly in construction, encounter precarious employment, communication barriers, and exclusion from occupational health structures, reinforcing their vulnerability. Young workers and women face higher exposure to emotional demands and work-life interference compared to their older or male counterparts. Recent national data confirm these disparities: women report more mental health issues than men, and young adults (18–24) are the most affected demographic group, while older adults (65–70) report the lowest levels of distress (Rosenkilde et al., 2023).

Sectoral data highlight pronounced disparities in PSR exposure. Construction workers are disproportionately affected by high time pressure, unpredictable project changes, financial insecurity, and heavy physical demands (EU-OSHA, 2024b, 2025a). Mental health concerns such as stress, depressive symptoms, and burnout are notably higher in this sector. Stress indices developed by the Danish Working Environment Authority (WEA) show that sectors such as meat packing, residential/home care, and water/sewage/sanitation consistently report the highest levels of PSR-related stress (EU-OSHA, 2025b). In micro and small enterprises (MSEs), workers face elevated PSR exposure due to limited OSH infrastructures and informal risk management (EU-OSHA, 2022a). Workers in MSEs (2–9 employees) report a rise in depressive symptoms from 25.9% to 35.8% between 2013 and 2021, whereas those in larger companies (250–499 employees) saw a decrease from 31.3% to 24.7% (Rosenkilde et al., 2023). Despite targeted national initiatives, improvements in MSE risk prevention remain slow and uneven across sectors.

2.1.4 Impact of the COVID-19 pandemic

It is difficult to disentangle the impact of the **COVID-19 pandemic** from broader labour market and societal trends. Nonetheless, evidence suggests that the pandemic did contribute to a rise in depressive symptoms in Denmark between 2019 and 2020 (Møller et al., 2021). For many workers, the pandemic significantly altered working conditions—at least temporarily—thereby influencing the psychosocial risks (PSRs) associated with their jobs (Eurofound, 2023). Data from the National Institute of Public Health (Møller et al., 2021) indicate that some PSRs actually slightly improved during the pandemic. For instance, job insecurity decreased, likely due to government protection measures, and there were modest reductions in work intensity and pressure to meet tight deadlines. Further, the pandemic accelerated the uptake of telework across Europe. Denmark, which already had a relatively high proportion of teleworkers (23%), saw this figure rise to 34% during the pandemic (Eurofound, 2021).

2.2 The unique characteristics of the construction impact PSR and their management

From the interviews with stakeholder, a good perspective was given on the unique characteristics of the Danish construction sector, that influence the psychosocial risks and their management. Each construction site is essentially a new project, with fresh site management, different main contractors, and a rotating group of subcontractors. This constant change means that teams often work together without prior relationships, creating a volatile and unpredictable working environment.

This dynamic setup brings specific PSR challenges. The **organisational aspect** is particularly critical—effective cooperation, communication, and conflict resolution between subcontractors are essential, as their work is interdependent. Mistakes or delays by one party can directly affect others, potentially leading to missed targets and increased individual **stress**. Despite its importance, construction site management and planning are often overlooked in discussions around PSR. The issue is not whether things will go wrong, but when they do—how problems are handled, how uncertainty is managed, and how rescheduling is approached in a transparent and inclusive way. Managers on construction sites frequently face high **emotional stress** due to these pressures. **Conflicts** between companies can escalate and become structural or personalised over time, highlighting the need for conflict mediation mechanisms.

Moreover, the **sector's diversity** adds further complexity. There are generational differences in how workers respond to workplace culture, particularly regarding social interactions, treatment of women and issues like sexual harassment. Younger workers are less tolerant of aggressive or unfriendly behaviour and often leave the sector despite attractive starting salaries after a few negative experiences in this regard. This points to the need for a more welcoming and respectful culture, especially for newcomers—an area addressed by initiatives such as the BFA (cfr. *Infra*) (*Interviews*).

2.2.1 Important and emerging psychosocial risks

The construction sector faces a **distinct set of psychosocial risks (PSR)**, shaped by this unique working conditions and culture. The traditionally male-dominated, the workplace culture has often included inappropriate humour, crude language, and discriminatory behaviour. While positive changes are emerging—with more companies setting standards for inclusive environments—issues such as **violence**, **threats**, and **discrimination** remain concerns. The **mental impact of physical accidents** is another serious PSR, particularly affecting migrant workers who may feel undervalued

or disrespected due to their background. **Emotional demands** also arise from difficult interpersonal relations on site, especially in high-pressure environments. A major stressor is the **pace of work**, often driven by performance-based pay systems. Workers may receive bonuses for speed but face penalties for delays, creating dual pressure from both employers and peers. This system can lead to conflict and heightened stress. A shift away from fee-based incentives is seen as a potential improvement (*Interviews*).

Emerging PSR topics include the working environment of **site managers**, who often experience high emotional stress, but remain difficult to reach through inspections due to anonymity. Some initiatives, such as hotlines, aim to support them more directly. **Stress** is increasingly recognised as a major issue. While once rarely discussed, it is now a prominent concern among workers and in public debate. **Time pressures and tight schedules** contribute significantly, and **personal life challenges**—such as family illness or divorce—can compound the problem. Addressing stress without overstepping personal boundaries remains a delicate task (*Interviews*).

2.2.2 Trends and tendencies regarding psychosocial risks

The *interviews* with stakeholders provided insights in several evolving trends that are shaping the psychosocial risk landscape in the construction sector, with implications for workers, managers, and companies alike (*Interviews*).

Public procurement pressures

Government tenders increasingly prioritise cost-efficiency, which often places pressure on the working environment. To remain competitive, companies may cut costs by subcontracting foreign companies with workers under poorer wage and working conditions, or struggle to compete with foreign companies. Since material costs are fixed, savings are typically made at the expense of labour. Additionally, Danish companies struggle to compete on time, as local workers tend to work fewer hours per week due to family and leisure commitments, while foreign workers often exceed legal working hour limits (*Interviews*).

Managerial stress and responsibility

Middle managers are particularly vulnerable to PSR in the Danish construction sector. They face high emotional stress due to conflicting demands, tight budgets, and the responsibility of coordinating workflows in volatile workplaces and resolving issues with subcontractors. Their role is central to site organisation, yet they often lack adequate support (*Interviews*).

Positive developments

Some companies are beginning to recognise that a safe and psychosocially healthy construction site is also an efficient one. These firms are investing in structured site organisation and respectful communication practices, such as “relational communication” frameworks that help prevent conflicts before they escalate. However, progress is uneven, and smaller companies often lack the resources or awareness to implement such changes (*Interviews*).

Digitalisation and surveillance

Digitalisation remains limited in construction, mostly confined to office-based roles. Telework is largely irrelevant for on-site workers. However, surveillance technologies - such as GPS tracking, vehicle cameras, and apps monitoring working hours - are increasingly used, often without sufficient transparency. This creates discomfort and mistrust among workers, especially when surveillance is

introduced without proper notice. There is little current focus on the opportunities or risks of AI (*Interviews*).

2.2.3 Migrant workers and foreign workers are additionally vulnerable for psychosocial risks

The Danish construction sector relies heavily on migrant labour, with foreign workers—primarily from Poland, Romania, and Lithuania—making up an estimated 25% of the workforce. While essential to the industry, these workers face heightened psychosocial risks (PSR), both typical and additional (*Interviews*).

Working conditions and vulnerabilities

Migrant workers often endure long hours, commonly 60 or more hours per week, with few breaks or holidays. Employers favour them for their availability and willingness to work extended hours, unlike Danish workers who prioritise family and leisure time. However, this leads to **constant pressure, emotional strain, and limited attention to psychological well-being** (*Interviews*).

These workers are typically at the bottom of the hierarchy—lowest paid, assigned the most demanding tasks, and unable to refuse poor conditions without risking dismissal and loss of employer-provided housing. Many work in isolation, within closed groups, often without Danish colleagues, and have minimal social integration. Their lives in Denmark are often limited to work, with little access to hobbies, community, or family life (*Interviews*).

Camp life and social integration

The “camp life” many migrant workers experience – working and living in camps on or near big construction sites - brings additional challenges. Often these camps struggle with problems concerning proper housing and food, lack of recreational opportunities. This is linked to workers working excessively or developing unhealthy coping mechanisms, such as heavy drinking. To improve conditions, initiatives should focus on providing spare time activities (e.g. sports), offering language and cultural courses to enhance integration, and ensuring decent housing and nutrition (*Interviews*).

Broader sectoral impacts

The high share of migrant workers also affects Danish workers, creating tensions due to cultural and language differences. Foreign companies, often less attentive to safety and labour standards, compete for the same tenders, sometimes undercutting Danish firms. These companies may also be ill-prepared for local conditions, such as winter weather, leading to delays and inefficiencies, increase time pressures for other subcontractors (*Interviews*).

Challenges in protection and representation of foreign workers

Although migrant workers are formally covered by collective agreements, enforcement is difficult. Trade union membership is low, partly due to unfamiliarity with union culture and fear of retaliation. Many construction sites are physically fenced off, limiting access for outreach and inspections. Some trade unions have responded by hiring officers who speak multiple languages (currently eight nationalities), aiming to improve communication and awareness of rights (*Interviews*).

2.3 Discourse on PSR in Denmark, in general and in specific sector

The interviews with stakeholders provided additional insights on the discourse on PSR in Denmark, in general and within the construction sector. Further they highlight challenges in addressing PSR. Psychosocial risks (PSR), particularly work-related stress, are increasingly recognised as a significant societal concern in Denmark. The discourse is most prominent within the social and healthcare sectors, where stress is often linked to labour shortages and tight labour markets. Public debate tends to focus on stress and work pressure, yet the broader occupational safety and health (OSH) narrative remains largely centred on physical risks (*Interviews*).

The prevailing OSH framework continues to prioritise physical wellbeing. Physical hazards—such as accidents, exposure to asbestos, and unsafe equipment—are more visible, easier to measure, and often have immediate and severe consequences. As a result, they receive greater attention from both policymakers and workplace inspectors, explaining their dominance in the general discourse on OSH. One inspector noted that psychological pressure is rarely raised during inspections, as the focus remains on tangible risks. Traditional hazards, particularly in sectors like construction, are still considered the most pressing concerns (*Interviews*).

Addressing psychosocial risks presents several challenges:

- **Measurement and regulation:** Unlike physical risks, PSR are difficult to quantify and regulate. There is no clear threshold for when job demands become problematic, and the subjective nature of stress complicates standardisation.
- **Data limitations:** Reliable data on the consequences of PSR is scarce. Privacy regulations (e.g. GDPR) limit access to medical information, making it difficult to assess the true impact in terms of work-related illness and absences. Insurance claims might offer some insight, but these are often underreported or not accepted due to the difficulty of proving causality.
- **Interpretation and time constraints:** Assessing PSR requires time and nuanced interpretation. The absence of straightforward diagnostic tools—such as a "thermometer" for stress—means that subjective experiences are often undervalued.
- **Employer resistance:** Despite regulatory advancements, such as executive orders enabling labour inspectorates to address PSR, the topic remains sensitive. Employers may resist scrutiny of mental health issues, viewing them as more complex and less actionable than physical risks (*Interviews*).

Psychosocial risks (PSR) are still receiving limited attention within the construction sector. The sector continues to prioritise physical safety, with mental wellbeing often overlooked. A culture of toughness persists, where admitting to physical or psychological strain is seen as weakness. Mental health concerns are often individualised, placing the burden solely on the person rather than the work environment. This approach increases pressure and discourages open discussion. Shifting the narrative to recognise environmental factors is essential. Encouragingly, attention to PSR is growing—though progress is uneven. Gender dynamics also play a role: women tend to speak more openly about mental health, making the topic more accessible in female-majority settings (*Interviews*).

3. Regulatory framework on psychosocial risks and workers' health and well-being

This section provides a concise overview of the regulatory framework surrounding psychosocial risks and mental wellbeing in Denmark. For a more detailed account, we refer to a recent report published by EU-OSHA, which offers an in-depth description of this topic: EU-OSHA. (2025). *Psychosocial risk prevention – strategies and legislation | Denmark. National report*. European Agency for Safety and Health at Work, 2025. <https://osha.europa.eu/en/publications/denmark-psychosocial-risk-prevention-strategies-and-legislation>

We start with a concise overview of the key actors in Denmark responsible for OSH), including PSR, and mental health. This is followed by a discussion of the relevant legislation, with particular emphasis on the Working Environment Act and the 2020 executive order that builds upon it. Next, we examine the role of political agreements in shaping legislation and initiatives related to PSR, and review the measures and activities that support implementation, including campaigns, toolkits, and inspections. We also consider the role of the Sectoral Working Environment Communities (BFAs) and, finally, outline plans for addressing PSR during its ongoing EU Presidency of Denmark.

3.1 Key actors

Table 3 provides a structured overview of the key actors in Denmark regarding occupational health and safety and psychosocial risks and mental health in specific. The table describes the actor and its main tasks, roles and responsibilities. For councils, organisations, etc. information is also included about the composition.

Table 3. Key actors regarding OSH and psychosocial risk and mental well-being at work in Denmark

Actor	Type	Tasks, roles, responsibilities
The Ministry of Employment	Government	Hold overall responsibility for occupational safety and health, including psychosocial risks (PSRs). Exercise executive authority in shaping and enforcing workplace safety legislation.
The Employment Committee	Government	Function as a standing committee within the Danish Parliament. Exercise legislative authority on matters related to occupational safety and health. Submit parliamentary questions and initiate formal inquiries.

The National Working Environment Council (WEC)	Tripartite	Tripartite: Representatives of trade unions and employers' associations; chaired by a ministry-appointed official. Ministry representatives (WEA, NRCWE) held observer status without voting rights. Facilitate dialogue between workers' and employers' organisations under the guidance of the Working Environment Authority (WEA) (WE-Act). Discuss PSR-related developments and innovations in a tripartite setting. Decommissioned in 2024, replaced by the Labour Market Council (from spring 2025), advising the Minister of Employment on labour market and working environment challenges.
The Working Environment Authority (WEA)	Government	Day-to-day responsibility for improving the working environment (Arbejdstilsynet). Goal: Support safe working conditions through supervision, regulation, and awareness efforts. Activities: - Enforce occupational health and safety regulations through inspections and sanctions. - Prepare legislation and develop tools, guidelines, and campaigns - Monitor working conditions and ensure compliance across all sectors - Provide information and guidance to employers and workers, including foreign enterprises and posted workers (EU-OSHA, n.d.) - Serve as Danish Liaison Office under the EU Posting of Workers Directive - Fund and promote research via the Occupational Health and Safety Research Foundation (Arbejdsmiljøforskningsfonden)
The National Research Centre for Working Environment (NRCWE)	a governmental research centre specialised in safety and health	Operate as an independent sector research body under the Ministry of Employment Conduct high-level research on occupational health and safety as Denmark's leading institution (NFA) Has a specialised PSR research unit with 40–45 scientific staff Develop key tools for PSR assessment, including Copenhagen Psychosocial Questionnaire (COPSOQ) and Danish Psychosocial Working Environment Questionnaire (DPQ) Contribute to national and international knowledge on psychosocial working conditions
Occupational medicine clinics:	Medical clinics	There are seven recognised occupational medicine clinics, as part of hospitals, across Denmark Assess and treat workers for occupational diseases and injuries Determine whether health issues are work-related or caused by other factors Provide specialised treatment for job-induced stress Conduct research on occupational health, including diagnostic criteria and stress interventions
Authorised working environment counsellors	Consultancy	Provide guidance to companies that fail WEA inspections Ensure compliance with psychosocial risk prevention strategies and legislation Provide expert advice to improve workplace conditions following regulatory breaches
The Labour Insurance Fund	Insurance fund	Provide financial compensation to workers following assessment of work-related injury or illness Operate through a fund financed by monthly employer contributions

Danish Labour Court	court	Ensure enforcement of employees' rights through labour courts and arbitration mechanisms Operate primarily via out-of-court resolution, supplemented by the Danish Labour Court (Arbejdsretten) Labour Court includes representatives from social partners and Supreme Court judges; Labour arbitration courts are supervised by social partners Public Conciliator (Forligsmanden) may intervene in case of breakdown in collective agreement negotiations
The Sectoral Working Environment Communities (BFAs)	Sectoral organisations - bipartite	Five sectoral organisations (BFAs), including one dedicated to construction and rail Develop and deliver sector-specific workshops, guides, toolboxes, and process templates on working environment issues Operate as mandatory structures, staffed and governed by the sector's social partners Support implementation of occupational health and safety practices at sectoral level

Sources *Actors and Institutions in Denmark*, n.d.; *Denmark | Safety and Health at Work EU-OSHA*, n.d.; EU-OSHA, 2025b and information for interviews.

3.2 Legislation and policy

3.2.1 Danish legislation on OSH and PSR

A wide range of laws, executive orders, and guidelines are relevant to psychosocial risks (PSR) and worker well-being. The key overarching legislation is the Working Environment Act of 1975, which has been amended several times, with the most recent major revision in 2021, which is complemented with executive orders and guidelines.

Working environment Act (WE-Act) of 1975

The **Danish Working Environment Act (Arbejdsmiljøloven) (WE-Act)**, first adopted in 1975 and most recently revised in 2021, is the overarching law governing occupational health and safety in Denmark. It sets out the general objectives and requirements for ensuring both a safe physical and psychosocial working environment, in line with technical and social developments in society (EU-OSHA, 2025b; *Working Environment Regulations*, n.d.). The WE-Act also provides a foundation for enterprises to address health and safety challenges themselves, supported by employers' and workers' organisations. Compliance with the WE-Act is overseen by the Danish Working Environment Authority (WEA) and applies to all citizens and workplaces in Denmark (*Actors and Institutions in Denmark*, n.d.; *Working Environment Regulations*, n.d.).

The We-Act defines employers' responsibilities, including the duty to provide safe and healthy working conditions and to carry out **a written workplace risk assessment** (*arbejdspladsvurdering*, APV). The APV must include four elements: identification of risks and problems; assessment of potential links to sickness absence; development of an action plan; and implementation with follow-up (*Working Environment Regulations*, n.d.).

Enterprises must also establish a cooperation with a health and safety organisation (**arbejdsmiljøorganisation, AMO**), a formal structure for cooperation on health and safety matters. The AMO consists of employer representatives, elected health and safety representatives, and managers, all of whom must complete occupational health and safety training. On construction sites, an AMO must be established if at least five employees are working simultaneously for a minimum of

14 days (*Working Environment Act - Arbejdstilsynet*, n.d.)(*Working Environment Act – Arbejdstilsynet*, n.d.).

Danish Working Environment Authority's Executive Order no. 1406 of 26 September 2020 on the health and safety of workers at work.

A range of executive orders and guidelines derive from the Danish Working Environment Act (WE-Act). Among the most relevant for psychosocial risks is the **Danish Working Environment Authority's Executive Order no. 1406 of 26 September 2020 on the health and safety of workers at work**.

Until 2013, the WE-Act contained no explicit reference to psychosocial risks. Since then, it has been revised to emphasise that employers are responsible not only for a safe physical environment but also for a safe psychosocial working environment, including the prevention of associated risks (EU-OSHA, 2025b; *interviews*).

The Executive Order no. 1406 strengthened this focus by addressing mental well-being and psychosocial risks in detail. Section 7 defines PSR as “psychosocial effects of the work that takes place in relation to: the way the work is planned and organised; organisational conditions of importance to the work; the content of the work, including its requirements; the way the work is performed; and the social relations in the workplace.” The order identifies five key areas of PSR (EU-OSHA, 2025b):

- Unclear or conflicting demands at work
- High emotional demands when working with people
- Offensive behaviour, including bullying and sexual harassment
- Heavy workload and time pressure
- Work-related violence and threats.

It is supplemented by specific guidelines outlining preventive measures and inspection principles, reinforcing the responsibility of employers to prevent and address psychosocial risks (*Interviews*).

Danish Act on Posting of Workers

The **Danish Act on Posting of Workers** safeguards employees sent to Denmark by foreign companies, ensuring they are covered by the core working conditions established under the EU Posting of Workers Directive. The Directive applies in full, except for provisions on minimum pay. However, trade unions are permitted to take industrial action to ensure that the minimum pay levels specified in collective agreements also apply to posted workers (DA et al., 2021).

Recognized occupational diseases related to PSR

Currently, only two psychosocial risk (PSR)-related conditions are listed as recognised occupational diseases in Denmark: **post-traumatic stress disorder (PTSD)** and **depression resulting from accidents or work-related events**. Other occupational diseases may be recognised on a case-by-case basis if it can be demonstrated that they are primarily caused by work, subject to approval by the **Industrial Diseases Authority**. Evidence must show that work-related strain was excessive and contributed to the development of a mental illness. Examples include exposure to violence, assault or threats, bullying, serious unjustified accusations, public shaming or negative media coverage, and chronic stress arising from high psychological demands, persistent pressure, and lack of support, where a diagnosis of depression has been made. Coverage is expected to improve following the publication of an **executive order in 2024** by the Ministry of Employment, which serves as an addendum to the 'law on compensation for occupational injuries and diseases' (EU-OSHA, 2025b).

3.2.2 Political agreements

Political agreements provide the foundation for the WEA's policy development and initiatives. These agreements are concluded on a three-year cycle, and they give direction to the actions of the WEA and set goals to reach and priorities to address (*Interviews*). The current agreement, "*Agreement on a future-proof working environment initiative and action against social dumping*"⁵, was adopted in 2023 and will remain in force until 2026. "It contains a number of specific initiatives addressing psychosocial risks (PSR).

1. Working with the BFAs, the WEA is to establish sector-specific communication initiatives to disseminate knowledge about new PSR legislative initiatives (see section 3.1.1, National PSR legislation).
2. The WEA is to establish communicative initiatives regarding its work on PSRs in relation to specific groups of workers.
3. The WEA is to continue to upskill inspectors and build capabilities in relation to PSRs.
4. The WEA is to improve its ability to identify companies that are prone to PSRs.
5. Sector-specific online information meetings are to be organised in sectors with high levels of occupational stress.
6. The WEA is to establish a call centre providing information, advice, resources and knowledge specifically in relation to stress. The call centre must be available for both workers and managers/employers.
7. A new WEA hotline for managers is to be established to specifically advise managers on how to deal with occupational stress.
8. The WEA is to arrange online information meetings for managers about stress prevention." (EU-OSHA, 2025b, p. 11).

3.2.3 Measures and initiatives following the PSR legislation

The **WEA** plays a central role in implementing the Working Environment Act and the related executive orders and guidelines. Its activities are organised around three broad tools: inspections, awareness campaigns and the provision of information, and the development of guidelines and practical toolkits.

3.2.3.1 Inspections by the WEA

Inspections of companies are conducted by the **Danish Working Environment Authority (WEA)**. Inspectors are organised into sector-specific teams and possess highly specialised knowledge relevant to their assigned industries. Regarding psychosocial risks (PSR), inspections focus on the five types outlined in the 2020 executive order. Inspectors use a thematic interview guide covering topics such as:

- Physical and/or psychosocial violence
- High emotional demands
- Bullying and harassment
- Psychological first aid
- High workload and/or time pressure
- Unclear or contradictory demands.

A formal report is produced only when violations are **established**. Inspection outcomes are made publicly accessible via a webpage, allowing users to check whether an organisation has received a ruling. **Identifying PSR violations during inspections** remains difficult, as inspections are typically brief, lasting only a few hours, and provide a snapshot of conditions at a specific moment (*Interviews*).

⁵ <https://bm.dk/arbejdsmiljoeaftaler/politiske-aftaler/politiske-aftaler/2023/arbejdsmiljoeaftale/>

While issues such as violence and harassment are relatively visible, more subtle risks, like conflicting demands, are harder to detect. Nevertheless, PSR topics are discussed during inspections, flags are raised, and guidance is provided. Inspections also involve discussions with companies on preventive strategies, including suggestions for good practices and the reasoning behind them. Few formal rulings are issued for PSR, but recommendations and agreements are often included in inspection reports (*Interviews*).

Insights from inspections also inform the development of practical tools, guides, and informational materials. For example, addressing sexual harassment during inspections proved challenging, prompting the creation of a dedicated folder and hotline for reporting and support (*Interviews*).

A key future goal is to improve efficiency by **combining WEA inspections with other regulatory inspections**, such as fire inspections, food inspections. Greater coordination across inspection areas is encouraged by policymakers, with the aim of reducing the cumulative burden of consecutive inspections and minimising the risk of conflicting requirements. This approach allows companies to address compliance and prevention in a more comprehensive and integrated manner. A pilot project is currently underway in the elderly care sector to test the integration of inspections across different regulatory areas (*Interviews*).

3.2.3.2 Information and campaigns

The **WEA** provides extensive information and campaigns addressing the five listed psychosocial risks, as well as stress and night work. Its website features dedicated pages for these PSRs, including definitions, guidance on recognising risks in the workplace, videos, and infographics. Information is also shared via the homepage, social media, webinars featuring external experts, and workshops (EU-OSHA, 2025b; *Interviews*).

Campaigns targeting PSR include (EU-OSHA, 2025b; *Interviews*).

- **‘Tag Snakken’ (Talk it Over!)** – focusing on harassment and violations in the workplace, with particular guidance for managers on how to communicate about these issues. The campaign draws on background materials and practical tools, including guides and talking points for meetings.
- An **anonymous hotline**, available to managers free of charge, provides advice on managing PSRs in the workplace

Specific campaigns, such as those addressing sexual harassment, are supported with additional funding provided through political agreements (*Interviews*).

The WEA also relies on the **Sectoral Working Environment Communities (BFAs)** to develop information and campaigns tailored to their sectors. While the WEA produces broad tools and campaigns that cover the entire labour market, BFAs translate and adapt these resources to their specific contexts (*Interviews*).

3.2.3.3 Tools and guidelines

Similarly, the WEA relies primarily on the BFAs to develop initiatives tailored to their specific sector (*Interviews*). However, the WEA also addresses broader topics, providing guidelines on stress detection and on how to develop action plans to manage psychosocial risks.

3.2.4 Sectoral level

3.2.4.1 National and sectoral goals

In 2020, the Minister for Employment and the social partners formulated the **tripartite agreement on national goals for the working environment**, establishing concrete, quantifiable targets to reduce risks and hazards and improve preventive measures at company level.

Regarding psychosocial risks (PSR), two overarching national goals were set:

1. to ensure a safe and healthy psychological working environment, and
2. to reduce the number of employees exposed to significant psychological stressors.

To monitor progress, specific indices were developed at the employee level and are included in the **National Surveillance of the Work Environment of Employees in Denmark survey (NASWEED)**:

- Imbalance between tasks (6 items)
- Influence and development opportunities (6 items)
- Harassment, violence, or threats of violence (4 items)

These national goals must subsequently be translated into sector-specific objectives by the **Sectoral Working Environment Communities (BFAs)**.

3.2.4.2 Collective agreements

At the sectoral level, psychosocial risks (PSR) and broader working environment issues are incorporated into **collective agreements**. Key agreements covering the period 2023–2025 in the construction sector include:

- The Building Agreement
- The Collective Agreement for Building and Construction
- Electricians' Collective Agreement
- Collective Agreement for Painters
- Collective Agreement for Bricklayers and Unskilled Bricklayers
- Collective Service Agreement (Cleaning)
- Collective Agreement for Carpenters and Cabinetmakers
- Collective Agreement for Plumbing and Heating Workers

3.2.5 EU presidency

From 1 July to 31 December 2025, Denmark will hold the **Presidency of the Council of the European Union** ('EU-Formandskab Arkiv', n.d.), under the slogan "*A strong Europe in a changing world.*" During this period, the Employment, Social Policy, Health and Consumer Affairs Council will focus on supporting a competitive Europe by promoting labour markets that are efficient, ensure decent and fair working conditions, safeguard jobs, and provide the right skills for the future workforce (*Programme of the Danish EU Presidency*, n.d.).

The **Danish Trade Union Confederation (FH)** emphasises that the presidency offers an opportunity to place workers' rights on the agenda for European leaders. Therefore, FH set out their position with four key topics:

- Employee rights must be included at the negotiation table
- Free and fair movement of worker, an internal labour market of Europe
- Strong competitiveness and quality jobs (in Denmark and Europe)
- Strong social dialogue (which is essential to achieve goals of the European pillar of social rights)

3.2.6 Assessment of the legislation and cooperation on the development of OSH regulation on PSR by interviewees

The cooperative model between government and social partners regarding OSH including PSR is widely regarded as effective and constructive. It ensures inclusive decision-making and has led to important outcomes, particularly in addressing psychosocial risks (PSR) in the workplace. However, this collaborative process can be time-consuming, and a more guiding role from the government could help accelerate progress without undermining the value of social dialogue.

A notable example is Denmark's **Executive Order no. 1406 of 26 September 2020**, which was the result of years of negotiation between the government and social partners. The COVID-19 pandemic provided a longer timeframe for discussions, and a strong governmental push helped bring the process to completion. The executive order was a significant milestone, introducing clear and specific language on PSR—an area that had previously been difficult to formalise.

This legislation is seen as highly valuable. It not only provides a framework for addressing mental health and well-being at work but also strengthens the legitimacy of PSR as a topic within social dialogue. By placing PSR firmly on the agenda, the government helped create momentum and clarity, enabling more focused and effective discussions among stakeholders.

In summary, while the collaborative approach remains essential, strategic leadership from the government—particularly in setting priorities and providing legislative impetus—can help move key issues forward more efficiently (*Interviews*).

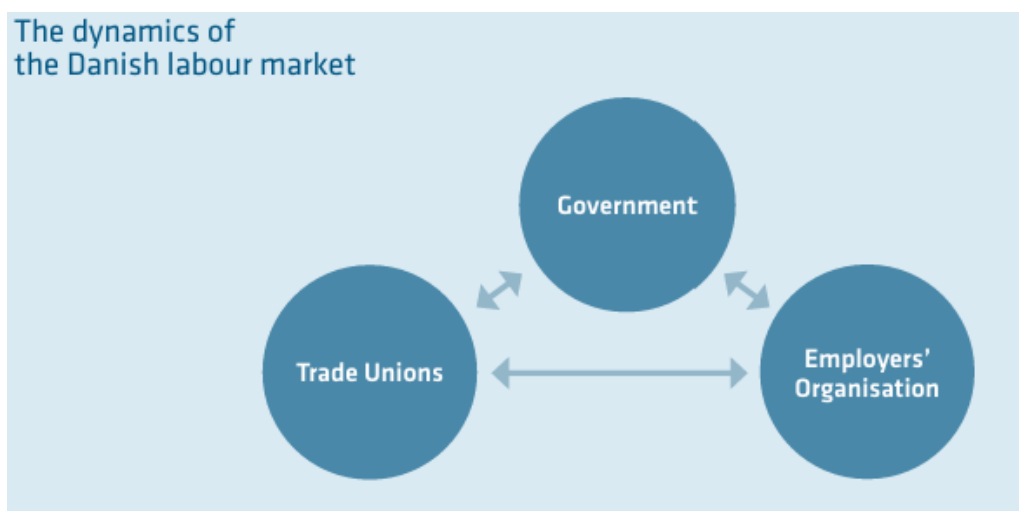
4. Industrial relations system and regulatory framework on social dialogue

4.1 Industrial relations system and its key actors for the Danish construction sector

4.1.1 Danish labour market model

The **Danish labour market model** is characterised by limited direct state involvement (government and ministries) in industrial relations, with government intervention focused primarily on formulating employment policy and the working environment (occupational health and safety) (*Actors and Institutions in Denmark*, n.d.). These are the responsibility of the Ministry of Employment and the agency, the Danish Working Environment Authority (WEA). Regulation of working conditions is instead largely entrusted to social partners - employers' associations and trade unions - who shape wages, working life, and well-being through **collective agreements** and structured tripartite cooperation with the state (*The Danish Labour Market*, n.d.) (Figure 1).

Figure 1. The Danish labour market model



Source taken from DA et al. (2021)

A high level of organisation underpins the Danish labour market model: both employers and employees are typically affiliated with representative bodies, ensuring effective collective bargaining. Therefore, high level of membership of these organisations is important, and facilitated by the **law on freedom of association in the labour market** (Act on freedom of organisation in the labour market, see Act no. 443 of 13 June 1990 as amended by Act no. 359 of 26 April 2006). This ensures that workers are free to join an association, prevents discrimination based on union membership.

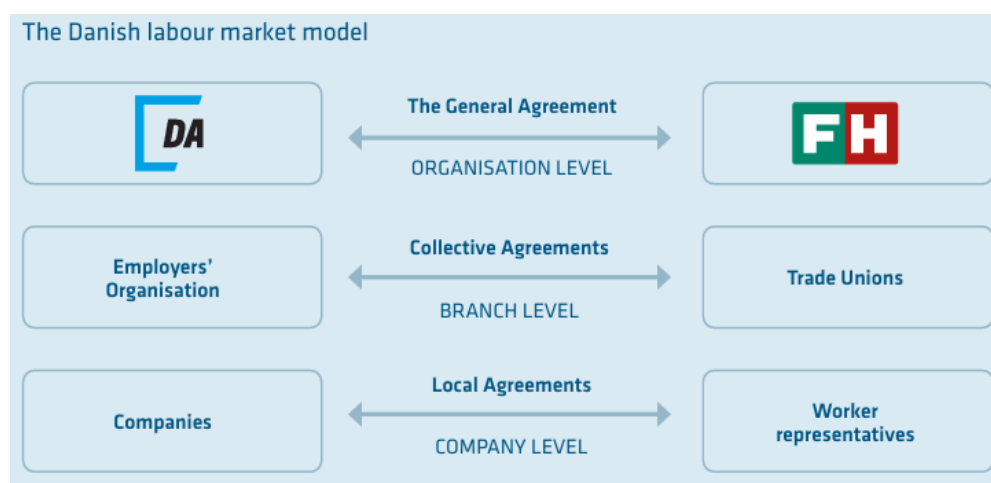
Further exclusivity clauses are prohibited in collective agreements, ensuring they cover all workers, and not only members of a specific association (*The Danish Labour Market*, n.d.).

The **framework for collective bargaining** dates back to the General Agreement of 1899 and remains central to industrial relations. The two main bodies are the **Danish Trade Union Confederation (FH)** and the **Confederation of Danish Employers (DA)**. Together, they maintain a cooperation agreement that underpins workplace dialogue. EU directives are implemented either via legislation, collective agreements, or both, ensuring comprehensive coverage (*The Danish Labour Market*, n.d.).

Policy development regarding the working environment (covering OSH in general as well as psychosocial risks) is shaped by consecutive '**working environment agreements**', renegotiated every three years. Drafted by the Ministry of Employment, these agreements are discussed with parliament. Until 2024, social partners were consulted about this through the tripartite Working Environment Council (WEC), where they could propose new initiatives and policies. Next to that tripartite collective agreements set sectoral targets, such as incidence rates and other indicators (e.g. stress indices).

At the level of the social partners, collective bargaining is organised as presented in Figure 2. At the **national level**, the two umbrella organisations - the Confederation of Danish Employers (DA) and the Danish Trade Union Confederation (FH) - conclude a general agreement. At the **sectoral level**, **collective agreements** are negotiated between employers' and workers' organisations. These agreements typically cover key working conditions, which can include minimum wages and wage increases, working hours, pay during maternity leave or sickness, occupational pensions, flexible working arrangements, and access to lifelong learning and continuous development. The export sector plays a central role, as the social partners here conclude the first agreement, setting the pace and benchmark for negotiations across all other sectors. At **company level**, **local agreements** are negotiated between employers and workers representatives. These agreements may supplement or deviate from the framework established at sectoral level, particularly regarding wages, which are determined in line with the sectoral collective agreement but can be adapted to company-specific circumstances (DA et al., 2021).

Figure 2. How the Danish labour market model works on working environment and OSH



Source taken from DA et al. (2021)

Companies that are not members of an employers' organisation may voluntarily adopt a collective agreement, while member companies are automatically bound by the agreements concluded between their organisation and the relevant trade unions. If a company refuses both to join an

employers' organisation and to sign a collective agreement, trade unions are entitled to initiate industrial action. Coverage through collective agreements is extensive: 100% of employees in the public sector, 73% in the private sector, and 87% of employees in companies affiliated with the Confederation of Danish Employers (DA). Foreign workers employed in companies covered by collective agreements enjoy the same rights and protections as Danish workers (DA et al., 2021).

4.1.2 Main social partners at national level and for the Danish construction sector

4.1.2.1 Employers' organisations

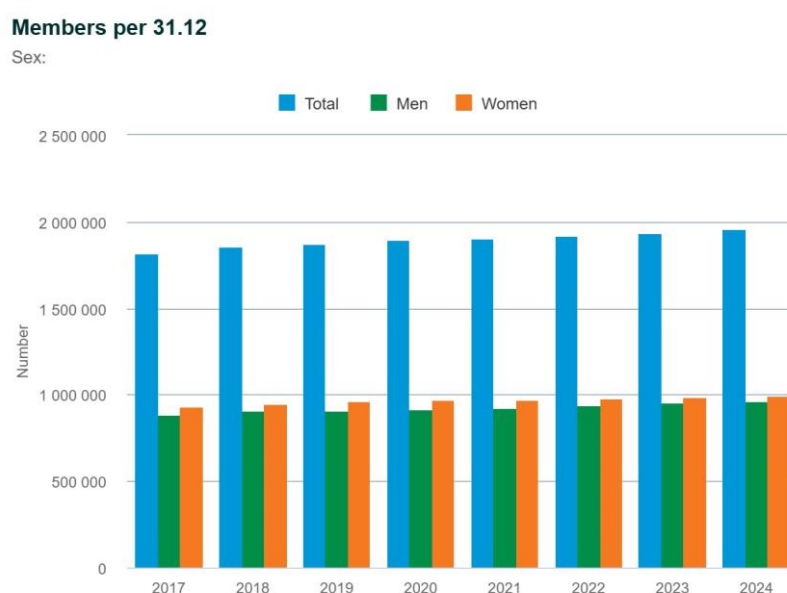
The **Confederation of Danish Employers (DA)** unites 12 employers' organisations from the private sector, including building and construction, industry, retail, transport, and services (*Actors and Institutions in Denmark*, n.d.) Together, its member organisations represent 25,000 companies employing around 30% of the Danish workforce (*The Danish Labour Market*, n.d.).

In the building and construction sector, representation is provided by **DI Byggeri**, a member of DA. Formerly known as the Danish Construction Association (Dansk Byggeri), it merged with Dansk Industri (DI) in 2020. DI Byggeri represents approximately 6,700 companies (*The Danish Labour Market*, n.d.).

4.1.2.2 Trade unions

The **Danish Trade Union Confederation** (Fagbevægelsens Hovedorganisation, FH) is the main umbrella organisation for trade unions in Denmark. It represents 64 affiliated unions with a combined membership of 1.3 million workers across both the private and public sectors (*The Danish Labour Market*, n.d.).

Figure 3. Number of workers member of a trade union in Denmark



Source Statistics Denmark (n.d.), consulted 01/07/2025

In the construction sector, several specialised unions are represented. These include **3F** – United Federation of Danish Workers (Fagligt Fælles Forbund), with 214,992 members (*Actors and*

Institutions in Denmark, n.d.), the (*The Danish Labour Market*, n.d.). (www.def.dk), and (*The Danish Labour Market*, n.d.). (www.maler.dk) (*The Danish Labour Market*, n.d.).

Unionisation in Denmark remains high compared with other European countries. According to the OECD, trade union density stood at 67% in 2019 (OECD, 2021). More than 60% of workers are members of strong, well-organised unions (DA et al., 2021), as illustrated in Figure 3.

4.2 Social partners' involvement in the prevention and management of psychosocial risks

4.2.1 Involvement social partners

As discussed above, social partners play a central role in shaping the working environment through general, sectoral, and local negotiations and agreements. In addition, the **Sectoral Working Environment Communities (BFAs)**—managed jointly by sectoral employers' and employees' organisations—play a key role in setting standards, procedures, and regulations, as well as in communication, campaigns, and initiatives to address workplace safety and well-being (EU-OSHA, 2025b). Each BFA maintains a dedicated website providing resources such as workshops, guides, toolboxes, and process templates for a wide range of working environment issues.

The BFAs cover the following sectors:

- welfare and public administration
- construction and rail
- industry
- commerce, finance and offices
- and transport, tourism, service, and agri-food

4.2.2 Initiatives

4.2.2.1 General initiative: website 'Workplace Denmark'

Workplace Denmark is a joint initiative of the Danish Working Environment Authority (WEA), the Ministry of Employment, the Danish Agency for Labour Market and Recruitment, Labour Market Insurance, the Danish Road Traffic Authority, and the Danish Tax Agency. It is the single official website for foreign workers and companies: www.workplacedenmark.dk.

The platform provides information on the Danish labour market, workplace environment, rights and obligations for employees and employers, safety rules, pay levels, and procedures for reporting work accidents or notifying the WEA. It serves as a comprehensive entry point for understanding both employment regulations and working conditions in Denmark.

The website is available in Danish, English, and several other languages, including Italian, Romanian, Lithuanian, Russian, Polish, German, Spanish, and Portuguese.

The **Workplace Denmark** website also includes dedicated pages on working safely in the construction sector⁶. These pages provide guidance on specific hazards and activities, including roof work, excavation, façade work, demolition, and preventing trips and slips (*Safety in the Building and Construction Industry*, n.d.).

⁶ <https://workplacedenmark.dk/health-and-safety/building-and-construction>

The website also provides dedicated guidance for posted workers⁷, including information on recognition of qualifications, residence and work permits, and the rights of posted workers, as well as specific rules for accommodation for foreign construction workers near worksites.

4.2.2.2 Webpages on working environment and OSH by the BFA building and construction

The BFA Construction and Civil Engineering (BFA Bygge & Anlæg) is the sectoral working environment community for construction and civil engineering. They maintain a dedicated website: bfa-ba.dk, which provides comprehensive guidance on occupational health and safety. A central resource is the **2025 Handbook**, an extensive document addressing a wide range of working environment issues, disseminated across all member companies.

The website covers practical topics, toolkits, guides, posters, campaign materials, ... such as:

- Practical guides for a wide variety of tasks, with particular attention to safety and ergonomics. f.e. 'A guide to diamond drilling and cutting'
- Fact sheets, for example on pregnant workers in construction
- Guidance on construction site layout
- The podcast series: "*Craftsmen Talk*" on ergonomics in small tasks and electrical work
- Safety films demonstrating good practices addressing issues such as winter safety measures and accident prevention. While most are in Danish, 16 are available in English, German, and Polish.

Psychosocial risks are also addressed through resources on:

- Prevention of sexual harassment
- Bullying
- Conflict resolution
- Collaboration
- Guidance on the psychological working environment in the construction industry
- Stress, time pressure and workload
- Well-being at work
- A "warm welcome" for newcomers to the sector (including a dedicated website)
- Coping with traumatic events, including access to psychological support after accidents.

Although psychosocial risks are covered, the website primarily focuses on physical risks and ergonomics.

In addition, BFA Bygge & Anlæg hosts several specialised sub-sites:

- bygero.dk – effective technical tools for the construction and civil engineering sector
- byggeproces.dk – construction processes and the working environment
- asbest-huset.dk – asbestos risks in housing
- renover-sikkert.dk – renovation risks, including asbestos, PCB, old mineral wool, lead, and other heavy metals
- bygpaagodmodtagelse.dk – guidance on offering a warm welcome to new employees, with particular attention to foreign workers and new entrants to the sector.

⁷ <https://workplacedenmark.dk/regulations-on-posting>

4.2.2.3 Bambus

Bambus is a joint initiative by the Danish social partners under the **BFA (Working Environment Council for Construction)**, funded through collective bargaining. It is designed to support companies covered by these agreements in improving workplace health and safety.

The Bambus operates as a fleet of small buses travelling across Denmark, staffed by 12 consultants who visit construction sites. They provide on-site guidance on safety equipment, work methods, and general working environment issues and OSH. The Bambus can be contacted by both workers and companies. It functions as a supplementary service to the official health and safety inspectorate but does not issue sanctions—its role is advisory.

While Bambus does touch on PSR topics, its current focus is primarily on physical safety. PSR is **not systematically addressed**, largely because the service is **question-driven**—and PSR issues are not often raised spontaneously by workers or employers. There is **untapped potential** for Bambus to play a stronger role in promoting psychosocial well-being on construction sites, especially given its accessibility and trusted presence in the field (*Interviews*).

5. Sectoral deep-dive: Industrial relations and psychosocial risks in the Danish construction sector

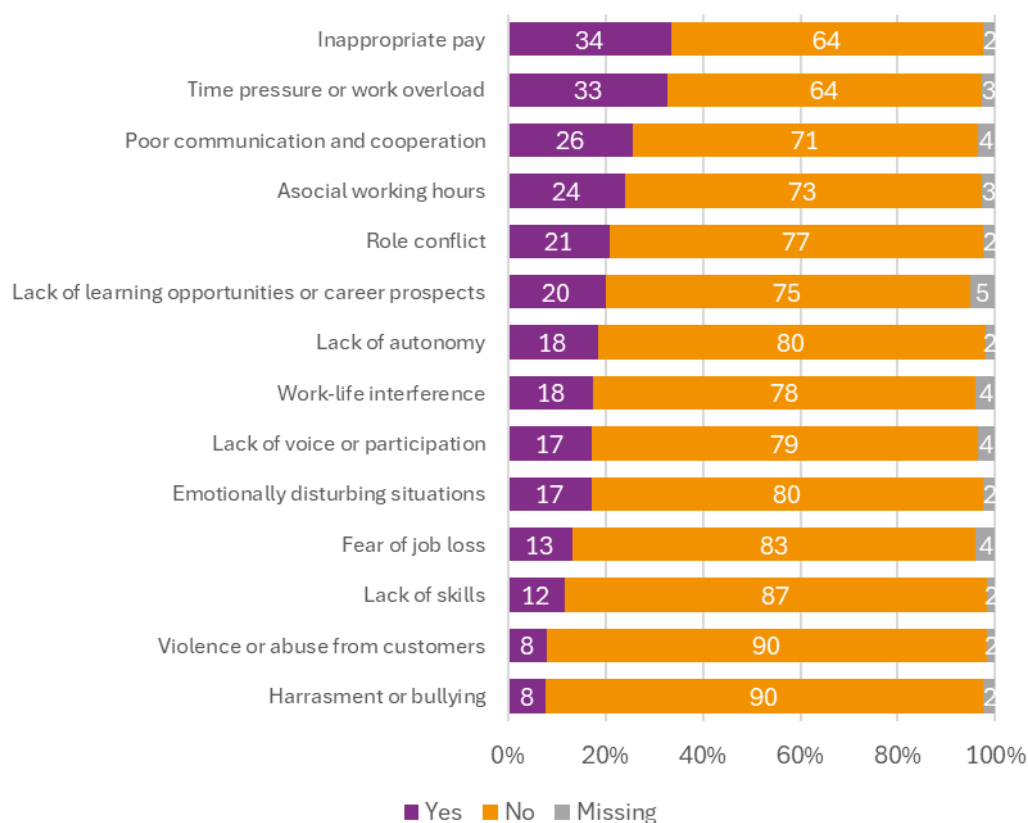
5.1 Survey findings: general insights on psychosocial risks exposure and management in Danish construction sector

This section presents key findings from the survey conducted among 250 Danish construction workers, focusing on their exposure to psychosocial risks and the implications for health and well-being, alongside the presence and quality of existing PSR management initiatives. Specifically, the results examine workers' perceptions of targeted measures, safety voice, and the overall quality of PSR management, including the psychosocial safety climate. The extent to which employees participate in the development and implementation of PSR strategies—whether through representatives, work groups, or direct involvement—is also assessed. Further, the section highlights common obstacles to effective PSR management, offering insights into barriers that may hinder the successful mitigation of psychosocial risks in the construction industry. Finally, the section provides insights into the relationship between PSR management and employee well-being.

5.1.1 Exposure to psychosocial risks in the Danish construction sector

The most frequently reported psychosocial risks by Danish construction workers include inappropriate pay (34%) and time pressure or work overload (33%). These are followed by poor communication and cooperation (26%) and asocial working hours (24%). Conversely, the least reported risks are harassment or bullying and violence or abuse from customers, each cited by only 8% of respondents (Figure 4). While these figures are comparatively low, they nonetheless warrant attention due to their potential severity and impact on mental health. Notably, several risks—such as lack of autonomy, work-life interference, and lack of learning opportunities or career prospects—cluster around the 17–18% mark, reflecting broader concerns about job design and career development. Hence the most prominent psychosocial risks concern financial dissatisfaction and excessive workload, as well communication issues.

Figure 4. Percentage of workers reporting they have been exposed to these psychosocial risks

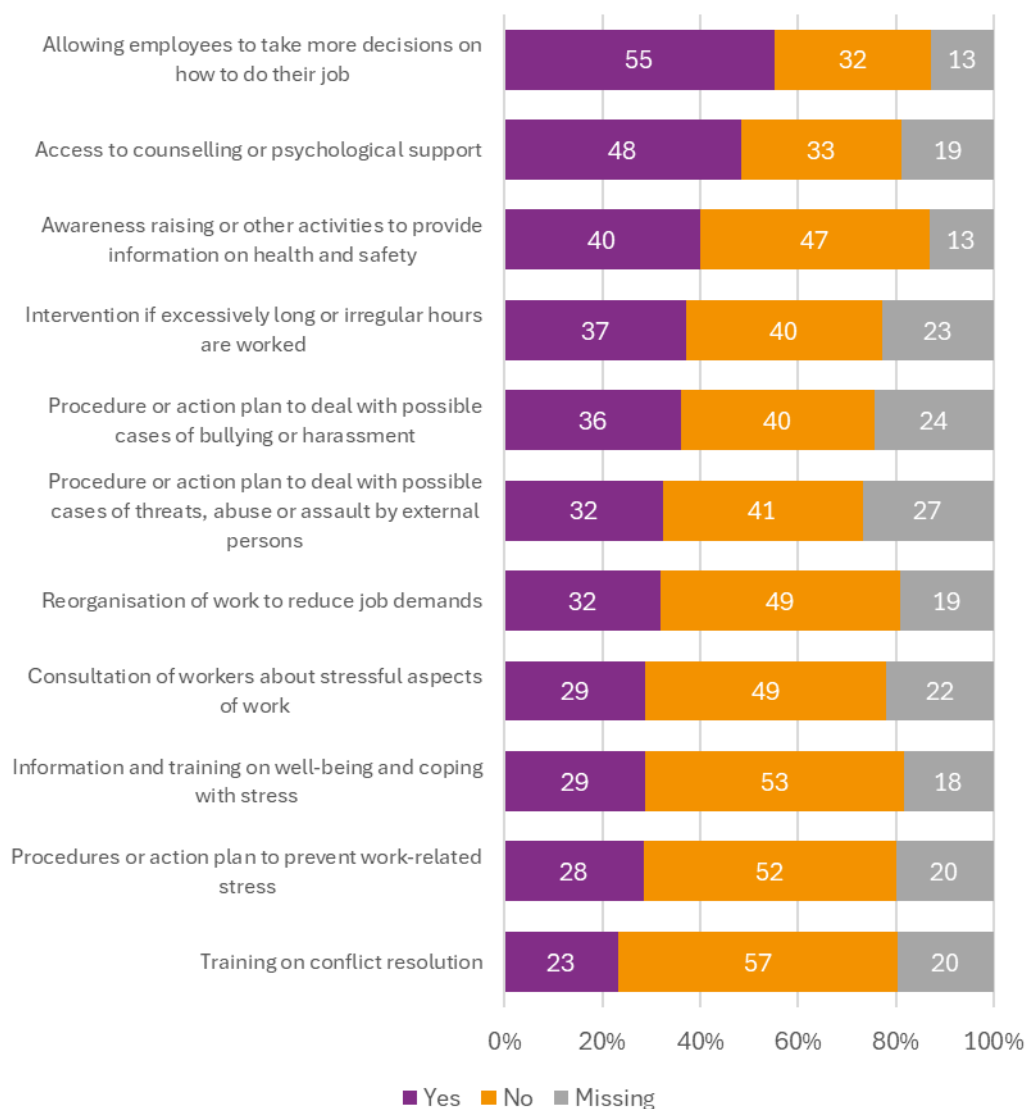


Source Own calculations, survey data collected among Danish construction workers (N=250)

5.1.2 Management of psychosocial risks

When we zoom in on the management of psychosocial risks at the workplace, we can first look at the very specific measures that are provided at the workplace that can allow employees to prevent and manage their individual psychosocial risks and mental well-being. Figure 5 provides information about these kinds of measures. More than half of the respondents report that their workplace allows employees greater decision-making autonomy in how they perform their jobs. Nearly half offer access to counselling or psychological support. Awareness-raising activities related to health and safety are available in 40% of workplaces. Measures addressing long or irregular working hours, bullying or harassment, and external threats are present in roughly one-third of cases. Reorganisation of work to reduce job demands and consultation with workers about stress are reported by less than a third. Training and procedures focused on stress prevention and conflict resolution are the least commonly available, with fewer than one in four workplaces reporting their implementation.

Figure 5. Percentage of workers indicating these measures are used in their organisation in the past 3 years



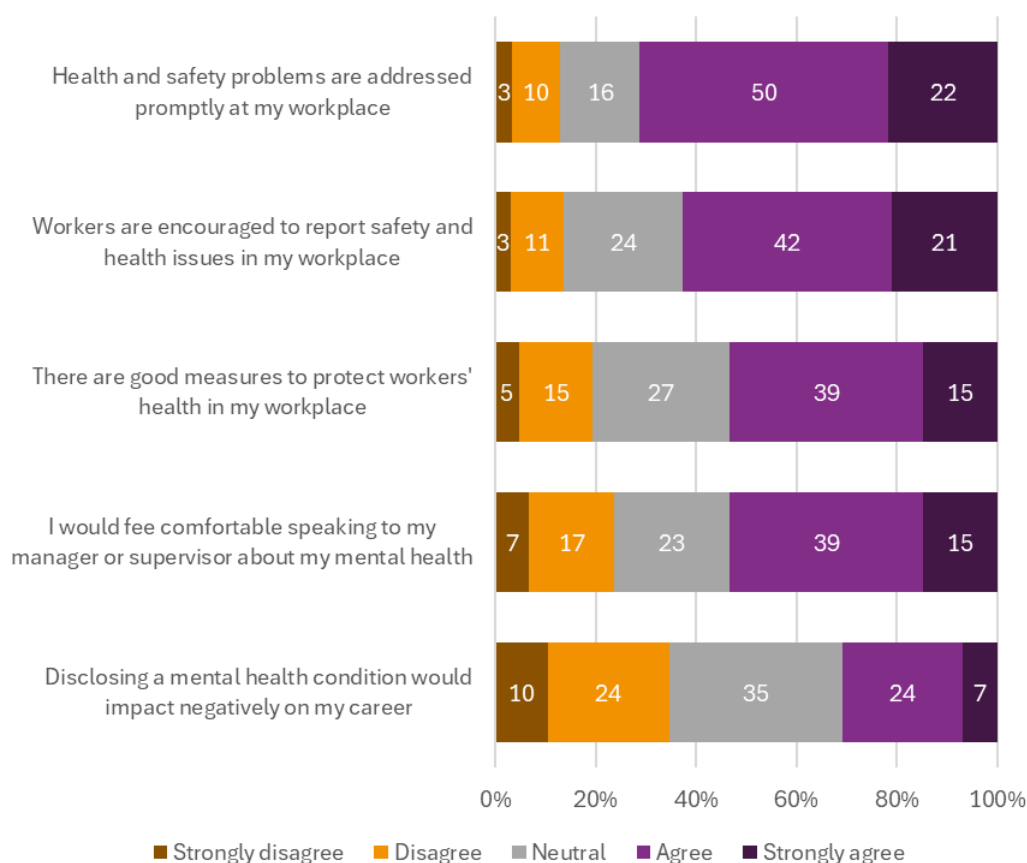
Source Own calculations, survey data collected among Danish construction workers (N=250)

Next to that, workers were requested to provide an assessment of the quality of psychosocial risks management policy, practices and techniques, provided by their organisation (Figure 6). More than 70% of the respondents agree that health and safety problems are addressed promptly in their workplace. Further nearly two out of three agree that workers are encouraged to report safety and health issues. Next to that half of the workers agree that their organisation provides good measures to protect workers' health, and that they feel comfortable to speak to a manager or supervisor about mental health. Regarding the impact of disclosing a mental health condition on career prospects, one out of three agree it would have a negative effect, while another third of them disagrees with this.

Hence, these findings for Denmark suggest that while most workers perceive their organisations as responsive to health and safety concerns and open to reporting issues, only half of the respondents is positive about the quality of available measures in their organisation or feels comfortable the talk with their supervisor about these issues. In addition, 1 out of 3 workers even thinks talking about mental health issues might hamper their career. This indicates that stigma

continues certainty around mental health disclosure, and that this continue to be a barrier in workplace culture, despite progress in other areas of psychosocial risk management.

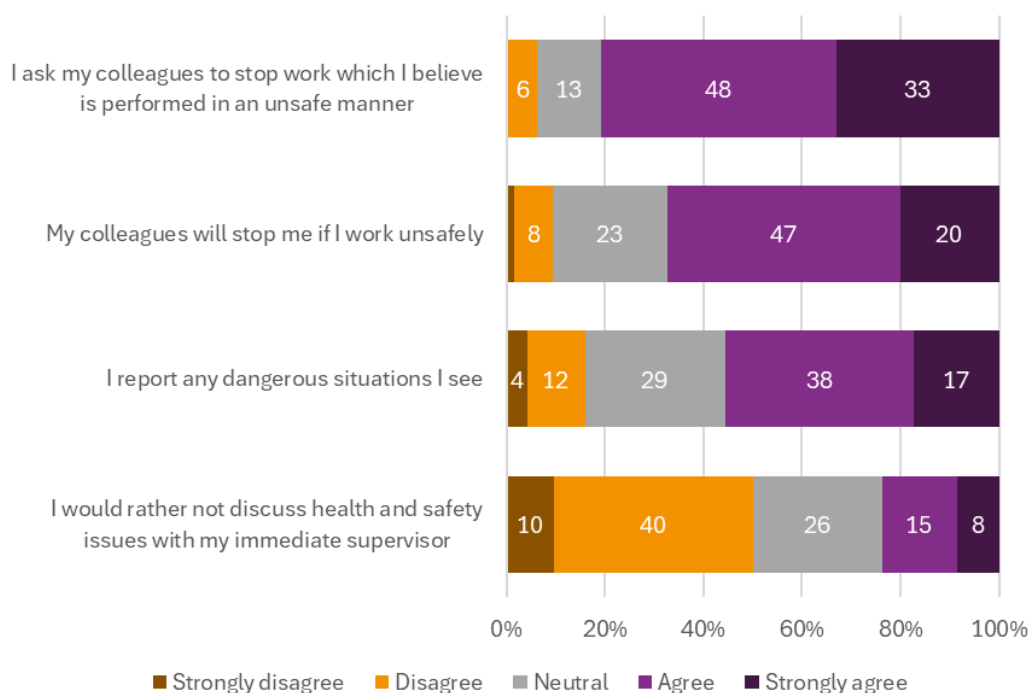
Figure 6. Extent to which workers agree that these techniques for PSR management are used within their organisations (%)



Source Own calculations, survey data collected among Danish construction workers (N=250)

Further, respondents were requested to make an evaluation to which extent they themselves have 'safety voice'. Safety voice is the believe and willingness that one can speak up for him/herself or someone else about safety-related risks and issues at the workplace. Concerning psychosocial risks, this could include raising concerns about mental health, stress, workload, interpersonal conflicts. The survey findings indicate that the vast majority (81%) agree they ask colleagues to stop work they believe is unsafe (Figure 7). Further nearly 70% thing their colleagues would do the same for them. In addition, more than half agrees they report dangerous situations they observe. Finally, when asked about discussing health and safety issues with their immediate supervisor, only 23% of the respondents indicate they would not rather do this. Hence these findings show us that it is easier for construction workers to actively engage in preventive safety behaviours for their direct colleagues, than to address this topic with their supervisor.

Figure 7. Extent to which workers agree to different aspects of safety voice (%)

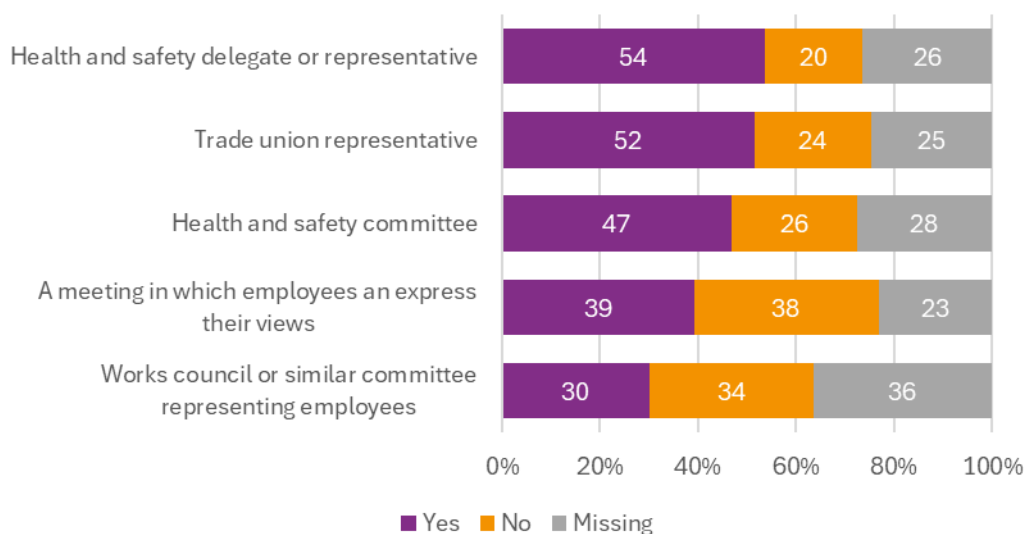


Source Own calculations, survey data collected among Danish construction workers (N=250)

The survey further tried to shed a light on who is involved in discussions and decisions regarding psychosocial risk management and mental wellbeing of workers in the organisation. Figure 8 shows the percentage of workers reporting these different ways of participation in PSR management. More than half of respondents report that health and safety delegates and trade union representatives are involved in discussions on PSR and mental wellbeing. Health and safety committees are mentioned by nearly half of workers (47%). Just under 40% indicate that meetings are held where employees can express their views. Only 30% report involvement of a works council or similar employee-representative committee.

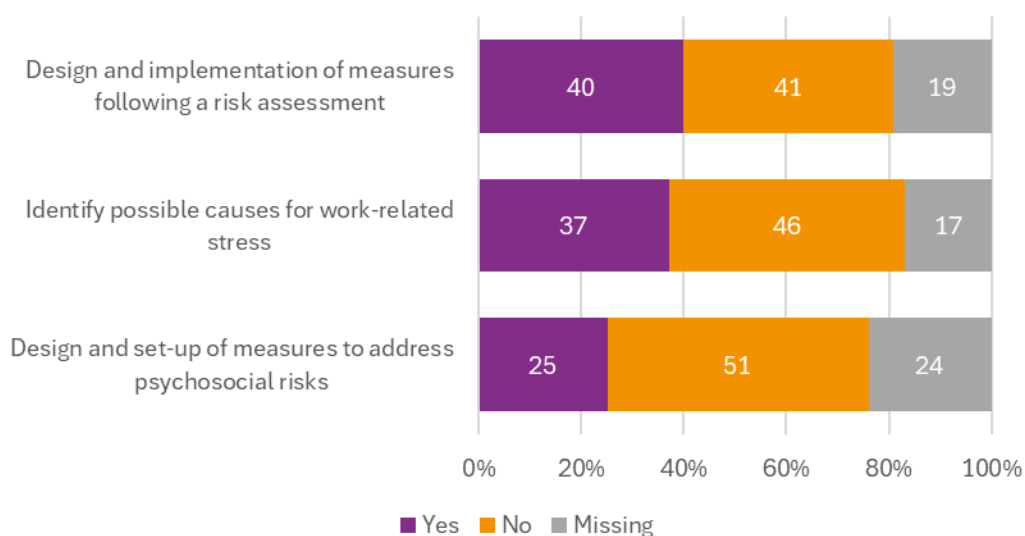
Next, figure 9 provides even more insight into direct employee involvement in actions regarding PSR management. These figures show that direct employee involvement is clearly lower than involvement through participatory groups and representation. Only 40% if the workers indicate they were involved in de design or implementation of certain PSR management measures following a risk assessment, and 37% in the identification of possible causes of their work-related stress. More broadly only one out of four reports employees in their organisation have been involved in the design and set-up of measures to address psychosocial risks. This is telling. Despite the fact that PSR management is already on the agenda in many organisational consultation bodies, the findings show that workers themselves are often not directly involved. Yet, they possess valuable insight into the concrete realities of their work and could make meaningful contributions, particularly in identifying sources of stress.

Figure 8. Percentage of workers indicating these representatives or groups are involved in discussions concerning PSR and mental wellbeing of workers



Source Own calculations, survey data collected among Danish construction workers (N=250)

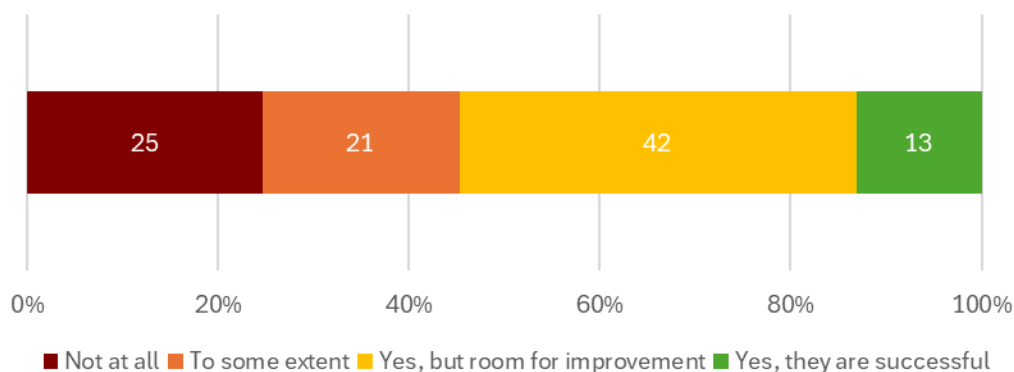
Figure 9. Percentage of workers reporting that employees have been involved in these PSR management activities



Source Own calculations, survey data collected among Danish construction workers (N=250)

Further, respondents were requested to evaluate whether the actors and initiatives in their organisation are successful in reducing stress and psychosocial risks. Only 13% is very positive and finds the actors and initiatives in their organisation successful. Another 42% is also positive but feels there is room for improvement. On the other hand, one in four indicates these actors and initiatives are not at all successful (Figure 10).

Figure 10. Evaluation of the success of actors and initiatives in the organisation to reduce stress and psychosocial risks (%)



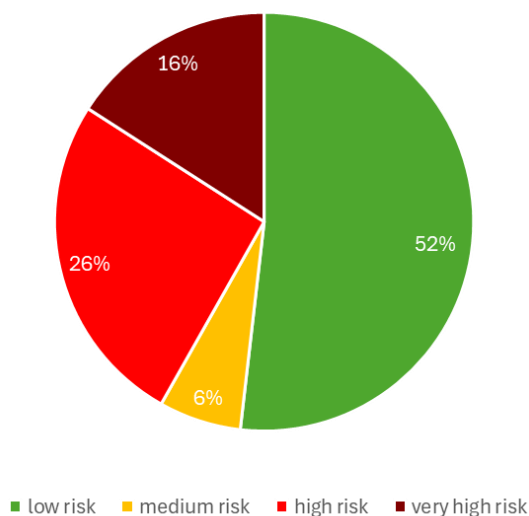
Source Own calculations, survey data collected among Danish construction workers (N=250)

As described in the theoretical and empirical paper (D2.1, Heylen et al., 2024), the concept of psychosocial safety climate can be very valuable when addressing PSR management. Psychosocial Safety Climate (PSC) is an organisational framework that focuses on how employees perceive their workplace's commitment to protecting psychological health. It reflects the extent to which policies, practices, and procedures prioritise stress prevention, address psychosocial risks over productivity, enable safe communication channels for concerns, and involve all organisational levels—including employees, management, and representatives—in discussions about mental wellbeing, as well as the involvement of top management in this issue (Dollard & Bakker, 2010).

Using the PSC-4 questions, an assessment was made of the psychosocial safety climate (PSC) in the organisation (Bailey et al., 2015). Using the benchmark standards from Bailey and Dollard (2019) this allowed us to assess the PSC of the respondents. When respondents report a low risk PSC, their organisation is performing well in PSR management, managers are performing well in this regard, and some improvements in PSR management can be observed. In a medium risk PSC, the current situation is under control, however there is need for more enacting on the PSC principles. In a high risk PSC, there is a clear need to improve the psychosocial safety climate through its four dimensions. Finally, in a very high risk PSC, urgent action is needed to prevent further increase in mental health issues and PSR.

Figure 11 provides an overview of the division of the respondents across these PSC risk groups. In the Danish construction sector, more than half of the workers report a low risk PSC, which is reassuring. On the other hand, 16% of the workers report a very high risk PSC, and another quarter of the workers has a high risk PCS. Hence many of the organisations can still make considerable progress in installing a safe and supportive psychosocial safety climate in which psychosocial risk and mental wellbeing are prioritised and thoroughly addressed throughout the organisation.

Figure 11. Percentage of respondents by PSC risk group*

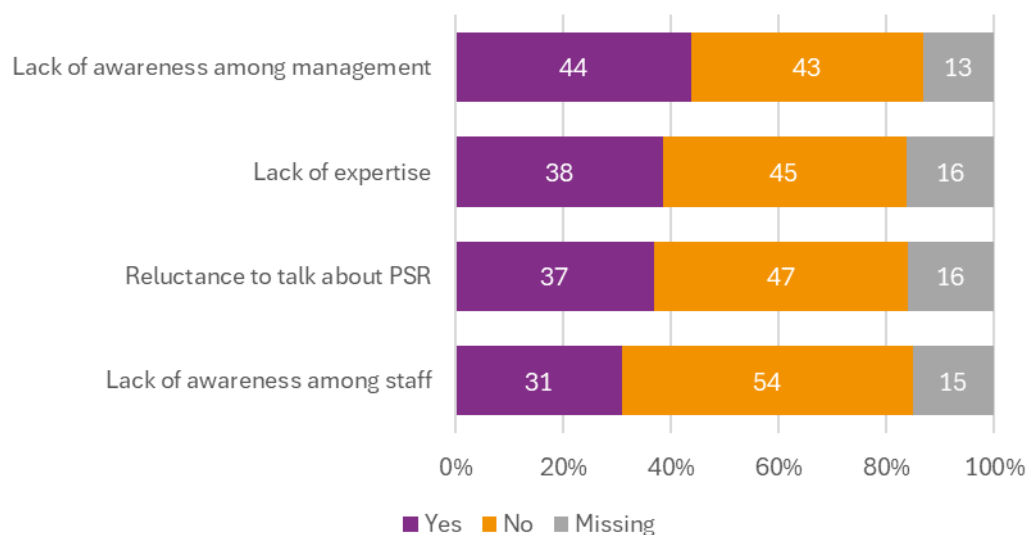


* Risk group benchmark standards based on Dollard & Bailey (2019)

Source Own calculations, survey data collected among Danish construction workers (N=250)

Nearly half of the respondents indicate that the lack of awareness about the importance of PSR and mental health among management is an obstacle to properly deal with PSR in their organisations (Figure 12). Other obstacles that are identified are a lack of expertise (38%), a reluctance to talk about PSR (37%) and a lack of awareness among staff (33%). These obstacles provide us with valuable ideas for tools to take initiative and strengthen both the psychosocial safety climate (PSC) and the management of psychosocial risks (PSR).

Figure 12. Percentage of workers reporting these obstacles to dealing with psychosocial risks in their organisation

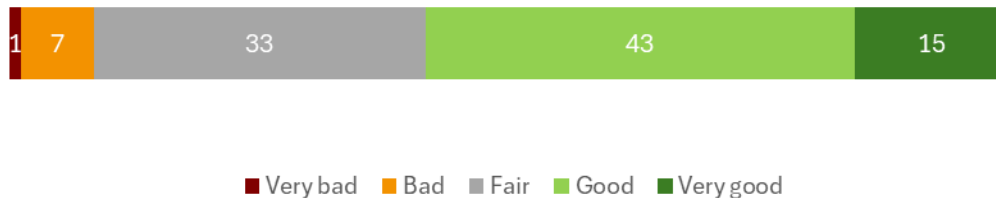


Source Own calculations, survey data collected among Danish construction workers (N=250)

5.1.3 Health of construction workers

In the survey, respondents were requested to assess their health in general (Figure 13). More than half of the respondents is positive, with 15% evaluating their health as very good, and another 43% indicating good health in general. Further, only a small share of 8% indicated a bad or very bad health.

Figure 13. Assessment of their health in general, percentages.

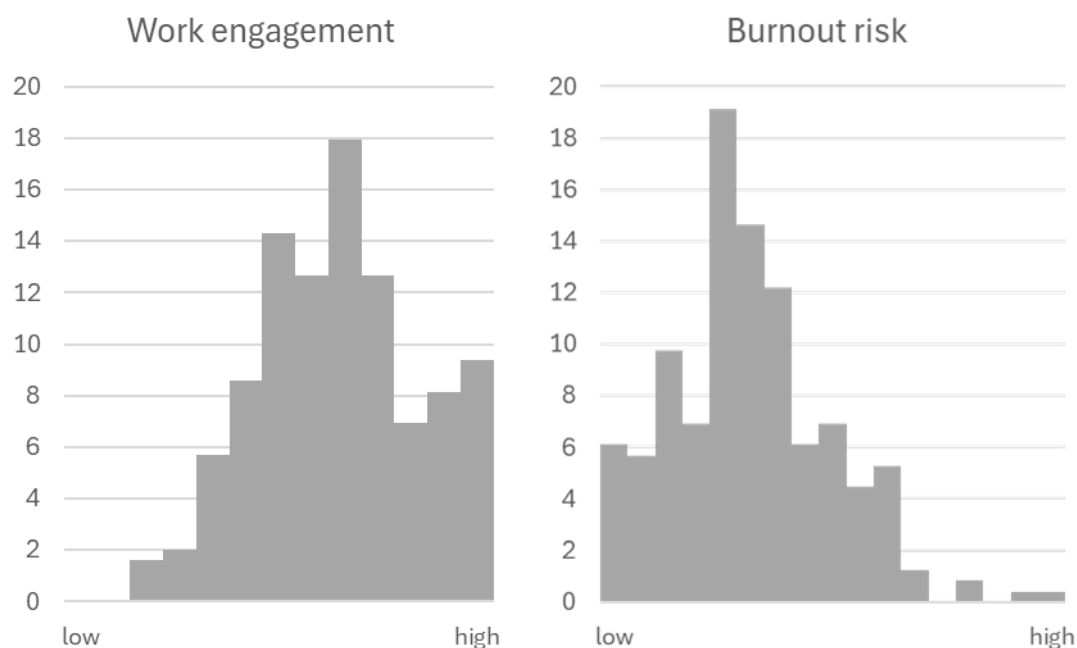


Source Own calculations, survey data collected among Danish construction workers (N=250)

Figure 14 presents the distribution of the work engagement and burnout risk scores, showing the percentage of Danish construction workers by scores. The average score for work engagement is 3.59 (SD = .823). As the distribution also shows, work engagement is moderate to high for most respondents, with only a small share indicating problematic work engagement. Women report somewhat higher average work engagement than men (M=3.72 vs. M=3.58) although this difference is not statistically significant. Older workers (+55 years) report significantly higher work engagement than young workers (16-24 years) (M=3.78 vs. M=3.48). Further, work engagement is higher among construction workers in very small (1-9 people) and very big (+250 people) companies.

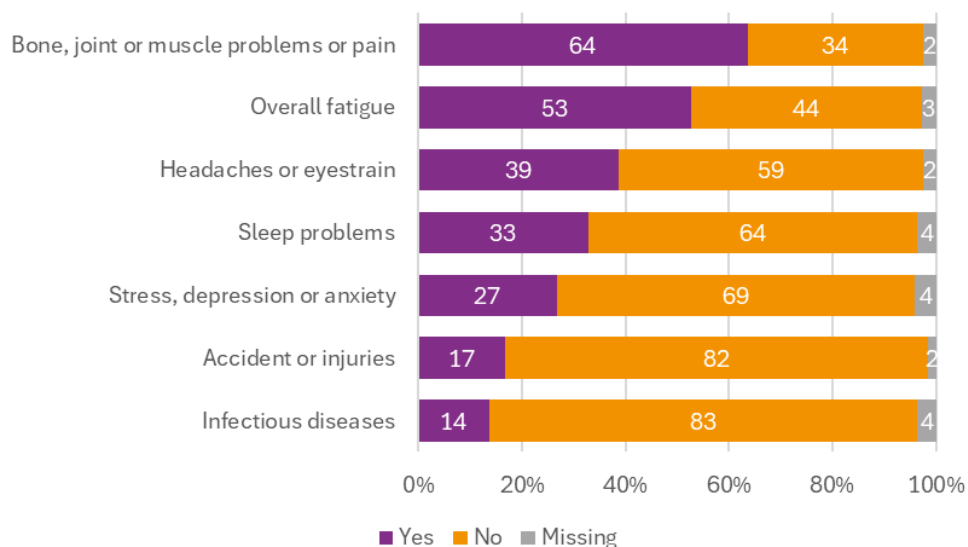
The average risk of burnout is 2.24 (SD=.737). The distribution of the scores shows us that only a very small share of the respondents reports a high risk of burn-out. Further, about a quarter of the respondents reports a (very) low risk of burnout, while most of the respondents score low to moderately concerning the risk of burnout. There are no significant differences in burnout risk for men or women. Age however does seem to be related to burnout risk, where the burnout risk for older workers above 55 years (M=2.04) is significantly lower than for their younger counterparts with an average burnout risk of 2.4 for works younger than 25, and 2.45 among the 25–54-year-olds. Further employees in small organisations with less than 10 employees report lower burnout risk, compared with larger organisations.

Figure 14. Distribution of the work engagement and burnout risk scores, percentages.



Source Own calculations, survey data collected among Danish construction workers (N=250)

Figure 15. Percentages of workers reporting these health issues, cause or made worse by their work, in the past 12 months



Source Own calculations, survey data collected among Danish construction workers (N=250)

As Figure 15 shows, musculoskeletal disorders (MSDs) are the most important health issue experienced by Danish construction workers linked to their work (64%). This is not surprising, given the high levels of physical work involved in this sector. Further, more than half of the respondents indicate experiencing overall fatigue, linked to their work, followed by headaches and eyestrain (39%), sleep problems (33%) and stress, depression or anxiety (27%). Accidents are also reported by a non-negligible share of 17% of the workers, showing this is still a very important issue of concern in Danish construction workplaces. On average workers report about 2.45 health issues. About 20%

of the report have no health issue at all, another 17% selected one health issue, 15% selected two health issues and 17% selected three health issues. On the other hand, a small share reports experiencing six out of the seven health issues (3%) or all health issues (2%).

5.1.3.1 Relationship health and PSR management

To conclude, the relationship between PSR management activities and employee well-being was investigated. The correlation matrix (Table 4) shows us that initiatives regarding PSR management tend to come together, as there is a positive correlation between all these PSR management activities and initiatives. Further, each of the PSR management initiatives has a positive relationship with work engagement and general health and seems to be buffering for burnout risk and number of health issues. Hence, this allows us to conclude that initiatives concerning PSR management can provide a valuable contribution to protecting employee wellbeing.

Table 4. Correlation matrix

	A	B	C	D	E	F	G	H
A) Psychosocial safety climate	1							
B) Safety voice	0.47	1						
C) Number of PSR measures applied in the organisation in the past 3 years	0.48	0.35	1					
D) Good PSR management practices	0.74	0.62	0.46	1				
E) Work engagement	0.53	0.42	0.37	0.48	1			
F) Burnout risk	-0.33	-0.35	-0.17	-0.40	-0.53	1		
G) General health	0.31	0.11	0.34	0.24	0.41	-0.25	1	
H) Number of health issues experienced	-0.33	-0.18	-0.18	-0.37	-0.33	0.49	-0.37	1

Source Own calculations, survey data collected among Danish construction workers (N=250)

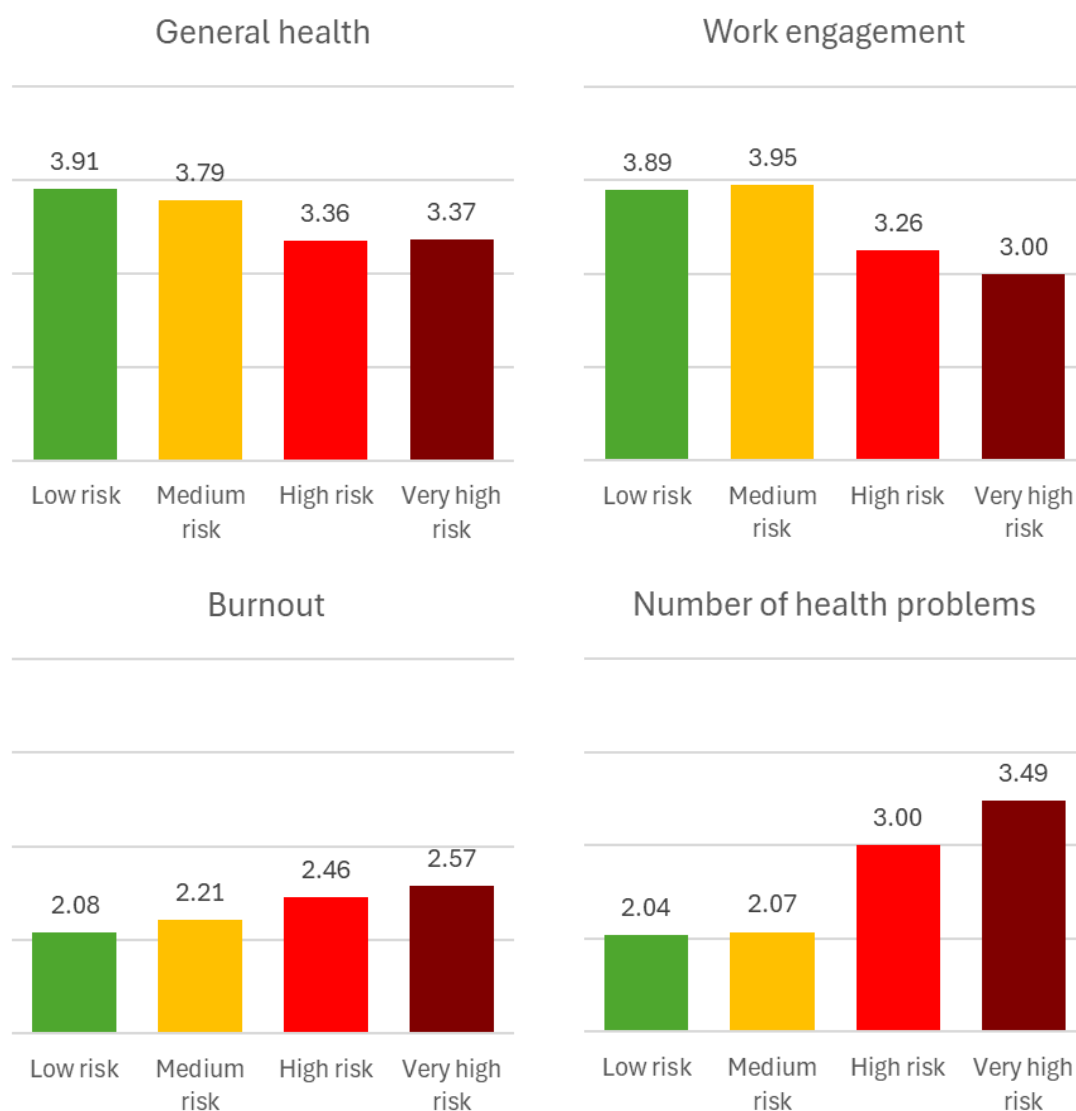
Further we investigated the relationship between the psychosocial safety climate (PSC) and several health outcomes, by comparing the average health scores for the different PSC risk groups. Post-hoc Bonferroni tests allowed to investigate significant differences between the risk groups. Figure 16 presents the mean scores for the health outcomes by PSC risk groups.

The post-hoc Bonferroni tests showed that the general health of the high risk group and very high risk group was significantly lower compared to the low risk group (both p 's < .05). No significant differences were found between the medium risk group and any other group (all p 's > .05), nor between the high and very high risk groups (p > .05). In other words, workers in a high or very high PSC risk environment report significantly poorer general health than those in a low risk PSC environment.

The work engagement scores in the low risk group and medium risk group are significantly higher than in the high and very high risk groups (all p 's < .05). No significant differences were found between the low risk group and medium risk group or between the high risk group and very high risk

group (p 's > .05). Or in other words, work engagement is significantly higher when workers report a low or medium risk PSC, compared with those reporting a high or very high risk PSC.

Figure 16. Average scores for health and well-being indicators, for each of the PSC risk groups.



* Details on significant differences between PSC risk groups are discussed in the text

Source Own calculations, survey data collected among Danish construction workers (N=250)

For burnout risk the analysis showed that the high risk group and very high risk group scored significantly higher on burnout risk than the low risk group (both p 's < .05). No significant differences were found between the other risk group comparisons (p 's > .05). In other words, workers with a low risk PSC have significantly less risk of suffering burnout compared to workers in a high or very high risk PSC.

For number of health problems, the analysis showed that the high risk group and very high risk group reported significantly more health problems than the low risk group (both p 's < .05). No significant differences were found between the medium risk group (2) and any other group (all p 's > .05), nor between the high and very high risk groups (p > .05). In other words, workers in high or very high PSC risk environments tend to experience significantly more health issues compared to those in low risk environments.

6. Conclusions

This national case study examines the legislative framework on psychosocial risks (PSR) in Denmark, the key actors involved, the role of social partners, and the priorities and challenges related to PSR. The analysis is based on a combination of desk research, qualitative stakeholder interviews, and a quantitative employee survey conducted among Danish construction workers.

The Danish case study presents a complex and evolving picture of psychosocial risks and mental health in the workplace. While Denmark performs relatively well compared to EU averages on many PSR indicators, significant challenges remain - particularly in the construction sector. Although public discourse increasingly addresses mental well-being and stress, PSRs are not yet a high priority within the Danish construction industry. The nature of construction work - characterized by volatility, numerous subcontractors, interdependent workflows, high physical demands, tight deadlines, and a diverse workforce - creates distinct psychosocial risks.

Workers report high levels of time pressure, poor communication, and financial dissatisfaction. Additional PSRs in the sector include violence, threats, discrimination, interpersonal conflicts, emotional demands, fast-paced work, and the psychological impact of workplace accidents. Emerging risks, such as the emotional demands placed on managers and the struggle to balance personal and professional life, may become increasingly relevant.

Migrant and foreign workers are particularly vulnerable. Often not covered by trade unions, they have limited power to resist poor working conditions and face constant pressure, long working hours, isolation, and substandard living conditions in camps near large construction sites.

A generational shift in attitudes toward workplace conditions is also evident. Older workers tend to accept traditional norms, even when problematic, while younger workers expect respectful treatment and are more likely to leave companies - or the sector entirely - if conditions do not improve. This shift is prompting companies to reconsider workplace culture and invest in more inclusive practices.

Denmark's legislative framework has made significant progress in recognizing and addressing PSRs. The Working Environment Act (WE-Act) of 1975 and Executive Order No. 1406 of 2020 provide a clear mandate for employers to manage psychosocial risks. The 2020 Executive Order marked a turning point, bringing visibility to the issue and reinforcing its importance. Stakeholders widely agree that this development has positively influenced the prevention and management of PSRs in Denmark.

The Danish labour market model facilitates strong and continuous involvement of social partners through BFAs and collective agreements, with a focus on practical implementation at the sectoral level. As a result, legislation, executive orders, guidelines, and toolkits are developed collaboratively, ensuring broad support and targeted action. However, while awareness campaigns and toolkits are available, their uptake and effectiveness vary significantly across organisations.

Survey findings highlight the critical role of organisational culture and the psychosocial safety climate (PSC) in shaping workers' experiences. Employees in low-risk PSC environments report better health outcomes, higher engagement, and lower burnout risk. In contrast, those in high-risk PSC settings face more health issues and reduced well-being. Despite the presence of consultation

bodies and trade union representatives, direct employee involvement in PSR management remains limited. This gap underscores the need for more participatory approaches that empower workers to help design and implement preventive measures.

Denmark has established a strong foundation for PSR prevention and management through legislation, social dialogue, and sectoral initiatives. However, continued efforts are needed to translate policy into practice - especially sectors like construction which are less prone to discuss these topics. Strengthening organisational culture, promoting direct worker involvement, and addressing the specific needs of vulnerable groups, particularly migrant workers, will be essential to creating healthier and more resilient workplaces.

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1. Introduction

In Estonia, awareness of mental health challenges and psychosocial risks (PSR) in the workplace has increased, especially during the COVID-19 pandemic. Public and professional debate has increasingly recognised the importance of issues such as stress, burnout, workplace bullying, work-life balance as well as job insecurity. While discussions on PSRs are not new, they were long framed within the broader context of health promotion, and persistent stigma around mental health problems has hindered their management in the working environment, limiting their systematic integration into occupational safety and health (OSH) frameworks

Over the past two decades, the development of Estonia's OSH system has been strongly influenced by EU membership and the alignment with European legislation. The Occupational Safety and Health Act (1999), obliges employers to assess and manage risks, including psychosocial hazards, although in practice implementation remains uneven. In 2022, the Act was amended to include remote working regulations, and PSRs were formally included in the list of recognised occupational diseases. The updated classification now includes post-traumatic stress disorder (PTSD) and other health disorders resulting from PSRs in the working environment. However, challenges include a shortage of occupational psychologists and limited psychosocial expertise among occupational health physicians, hindering their accurate diagnosis of work-related psychological conditions.

The Labour Inspectorate plays a central role in ensuring compliance and providing preventive support, while social partners, professional associations, and NGOs have contributed to raising awareness and developing practical tools, such as handbooks, training, and self-assessment instruments for mental health at work.

Despite these efforts, the prevalence of stress-related health problems, burnout and workplace harassment has remained high, particularly in healthcare, education, and ICT sectors marked by high workloads and rapid organisational change (EU-OSHA, 2025a). At the same time, Estonia's relatively weak social dialogue and low trade union membership limit the systematic integration of PSRs prevention into collective bargaining and workplace practices. While employers generally conduct risk assessments, preventive measures and follow-up interventions are often lacking, and rehabilitation or return-to-work programmes for mental health conditions are not well developed.

Having established the critical context of PSRs and mental health in Estonia, this report now sets out the approach taken to examine these issues, including the influence of the COVID-19 pandemic, the effects of digitalisation, and the roles of key institutional and social actors. This national case study focuses on OSH, with particular emphasis on PSR factors, their prevention, management, and the broader systems that support these processes. It analyses how PSRs are addressed across Estonia's OSH framework, identifying both strengths and persistent challenges.

The report is structured as follows: the next chapter outlines the methodology applied, followed by the findings of the Estonian case study, and a discussion of their broader policy implications within both the national and European context.

1.1 Methodology

This national case study focuses on OSH, with particular emphasis on PSR factors - their prevention, management, and the broader systems that support these processes. The study explores the roles of key stakeholders at the national, sectoral, and organisational levels, while assessing the policies, practices, tools, actions, and initiatives that are being, or could be, adopted to address PSRs. Special attention is also given to the role of social partners and industrial relations, highlighting the importance of worker participation in OSH as an essential component of effective risk prevention and management.

In Estonia, the study concentrated on male-dominated sectors, specifically the construction and certain manufacturing industries. The findings are based on both desk research and empirical data collected through interviews with key stakeholders and a questionnaire survey among employees working in these sectors.

Eleven semi-structured interviews were conducted with stakeholders from a various institution, including the Ministry of Economic Affairs and Communications, the Ministry of Social Affairs, the Labour Inspectorate, the Estonian Employers' Confederation, the Estonian Trade Union Confederation, sectoral associations and employer representatives, as well as an academic expert (Table 1). These interviews provided valuable insights into current challenges related to PSR factors at work, existing policy and regulatory frameworks, approaches to risk management and the role of industrial relations in addressing these issues. Together with a complementary employee survey, the findings offer an overview of the current state of PSR management in Estonia, highlighting key challenges and sectoral practices.

All interview participants were fully informed about the study's purpose and provided their signed consent. The interviews were then recorded, transcribed anonymously and analysed.

Table 1. List of Stakeholders Interviewed According to Representational Level

Interview number	Stakeholder	Level of Representation
1	Ministry of Economic Affairs and Communications	National level
2	Ministry of Social Affairs	National level
3	The Labour Inspectorate	National level
4	The Labour Inspectorate	National level
5	Academic expert / Researcher on OSH and employee well-being	National level
6	The Estonian Employers' Confederation	National level/ Sectoral level
7	The Estonian Trade Union Confederation	National level/ Sectoral level
8	The Estonian Association of Construction Entrepreneurs	Sectoral level/ Company level

9	The Estonian Association of Machinery Industry	Sectoral level/ Company level
10	Health, Safety and Environment (HSE) expert and advisor in the construction sector	Sectoral level/ Company level
11	Company representative from the Estonian Forest and Wood Industries Association	Sectoral level/ Company level

This report also presents findings from an employee questionnaire (hereafter referred to as project questionnaire) conducted between April and June 2025 in two traditionally male-dominated sectors in Estonia: manufacturing (including wood, metal and related industries) and the construction sector. The aim of the study was to gain a deeper understanding of employees' views on work-related matters, with a particular focus on PSR factors and how these risks are managed in the workplace.

In total, 386 responses were collected during the survey period. To ensure broad coverage, the questionnaire was disseminated through multiple channels. Sectoral institutions distributed the survey and encouraged companies to share it directly to their employees. Additional responses were obtained through fieldwork at the *Eesti Ehitab* construction fair and at selected worksites, which allowed direct engagement with employees. To complement these efforts, further data collection was carried out through telephone interviews conducted by survey company Norstat (Table 2). This multi-channel approach provided access to a diverse group of employees across sectors. Nonetheless, it should be noted that the sample cannot be considered fully representative of the entire workforce in the construction and manufacturing sectors.

Table 2. Distribution of Respondents by Sector and Data Collection Method

Data source	Construction	Manufacturing	Total
Survey distribution and fieldwork (fair, worksites)	89	93	182
Norstat	58	146	206
Total	147	239	386

The project questionnaire was completed by 258 male and 124 female respondents. The mean age of respondents, calculated as a weighted average from the frequency distribution, was 47.6 years. Participants represented a broad spectrum of occupational categories. The largest group consisted of higher-skilled employees, including professional occupations such as engineers (16.8%, n = 65), technical or associate professionals (3.6%, n = 14), and skilled manual workers such as foremen, mechanics, electricians, machine operators, and repairers (25.4%, n = 98). Senior managers accounted for 9.8% (n = 38) of respondents, while office workers (10.1%, n = 39), sales workers (7.3%, n = 28), and service workers (0.3%, n = 1) were also represented. Lower-skilled groups comprised semi-skilled workers, such as bricklayers, roofers, sheet metalworkers, housebuilders, and painters (19.4%, n = 75), alongside unskilled workers, such as factory workers (5.7%, n = 22). A small proportion (1.6%, n = 6) reported that they did not know or preferred not to indicate their occupation. For the purposes of comparative analysis, the reported occupations were consolidated into four broader groups, as presented in Table 3.

Table 3. Distribution of Respondents by Occupational Group (Project Questionnaire)

Occupational group	Frequency	Percentage (%)	Included occupations
Senior managers	38	10,1	Higher managers
Clerical and sales workers	67	17,9	Office and administrative workers
			Sales workers
Higher-skilled workers	174	46,4	Professional occupations
			Technical or associate professionals
			Skilled manual workers
Lower-skilled workers	96	25,6	Semi-skilled workers
			Unskilled workers

Regarding employment status, most respondents were employees with a permanent contract (85.5%, n = 330). Smaller groups included the self-employed (4.1%, n = 16) and employees with a temporary contract (2.8%, n = 11). In addition, 1.8% (n = 7) reported being without a professional activity, while 3.4% (n = 13) indicated another employment status. A small proportion (2.3%, n = 9) stated that they did not know or preferred not to answer.

Company size was also diverse among respondents. Almost one-third worked in organisations with 10–49 employees (32.9%, n = 127), while a slightly smaller share was employed in companies with 50–249 employees (29.8%, n = 115). Small workplaces with fewer than 10 employees accounted for nearly one-quarter of responses (23.3%, n = 90). Large organisations with 250 or more employees represented 12.7% (n = 49) of the sample, and only a very small number (1.3%, n = 5) indicated that they did not know or preferred not to answer.

The questionnaire data offers important insights into working conditions and employee perceptions in these sectors in Estonia. It reflects employees' experiences and highlights several aspects that are critical for understanding the current challenges in managing OSH and PSRs. The following sections present a detailed analysis of the main findings.

2. Context

This chapter examines the current state of knowledge on PSRs and workplace mental health, situating them within both international and Estonian contexts. The chapter also addresses the broader mental health dimension, highlighting its significance for public health, social stability, and economic productivity. In addition, special attention is given to the impact of the COVID-19 pandemic, which reshaped working conditions and intensified existing psychosocial challenges. By reviewing these interconnected themes, the chapter provides the necessary background for understanding the drivers and consequences of PSRs in Estonia as well as frames the discussion for subsequent analysis in the report.

2.1 State of play of psychosocial risks and mental health

In recent years, PSRs and mental health in the workplace have gained increasing attention in Estonia, reflecting broader European and global trends. Estonia does not have a nationwide survey on working conditions to track the development of PSRs and their impact on workers' health over time. However, an analysis by the Estonian Ministry of Social Affairs (2019) on mental health and PSRs in the workplace highlight the growing importance of these issues in the national context. The report found that mental health disorders are the second leading cause of reduced work capacity in Estonia, underscoring both the societal and economic burden associated with unaddressed PSRs. Interviews with experts indicate that awareness has risen among employers. Interviewees described the topic as highly relevant for employees, noting a clear shift from ad-hoc well-being activities to recognising PSRs as core OSH matters that require structured assessment and follow-up. However, according to interviewees, employers often lack adequate guidance, training, and practical tools as well as an organisational workplace culture that encourages more open discussion in workplaces.

At the European level, the direct and indirect costs of poor mental health on the general population are estimated at approximately 4% of GDP, while in Estonia is 2.8% of GDP, equivalent to nearly 572 million euros annually (OECD & European Union, 2018). These costs reflect a combination of healthcare costs, productivity losses and broader societal impacts. In 2024, mental health disorders affected 122,830 individuals in the general population of Estonia, according to data from the Estonian Health Insurance Fund. Treatment costs have also increased, with the Health Insurance Fund reimbursing 2.08 million euros in prescription expenditures related to mental health care in the same year. The prevalence of diagnosed mental health conditions therefore offers additional insight into the magnitude of the issue across the population.

Evidence from European and national surveys illustrates the scope of the challenge. According to Eurostat (2021), a significant share of Estonia's workforce perceives their working conditions as negatively affecting their mental well-being. Based on the same survey results, 41% of women and 34% of men reported that PSR factors are present in their work environment, potentially negatively impacting their mental health. The most cited work-related stressors in Estonia include high workloads, time pressure and strained interpersonal interactions with colleagues or clients

(EU-OSHA, 2022, Heylen et al., 2024).). These risk factors not only contribute to short-term stress and decreased productivity, but also increase the risk of burnout, long-term mental health disorders, absenteeism, as well as staff turnover. As a result, PSRs represent not only a pressing occupational health concern but also a significant policy challenge for Estonia, with direct implications for economic performance, organisational sustainability as well as public well-being. Within the framework of this national case study, these findings highlight the need to understand the scope and dynamics of PSRs in the Estonian context, providing the foundation for evidence-based strategies, policy recommendations and practical interventions aimed at improving mental health and management of PSRs in Estonian workplaces.

2.2 Impact of Covid pandemic

The COVID-19 pandemic brought about profound and often unforeseen changes in the world of work, significantly intensifying existing PSRs and creating new ones. Like many other EU Member States, Estonia experienced a rapid shift in working conditions that continues to shape workers' mental health, work-life balance and overall well-being.

The pandemic significantly encouraged widespread discussions about mental health in Estonian society, leading to increased public awareness regarding the importance of psychological well-being. This growing awareness brought greater attention to mental health challenges within the workplace, prompting both employers and policymakers to prioritize PSRs. Consequently, there has been a rise in employees reporting mentally exhausting working environment to the Labour Inspectorate (EU-OSHA, 2025a). This increase in reporting is likely a direct result of enhanced awareness and targeted information campaigns, which have equipped workers to identify and address detrimental workplace conditions more effectively.

According to the Eurofound Living, Working, and COVID-19 e-survey (COVID e-survey), Estonian workers reported a marked increase in working hours beginning in 2020, a trend that persisted well into 2022. Average working hours regularly exceeding the standard 40-hour workweek, reaching approximately 42 hours per week on average. Extended working time was particularly prevalent in knowledge-based sectors such as ICT, education, and professional services, where remote work practices quickly became widespread.

Among the most immediate psychosocial effects of the pandemic was its disruption of work-life balance. During the initial stage of lockdown, boundaries between work and private life became increasingly blurred. While COVID e-survey results from 2022 indicate a slight improvement, mental well-being across EU Member States, including Estonia, has not returned to pre-pandemic levels, even after restrictions were lifted in spring 2022 (Heylen et al., 2024). Employees often remain mentally engaged with work outside of official hours, continuing to perform work-related tasks during their personal time. Persistent symptoms of “always-on” work organisational culture remain visible.

Estonian data shows that 22% of employees experience frequent or constant worry about work, while another 34% report such concerns occasionally. Moreover, work obligations frequently extend into employees' private lives work obligations often interfere with family life, 79% of Estonian workers report that their job interferes so some extent with time spent with family members (Eurofound, 2022). These patterns were also confirmed by interviewees, indicating that work-life balance challenges, exacerbated during the pandemic, have now become a regular feature of daily work.

In addition to affecting working hours and work-life balance, the pandemic increased risks of social isolation, job insecurity, long periods of working alone and burnout (Heylen et al., 2024). Healthcare and education workers faced especially heavy pressures, while many service sector and temporary employees struggled with job losses and uncertainty. This was also confirmed by the results from interviews with representatives from governmental organizations.

Furthermore, the representatives from Labour Inspectorate and the Ministry of Social affairs interviewed for this study emphasised that remote work creates many challenges for employers, such as the difficulty of identifying risks, and relies largely on trust as well as management of PSRs; returning to the workplace after the COVID period has also led to related conflicts and tension among employer and employees.

The pandemic made existing PSRs worse and brought lasting changes. It showed that workplace mental health is vulnerable and that Estonia was not fully prepared. Although flexible work and digital health services have grown, the continuing impact on employees shows the need for ongoing policies and workplace measures. Responding to the significant increase in teleworking during the 2020-2021, COVID-19 pandemic, Estonia's Ministry of Social Affairs revised the Occupational Health and Safety Act in November 2022. This update addressed the previous lack of specific regulations for telework safety. New requirements now mandate employers to conduct risk assessments for teleworking arrangements, including PSRs, and to provide employees with comprehensive guidance on telework-related risks and prevention strategies.

3. Regulatory framework on psychosocial risks and workers' health and well-being

3.1 Legislation and policy

This section provides an overview of the Estonian OSH legal framework, emphasising significant legislative developments and defining the statutory provisions pertaining to psychosocial risks.

3.1.1 Legislative measures

In Estonia, the key legislative foundation for OSH is the Occupational Safety and Health Act, in force since 1999. The Act is based on the European Framework Directive and has a broad scope. It places responsibility on employers to ensure a safe and healthy working environment and to manage OSH at the enterprise level. This includes conducting risk assessments, carrying out regular internal controls, and preparing action plans to address identified risks. These assessments must also cover PSRs, with follow-up measures aimed at preventing or reducing them. Such measures may involve improving workload management, integrating breaks, adjusting work organisation and enhancing the overall psychosocial work environment.

Over the past decade, the Occupational Safety and Health Act in Estonia has undergone substantial revisions, placing greater emphasis not only on occupational safety but also on the promotion of occupational health, including the specification of PSRs. In 2019, the Act was amended to expand its coverage of PSRs. The legislation currently defines PSRs as: “work involving a risk of an accident or violence, unequal treatment, bullying and harassment at work, work not corresponding to the abilities of an employee, working alone for an extended period of time and monotonous work and other factors related to management, organisation of work and working environment that may affect the mental or physical health of an employee and that may cause stress.”

These changes were noted in many of the stakeholder interviews conducted as part of this study. Both the representative of the Labour Inspectorate and the academic expert interviewed agreed that the definition provided in the legislation is sufficiently clear to support the initial identification of PSRs by employers. They also highlighted the benefit of maintaining an open-ended list of risk factors in the law, allowing flexibility in addressing emerging risks. However, a representative from the Estonian Employers' Confederation expressed concerns during the interview that the broad and open-ended nature of the list may lead to differing interpretations. This uncertainty can make it difficult for employers to be confident that all relevant PSRs are adequately identified and managed. These insights underline the importance of a comprehensive and practical understanding of PSRs in supporting effective implementation.

In November 2022, Estonia's Occupational Health and Safety Act was amended to include specific regulations for remote working. These revisions mandate employers to conduct risk

assessments for telework, encompassing health and safety, and to implement mitigation measures. Employers must also provide guidance on telework risks, supply suitable equipment, arrange health examinations, investigate incidents, and pay sickness benefits. Crucially, the remote workplace setup requires mutual agreement between employer and employee.

In Estonia, work-related diseases are categorised into two groups: occupational diseases and work-induced diseases, both of which are defined in a specific government regulation. In 2022, this regulation was revised to include a new category related to PSRs, which had not been explicitly recognised before. According to the updated regulation, occupational diseases linked to PSRs in the working environment now include post-traumatic stress disorder (PTSD) and other illnesses caused by PSR factors in the workplace.

Occupational health physicians are responsible for diagnosing work-related diseases in Estonia. According to data from the Labour Inspectorate, only one occupational disease directly linked to PSRs - classified under “other general work-related physical or mental stress” -was diagnosed in 2023. In total, ten work-related diseases were reported in 2023, compared to seven cases in 2024. Representatives of the Labour Inspector interviewed for the study emphasised these low numbers reflect systemic barriers. Among the most significant are limited psychological expertise in diagnosing PSR-related occupational diseases, scarce and inconsistent documentation of workplace exposure, and a demanding evidentiary threshold to prove work-relatedness. In addition, they pointed to time-consuming procedures, and persistent stigma, all of which discourage reporting and lead many conditions, especially those linked to PSRs, to be coded as general illnesses rather than occupational diseases. These relatively low numbers highlight the ongoing challenges in identifying, diagnosing, and adequately addressing the health impacts of PSRs in the workplace (EU-OSHA, 2025a).

3.1.2 Non-legislative measures

Over the past decade, there has been increasing recognition in Estonia of the importance of addressing PSRs in the workplace and their impact on public mental health. In Estonia, relevant strategic policies addressing PSRs at work include the Population Health Development Plan 2020–2030, the Mental Health and Well-being policy, and the Green Paper on Mental Health.

The Population Health Development Plan 2020–2030 is one of Estonia’s central strategic documents at the national level. Developed by the Ministry of Social Affairs and approved by the government, the plan outlines various measures aimed at preventing mental health issues in the workplace and underscores the importance of mental wellbeing at the population level. It sets out three primary objectives: to increase the number of healthy life years; to ensure that healthy life years grow more rapidly than overall life expectancy; to reduce health inequalities by gender, region, and educational level.

The Green Paper on Mental Health (*Vaimse tervise roheline raamat*), prepared by the Ministry of Social Affairs in 2020, is another key national policy document. It sets a clear goal for the Ministry to assist employers and occupational health service providers in identifying, assessing, and applying additional measures to prevent PSRs in the workplace. These measures are intended to strengthen the psychosocial work environment through various targeted approaches. The document also underlines the importance of improving supervision and counselling related to PSRs to ensure adequate support for employees.

3.2 Key actors

The Estonian governance of OSH involves a number of institutions and stakeholders with distinct roles and responsibilities, each contributing to the prevention and management of PSRs at work.

In Estonia, the **Ministry of Social Affairs** and the **Ministry of Economic Affairs and Communication** are responsible for formulating policies and OSH regulations impacting mental health and labor welfare, respectively. At present, the regulation of the working environment is currently the responsibility of the Ministry of Economic Affairs and Communications, which plays a central role in policy design and in facilitating social dialogue between the main labour market actors. This arrangement is relatively recent. In 2023, the mandate for occupational health and safety was transferred from the Ministry of Social Affairs to the Ministry of Economic Affairs and Communications. Under the previous structure, the area was overseen by the Minister of Health and Labour, reflecting a stronger connection to public health. Following the reform, responsibility lies with the Minister of Economic Affairs and Industry, based on the rationale that occupational health and safety is more closely aligned with economic policy and enterprise development than with social policy. In the field of mental health, the Ministry of Social Affairs continues to play an important role. The Ministry has a dedicated department responsible for mental health issues and the development of related policies in Estonia. However, its activities do not specifically focus on the workplace or occupational health and safety, and it does not regulate this field. The regulation of the working environment is the responsibility of the Ministry of Economic Affairs and Communications, which cooperates with the Ministry of Social Affairs to draw on its expertise in mental health.

While the Ministry of Economic Affairs and Communications provides the overall policy framework for OSH, the **Estonian Labour Inspectorate** (*Tööinspektsioon* www.ti.ee) plays the central role in ensuring practical implementation. Its responsibilities include supervising compliance with labour and OSH legislation, providing guidance to employers and employees, investigating serious workplace accidents, and running prevention campaigns in high-risk sectors. In recent years, the Inspectorate has broadened its focus from enforcement and sanctions to awareness-raising and preventive measures, such as communication campaigns, information days, and counselling on OSH and labour relations.

In addition to its general mandate, the Labour Inspectorate has become increasingly active in supporting PSR management and workplace mental health. Its initiatives include the publication of brochures and guidance materials on stress and burnout, as well as the development of practical assessment tools to help organisations identify and address PSRs. Among these are the Tool for Risk Assessment of Psychological Distress from the Perspective of Psychological Stress (2021a) and the Questionnaire for the Assessment of Psychosocial Risks (2021b). These instruments are designed to promote mental health among employees and to support the creation of healthier, safer working environments. A dedicated online self-analysis tool was available between 2010 and 2020, while targeted PSR inspections were carried out in 2018 (transport sector) and 2019 (healthcare and nursing homes). Although no further campaigns have been conducted since, the Inspectorate's annual good practice awards now highlight efforts to prevent PSRs and promote mental health.

Since 2015, its advisory role has been strengthened by an EU-funded consultancy service, offering face-to-face OSH support. Awareness-raising has also been enhanced through the Work Life Portal (<https://www.tooelu.ee/>), which provides guidance, fact sheets, and examples of good practice. A major development in 2023 was the recruitment of a mental health consultant, whose

services are in high demand. The consultant provides training, on-site guidance, and support for compliance inspections, with particular attention to bullying, extended remote work, and workplace violence, especially in schools and public safety authorities. According to an interview with a representative from the Labour Inspectorate, significant gaps remain while most employers carry out PSR assessments, preventive measures and follow-up actions are often missing, and Estonia lacks structured rehabilitation and return-to-work programmes to support employees following mental health issues.

Estonian Labour Inspectorate plays a key role in raising awareness of PSRs among employers and employees through guidance materials, information campaigns and advisory services, particularly strengthened by the work of its dedicated mental health consultant. However, the Inspectorate can't check workplaces for PSRs as often as needed. Sectoral interviews also emphasised that supervision related to PSRs remains weak, and that meaningful progress in PSR management will require stronger and more consistent oversight.

Another key body at national level is **the Health Board** (*Terviseamet*, <https://terviseamet.ee/>), operating under the Ministry of Social Affairs, is a government organisation essential for public health in Estonia. It ensures health protection, environmental health, chemical safety, and medical device safety through both proactive and complaint-based supervision. Additionally, the Health Board participates in developing and implementing occupational health programs, analyses data on occupational and work-related diseases, and registers occupational health professionals. Its guidance and oversight on public health matters, particularly occupational health services, are crucial for preventing PSRs and promoting mental health in the workplace.

Employer interests are represented by the **Estonian Employers' Confederation**, which defends collective interests and collaborates with state authorities and trade unions.

The Estonian Trade Union Confederation (EAKL) is the country's largest trade union body, bringing together 15 branch unions and representing workers across diverse sectors. While it plays an important role in defending employee interests and has the capacity to influence OSH policies, its activity in this field remains limited. The second largest organisation is the Estonian Employees' Unions' Confederation (TALO), representing cultural workers and public sector employees.

Various ministries, departments, and boards have developed different tools and documents to support PSRs prevention and promote mental health in the workplace. One more institution is **NGO Peaasjad**, established in 2009 with support from various ministries, is a prominent initiative focused on mental health awareness and support in Estonia. Its mission is to reduce stigma, promote mental well-being, and, since 2021, assist employers in PSR prevention. The NGO's platform, www.peaasi.ee, offers extensive resources, including articles, guides, and tools, which the Labour Inspectorate also recommends for employers and employees. However, social dialogue organizations note a lack of formal assessment on these tools' usability and effectiveness. Among its practical tools, the 'Mental Health Good Practice and Action Plan in the Workplace' (available in Estonian, English, and Russian) aims to boost awareness, prevention, counselling, and support for mental health, ultimately improving productivity and fostering supportive work environments. Training and counselling services are particularly utilised. Peaasjad NGO also awards Mental Health Labels (gold, silver, bronze, asterisk) to organizations prioritizing workplace mental health. In 2023, 126 employers received this recognition, with another 100 awarded in 2024. A representative of the Labour Inspectorate said he calls it a good step that motivates employers. The presence of Mental Health Labels is also especially important

for young employees, who see it as a clear sign that the employer is committed to protecting workers' mental health; as such, the label provides added value and strengthens the employer's reputation.

Several tools have been developed in Estonia to support the implementation of the legislation. **The National Institute for Health Development (NIHD)** published the handbook *Mental Health in the Workplace* (2015), which shares best practices from Estonian organisations and offers practical recommendations for employers and employees to prevent PSRs. In 2020, the Social Insurance Board issued guidance on *Psychosocial Crisis Support* (2020) providing online and phone-based services along with a “traffic light” support package to promote self-care, peer support, and organisational resilience during crises. NIHD has also developed a *Workplace Health Promotion Self-Assessment Tool*, enabling employers to evaluate and strengthen health promotion measures within their organisations.

The Estonian Association of Occupational and Organisational Psychologists (EAOOP) plays an important role in advancing professional development, standards, education, research, and advocacy in the field of occupational and organisational psychology. However, interviewed stakeholders did not specifically mention any existing cooperation with the Association.

The Estonian Society of Occupational Health Physicians, established in the 1990s, plays a vital role in strengthening occupational health and preventing PSRs. Its members are responsible for both preventive measures and for diagnosing and registering occupational diseases, including those linked to psychosocial factors. The Society collaborates with the Ministry of Social Affairs and the Labour Inspectorate mainly on OSH legislation and policy development as well as on occupational disease classifications. Interviews with stakeholders conducted for this study highlighted several challenges, including a shortage of occupational psychologists and limited psychosocial expertise among physicians, which hinder the accurate identification of work-related mental health conditions. Additional systemic barriers include weak social dialogue in Estonia, insufficient OSH data and research, and inconsistent quality of PSR assessments (Labour Inspectorate, 2019; Ministry of Social Affairs, 2019).

4. Industrial relations system and regulatory framework on social dialogue

4.1 Industrial relations system and its key actors

The system of industrial relations in Estonia is characterised by a liberal labour market model, shaped by the country's post-Soviet transition and subsequent integration into the European Union. Collective bargaining coverage in Estonia is limited compared to most EU Member States, and trade union membership remains among the lowest in Europe (OECD, 2019). This weakens the direct influence of employee representation in shaping working conditions, including occupational safety and health and the prevention of PSRs. Social dialogue tends to be fragmented and actor-driven, with limited institutionalised structures for tripartite negotiation. Despite these structural weaknesses, Estonia has developed a system of state institutions, professional organisations, and social partners that, collectively, shape workplace governance and contribute to OSH and PSR prevention.

Estonia's OSH framework is primarily managed by two ministries and a central enforcement body. The Ministry of Economic Affairs and Communications oversees the OSH framework. The Ministry of Social Affairs contributes to OSH legislation and public health policy, particularly regarding mental health. The Labour Inspectorate is the main enforcement and advisory body, conducting inspections, offering counselling, running awareness campaigns, and, since 2023, employing a dedicated mental health consultant to address PSRs in the workplace.

At the national level, employers are represented by the **Estonian Employers' Confederation**. The Confederation functions as a central umbrella organisation, uniting many of the main sectoral associations as well as many of the country's major companies. It plays an important role in social dialogue, serving as the official representative of employers in tripartite negotiations alongside trade unions and the government. In addition, the Confederation engages in knowledge-sharing, promotes good practices, and carries out various initiatives to support employers and strengthen the business environment.

According to interview results with stakeholders, the Employers' Confederation actively cooperates with the government and unions in policy discussions, although its influence on PSR prevention has so far been limited. According to the interview with the Employers' representative, while both the Confederation and its member associations recognise PSRs as an important issue, stigma and prevailing social attitudes continue to discourage open discussion and make it difficult to develop a systematic approach. The issue is periodically placed on the agenda but tends to fade, because beyond underscoring the value of trainings, employers lack clarity on what effective organisation-level interventions should look like (e.g., leadership accountability, workload and job design reviews, monitoring of indicators over time). As a result, initiatives have been limited, but still some efforts deserve mention, such as development of Mental Health First-Aid Kid (see section 4.2).

Regarding sectoral activities, there are several **sectoral associations** that bring together companies and employers within specific industries. For example, in the construction sector, employers are represented by the Estonian Association of Construction Entrepreneurs, while in manufacturing there are organizations such as the Estonian Machine Industry Association and the Estonian Forest and Wood Industries Association. These sectoral associations are members of the Estonian Employers' Confederation but operate with a stronger focus on sector-specific issues. Their activities include addressing industry-related challenges, sharing information, and facilitating contacts and cooperation among member companies.

Sectoral associations are also involved in certain negotiations; however, according to interviews with sectoral representatives, their role is usually more narrowly focused on issues specific to their respective industries. In such cases, additional stakeholders may also take part in the process, for example, local governments, other ministries, or sector-related organizations, depending on the topic under discussion.

In Estonia, employees are represented at the national level by the **Estonian Trade Union Confederation**. According to its representatives, the Confederation's key functions include participation in tripartite negotiations, where trade unions represent employees, the Estonian Employers' Confederation represents employers, and the government participates in its role as legislator and regulator. In addition, the Confederation supports sectoral unions and provides members with relevant information and training opportunities.

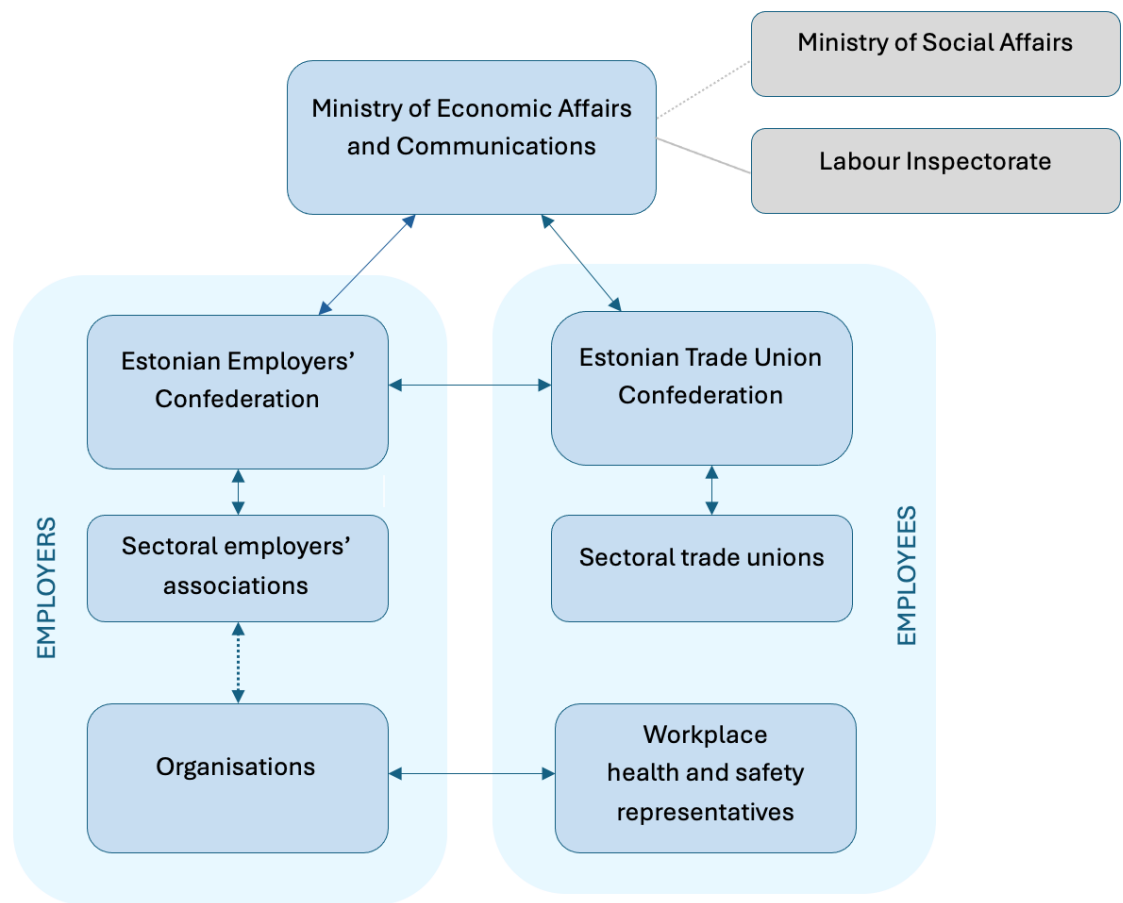
Despite this institutional framework, trade union activity and membership in Estonia remain relatively limited. According to OECD (2019), trade union density in Estonia was 6%, referring to the share of employees who are members of a trade union. This trend was also evident in the empirical study conducted within the project, where only 6% of respondents reported being affiliated with a trade union. **Sectoral unions** are weakly represented, which further weakens the potential for collective employee representation in industries such as construction and manufacturing. As a result, opportunities for coordinated bargaining and sector-level employee advocacy are very limited.

According to the interview with a trade union representative, collective agreements in Estonia primarily regulate salary and working time. While other issues, such as the psychosocial work environment - may also be negotiated, these are generally addressed at the company level. At the sectoral level, such provisions can be formulated as guidance rather than binding requirements.

According to OSH Act, at the organisational level in Estonia, employees elect working environment representatives in companies with ten or more staff to deal with daily OSH issues. In enterprises with at least 150 employees, a working environment council must also be established as a formal cooperation body, consisting of an equal number of employer and employee representatives. While working environment representatives primarily address individual employee concerns, council members focus on OSH issues affecting the company, thereby ensuring employee voice at both operational and strategic levels. Although this regulatory framework establishes a formal structure for employee representation within organisations, several interviewees emphasised that, in practice, representatives are often inactive or elected primarily to meet formal requirements, lack sufficient knowledge of their role, receive limited support from their organisations, and have no networks through which to exchange knowledge, share experiences, or provide mutual support. These observations are also supported from the European Working Conditions Survey (EWCS) 2015 and 2021, which show that in Estonia a

considerable share of employees reported limited organisational participation (52% in 2015 and 37% in 2021), although the data also indicate some improvement over time (Heylen et al., 2024). The structure illustrates an OSH and labour relations system (Figure 1), where regulatory

Figure 1. Institutional Structure of Industrial Relations in Estonia



oversight remains strong, but the influence of social partners is relatively weak compared to many EU countries. This imbalance poses challenges for effectively addressing PSRs, which require collective bargaining, participatory mechanisms as well as joint solutions between employers and employees.

4.2 Social partners’ involvement in the prevention and management of psychosocial risks

Stakeholder interviews indicated that PSRs are considered a relevant topic, though their role in national-level dialogue remains limited. In addition, the interviewees stated that during tripartite negotiations in Estonia, highly specific PSR-related issues have not been formally addressed, as discussions have largely focused on broader themes such as legislative changes and general employment relations. However, more targeted concerns are occasionally addressed in lower-level meetings, held separately with either trade unions or the Estonian Employers’ Confederation.

While the existence of social dialogue is acknowledged, supported by active trade unions, these organisations wield relatively limited influence compared with other countries, for example, in

Belgium, Denmark, Finland and Sweden, where trade unions have traditionally played a much stronger role in shaping labour markets and policy (Kjellberg, 2021). Weak social dialogue and cooperation were also emphasised by an academic expert interviewed for the study, who is familiar with both the Estonian OSH system and those of other EU countries. In the interview, the expert noted that Estonia lacks a strong culture of collaboration between social partners, institutions and professional associations, which results in comparatively weaker networks than in many other European countries. While there is a clear and growing interest in PSRs, this interest has not yet translated into a systematic or coordinated national effort. The expert emphasised that the knowledge on PSRs remains limited, initiatives are fragmented and not insufficiently resourced, and no comprehensive strategy has been developed to address these risks in a structured way.

As a result, the management of PSRs in Estonia often depends on isolated projects, voluntary initiatives by employers, or activities by NGOs, rather than being integrated into established OSH and industrial relations frameworks.

With respect to social dialogue and stakeholder involvement, several interviewees identified essential areas for improvement. While institutions and social partners are often formally invited to comment on draft policies or related initiatives, the timeframes for consultations are frequently too short, limiting the possibility for thorough analysis and meaningful engagement. Moreover, respondents also raised concerns during the interviews about the follow-up on stakeholder input, in some cases, comprehensive feedback was submitted but ultimately disregarded, with no explanation or justification provided by the authorities.

On the legislative side, within the Ministry of Economic Affairs and Communications, and on the implementation side, through the Labour Inspectorate, PSRs have received some attention. According to a ministry representative, the issue is addressed in national development strategies, such as the Estonia 2035 strategy, which emphasises a health-preserving environment, as well as in the Welfare Development Plan 2030 and the Health Development Plan 2030. In the past, PSRs have also been the focus of awareness-raising campaigns and targeted inspections linked to legislative changes. At present, the main initiative in this area is a free counselling service provided by the Labour Inspectorate to support employers in managing PSRs.

While PSR factors are recognised as important, they are generally not placed among the top priorities in workplace practices. Nevertheless, the Estonian Employers' Confederation has taken certain steps to promote workplace mental health. Notably, in cooperation with other partners, the Estonian Employers' Confederation developed a Mental Health First Aid Kit, an electronic resource compiling best practices and practical advice to support both organisations and employees, made available via the Work Life Portal (www.tööelu.ee). To accompany this initiative, it organised several awareness events in 2021 under the *Töövõime reform* (Work Ability Reform), including seminars such as “How to Maintain Your Own and Your Team's Mental Health” and “Mental Health and Work - How They Are Connected and How to Help?”.

Within the scope of this research, which focused on male-dominated sectors such as construction and parts of manufacturing, it became clear that employers' associations have not developed any dedicated initiatives specifically addressing PSRs. Interviews with sectoral representatives revealed, however, a growing awareness of the issue. Respondents acknowledged the increasing relevance of mental health at work and noted that cases of stress, burnout, and other psychosocial difficulties are being observed among employees in these sectors. Despite this recognition, employers' associations do not yet view themselves as active drivers, advocates or

enforcers of PSR prevention. Instead, they tend to position their role as limited, relying on external factors, such as state authorities, the Labour Inspectorate, or specialist organisations, to provide guidance, tools, and enforcement. Several interviewees stressed that clearer direction and stricter supervision from Labour Inspectorate would be both necessary and expected to achieve more consistent PSR management. This illustrates a gap between growing awareness of the risks on one hand and active sectoral ownership and initiative on the other, suggesting that formalised support structures and stronger oversight may be required to stimulate employer action in these fields.

PSRs have also been recognised as a relevant concern by trade unions, which have taken several initiatives in this area despite their comparatively limited resources and influence. For example, in 2023 the Estonian Trade Union Confederation organised a dedicated training session on workplace bullying. According to interviewees, the event drew considerable interest, engaging a broad group of participants and resonating strongly with employees who viewed bullying as a critical and under-addressed workplace problem. Such activities reflect the unions' growing recognition of the need to address not only traditional labour issues such as wages and working hours, but also the psychological and social dimensions of working conditions. Trade unions have also contributed to advancing PSR-related issues through social dialogue and cooperation with employer organisations. A notable example is the joint adoption of the Telework Agreement in 2017, signed by the Estonian Employers' Confederation and the trade unions. This document sets out responsibilities for both employers and employees in remote working arrangements and explicitly includes provisions related to OSH, thereby recognising PSRs such as isolation, work intensification, blurred boundaries between work and personal life. As noted by several interviewees, these initiatives demonstrate a clear willingness of trade unions to engage with PSRs topics. However, their impact remains constrained by the overall weakness of social dialogue structures in Estonia and the low level of trade union membership.

5. Sectoral deep-dive: Industrial relations and psychosocial risks in construction and male-dominated manufacturing sector

5.1 Main psychosocial risk factors

In Estonia, the project focused on male-dominated sectors, with particular attention given to construction and manufacturing industries. Within manufacturing, subsectors such as metalwork, woodworking, and machinery were prioritized, as they represent areas where the workforce is predominantly male. As part of the project, stakeholder interviews were conducted with sectoral representatives and trade union representative to gain insights into the specific challenges and perspectives within these industries.

Prior to the COVID-19 pandemic, data from the ESENER 2019 survey indicated that the most prevalent PSR factors in Estonia's construction and manufacturing sectors were: severe time pressure and work overload, followed by violence or verbal abuse from customers, poor communication or cooperation within the organisation, and long or irregular working hours (EU-OSHA, 2022). Findings from the employee questionnaire conducted as part of the current PSYR-IR project (2025) suggest that these concerns remain highly relevant. The most reported PSR factor was still severe time pressure and work overload, cited by 52% of respondents. This was followed by concerns related to inadequate pay in relation to effort and achievement, emotionally disturbing situations, and poor communication or cooperation within the organisation (Table 4).

Table 4. Main PSRs identified by employees in the project questionnaire

	Psychosocial Risks	Yes	No
1.	Severe time pressure or overload of work	52.4 %	47.6 %
2.	No appropriate pay, considering your efforts and achievements	46 %	54 %
3.	Situations that are emotionally disturbing	43.4 %	56.6 %
4.	Poor communication or cooperation within the organisation	43.2 %	56.8 %
5.	Lack of opportunities to learn and grow or lack of career prospects	29.5 %	70.5 %
6.	Conflicting expectations of your work or conflicting tasks	25.3 %	74.7 %
7.	Lack of autonomy, or lack of influence over the work pace or work processes	23.6 %	76.4 %
8.	Fear of job loss	25.1 %	74.9 %
9.	Lack of voice or participation	23.5 %	76.5 %
10.	Long or irregular working hours	22.9 %	77,1 %
11.	Interference of your work in your private life or interference of your private life in your work performance	20.9 %	79.1 %
12.	Lack of skills to execute your work tasks	12.4 %	87.6 %
13.	Violence or verbal abuse from customers, patients, pupils, etc].	9.6 %	90.4 %

14.	Harassment or bullying	8.3 %	91.7 %
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When comparing PSRs across occupational groups (Table 5), notable differences can be observed. Survey results indicate that severe time pressure or work overload are reported more frequently by higher-level managers and highly skilled workers in construction and manufacturing. In contrast, such pressures are less commonly experienced by clerical, sales, and lower-skilled employees. Issues of work-life balance are also particularly pronounced among senior managers, who more often report that work interferes with their personal life. This reflects the long working hours, high workload, and constant availability demands that are typical at higher levels of responsibility.

Table 5. Prevalence of selected psychosocial risks across occupational groups (% of respondents)

	Severe time pressure or overload of work	Interference of your work in your private life or interference of your private life in your work performance	Poor communication or cooperation within the organisation	Lack of voice or participation	Long or irregular working hours	No appropriate pay, considering your efforts and achievements
Senior managers	68,4	34,2	36,8	10,5	34,2	21,1
Clerical and sales workers	49,3	20,9	54,5	33,3	7,5	32,3
Higher-skilled workers	56,7	20,8	37,9	21,4	30,2	53
Lower-skilled workers	40,2	16,8	46,8	24,5	15,8	56,8

These statistical findings are corroborated by stakeholder interviews, which provide richer context. Sectoral representatives in construction highlighted that managers, particularly project and site managers, are regularly exposed to intense demands due to the strict deadlines of large projects, limited workforce availability, and competing requirements from contractors, regulators and clients. Similarly, in manufacturing, managers at different levels carry heightened responsibility for production targets, efficiency as well as compliance, which translates into persistent time pressure and psychosocial strain.

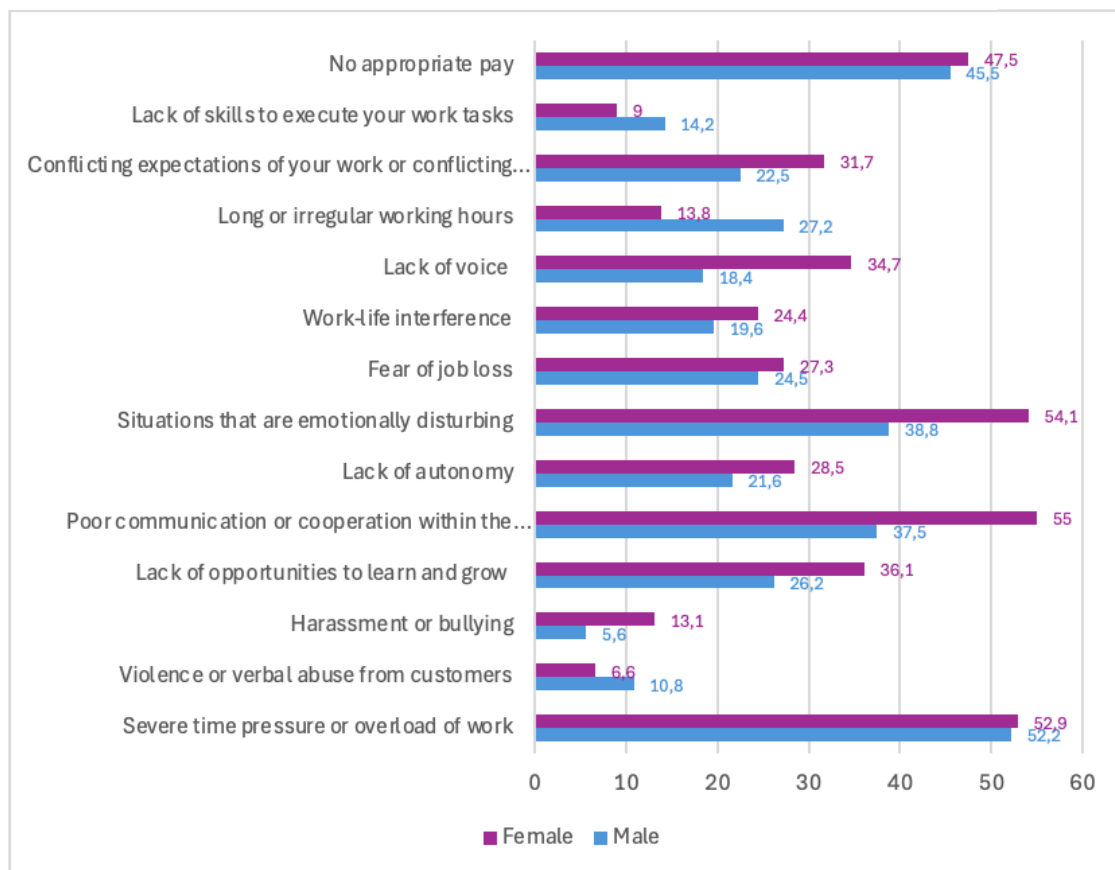
In addition to workload-related pressures, further differences in PSRs emerge across occupational groups. Employees in clerical, sales, and lower-skilled positions more frequently encounter challenges related to poor communication, limited cooperation, and restricted opportunities for participation in organisational matters. These patterns suggest that employees in less senior roles may feel excluded from important information flows or decision-making processes, which can undermine their sense of inclusion.

Perceptions of fairness and reward also vary across occupational groups. While managers predominantly report challenges linked to workload and time pressure, employees in both higher- and lower-skilled positions are more likely to perceive a mismatch between their efforts and the compensation received. When coupled with limited opportunities for voice and participation, this

perceived lack of fair recognition can reinforce feelings of undervaluation and, in turn, exacerbate work-related stress.

The project questionnaire also revealed gender-based differences in the experience of PSRs (Figure 2). While both men and women reported high levels of time pressure and work overload, women were more likely to identify several other challenges, including harassment or bullying, lack of opportunities for development, emotionally disturbing situations, poor communication and cooperation, and restricted voice in organisational decision-making. Men, by contrast, were somewhat more likely to report long or irregular working hours and a lack of sufficient skills to perform their tasks. Concerns about inadequate pay were widespread and reported at nearly equal levels by both genders. Harassment and bullying also warrant attention, as both male and female respondents in this study reported these problems more often than indicated in the Flash Eurobarometer OSH Pulse 2022 (3% for Estonia), with the prevalence notably higher among women. Similarly, poor communication or cooperation within the organisation was reported more often in this study than in the OSH Pulse survey (26% for Estonia), again with higher rates among women.

Figure 2. Psychosocial Risk Factors Reported by Employees, by Gender (%)



Taken together, these findings suggest that while some PSRs are shared across genders, women are more likely to encounter risks related to interpersonal dynamics, inclusion, and career development, whereas men more often point to structural aspects of work organisation. These results highlight the importance of managing PSRs through a comprehensive approach that

considers both organisational structures and the relational and developmental dimensions of work.

5.2 Main OSH focus

In both the construction and manufacturing sectors, the primary emphasis of occupational safety and health (OSH) continues to be placed on traditional physical risks, such as noise, vibration, chemical exposure, and machinery safety. This mirrors findings from previous studies, including ESENER 2019 (EU-OSHA, 2022), and was consistently confirmed during the sectoral interviews conducted for this project.

Representatives from both the construction and manufacturing associations repeatedly underlined that these risks remain at the centre of workplace safety practices and monitoring. They also noted that, over time, the situation concerning physical hazards has gradually improved, with stricter regulations, technological upgrades as well as enhanced awareness among employers and employees contributing to safer environments. In construction, for instance, risk assessments and compliance checks are strongly oriented towards machinery safety and fall prevention, while in manufacturing, chemical handling and protective equipment remain the core focus of OSH protocols.

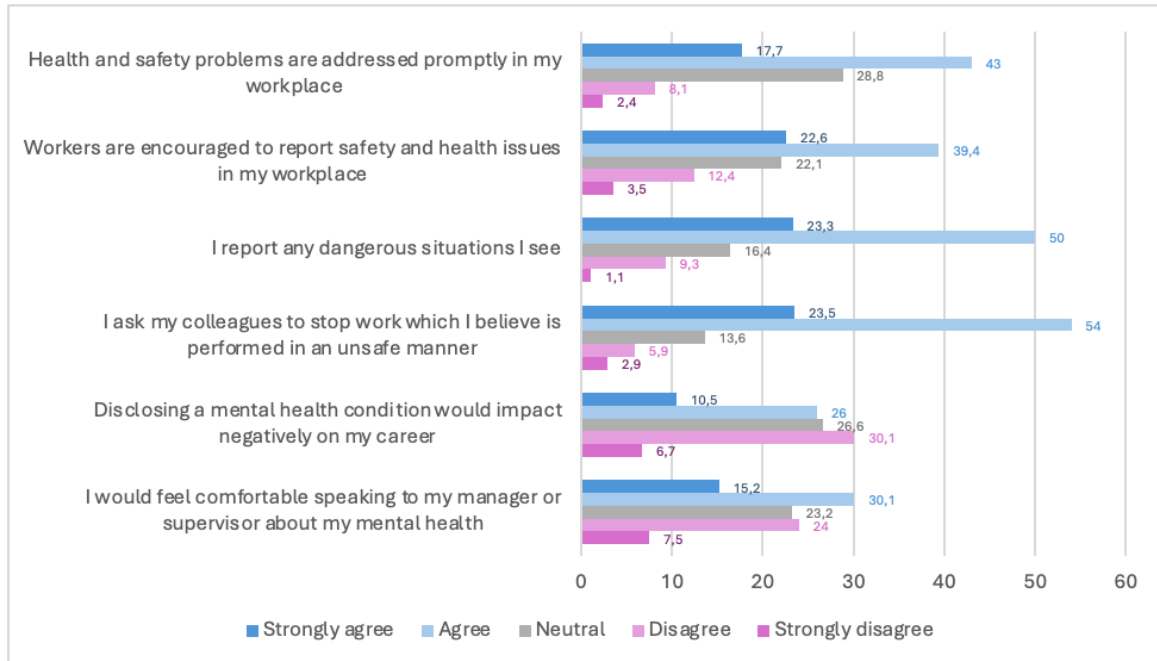
A representative from the manufacturing sector stressed that a considerable share of production is oriented toward export markets in Scandinavia and the wider EU, where clients increasingly demand proof of compliance with high OSH standards. This external market pressure has created additional incentives for Estonian companies to adopt better safety practices, improve monitoring mechanisms, and align with international expectations. As a result, exporters often act as drivers of higher OSH performance, diffusing good practices more widely in the sector. At the same time, the strong emphasis on physical risks creates the risk of underestimating PSRs, which receive less systematic attention in both sectors. While prevention of physical hazards is relatively well institutionalised, PSRs management remains underdeveloped and is not yet perceived as an equal priority, despite increasing evidence of their impact on health, well-being, and productivity.

The project questionnaire results suggest that while traditional safety practices are relatively well established in the manufacturing and construction sectors, challenges remain around mental health openness and workplace communication culture (Figure 3). Many respondents confirmed that health and safety issues are addressed promptly (43% agreed and 17.7% strongly agreed), while most employees reported that they actively flag dangerous situations (50% agreed and 23.3% strongly agreed). Similarly, more than three-quarters (77%) indicated that they feel comfortable asking colleagues to stop unsafe work. These findings point to a broadly functional safety culture in relation to physical risks

By contrast, the data shows significantly lower confidence when it comes to addressing mental health at work. Nearly one-third of respondents agreed or strongly agreed that disclosing a mental health condition would negatively affect their career prospects, while a similar share disagreed, highlighting divided perceptions. Only 45.3% of respondents reported feeling comfortable discussing mental health with their manager, while 31.5% reported being uncomfortable doing so. Notably, employees in male-dominated sectors reported much lower confidence in feeling

comfortable discussing mental health with their manager or supervisor compared to the OSH Pulse 2022 survey, where 72% of employees in Estonia overall expressed such confidence.

Figure 3. Distribution (%) of project questionnaire responses on workplace safety practices and mental health openness in construction and manufacturing sectors



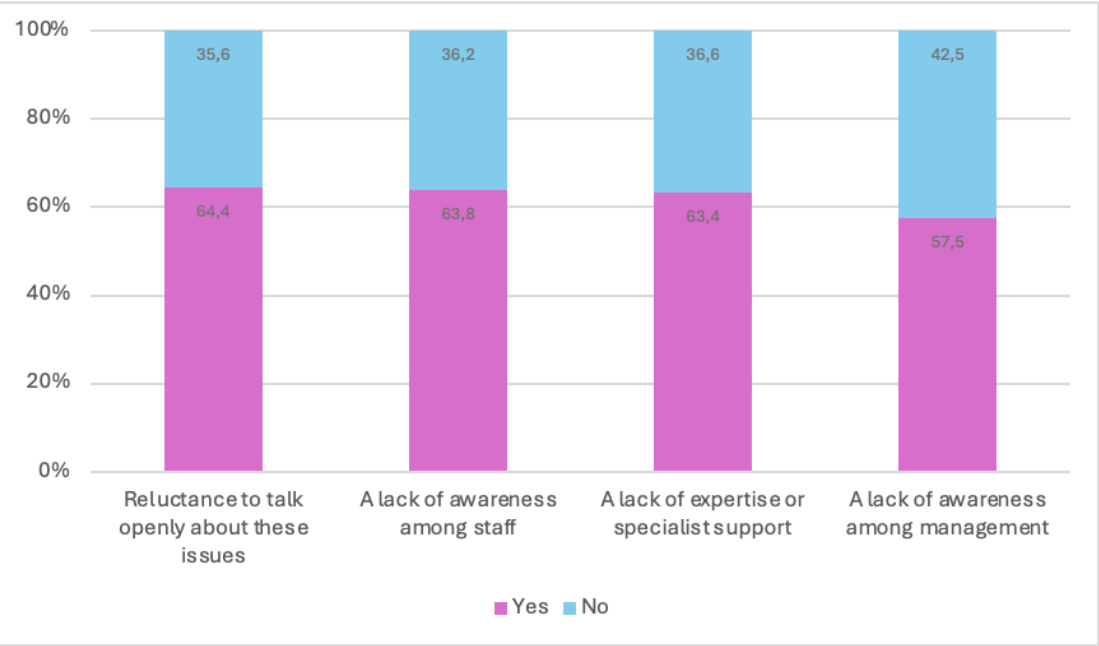
These findings reveal to the persistence of stigma, which discourage openness, delays early intervention, and undermines the effective management of PSRs. Stakeholder interviews confirmed that stigma around mental health remains pervasive in Estonia. Employees often avoid talking about their struggles at work due to fears of judgment, discrimination, or being perceived as weak. This reluctance may discourage individuals from seeking support or using available services, which can cause problems to worsen over time and make workplace prevention efforts less effective.

5.3 Main barriers to psychosocial risk management

According to stakeholder interviews, sectoral representatives acknowledged the importance of PSR factors and recognised the need for them to be addressed in a more structured and systematic way. At the same time, they stressed that in male - dominated sectors such as construction and manufacturing, these issues often remain under - prioritised. One explanation offered was the persistence of traditional workplace (organisational) cultures in which discussions about mental well - being are perceived as uncommon or even uncomfortable, making it more difficult to initiate open dialogue on psychosocial challenges. As a result, the development and implementation of awareness and prevention measures for PSRs tend to be less advanced than those for physical hazards.

This qualitative finding is strongly reinforced by the results of the survey, which highlight several key barriers perceived by employees to the effective management of PSRs at work (Figure 4). The most frequently reported obstacle was a reluctance to talk openly about psychosocial risks (64.4%), reflecting persistent stigma. A similarly large share of respondents identified a lack of awareness among staff (63.8%) and limited understanding among management (57.5%) as major obstacles to progress. In addition, 63.4% pointed to limited expertise or specialist support, such as occupational psychologists, as a significant barrier.

Figure 4. Main Barriers to Addressing Psychosocial Risks in the Workplace



These results reflect both structural and cultural obstacles to effective PSR management. The reluctance to engage in open discussions on these topics may reflect an underlying stigma associated with mental health and stress, which can discourage employees from speaking up and hinder organisations from responding proactively. Altogether, the findings suggest a clear need to enhance awareness, strengthen leadership involvement, and foster a workplace culture where PSRs can be addressed openly and without stigma. Creating space for regular dialogue on these issues, supported by adequate knowledge and resources, is essential for advancing employee well-being.

Findings from the project questionnaire show that a considerable share of employees perceive a lack of awareness among management in addressing PSRs. This concern was strongly echoed in stakeholder interviews, where sectoral representatives observed that these risks are often not treated as a workplace priority. Interviewees further noted that management attitudes vary across generations, older male managers are generally less inclined to view PSRs as significant, while younger managers tend to be more aware of these challenges and place greater emphasis on employee well-being.

Stakeholder interviews highlighted significant gaps in awareness and expertise among managers when it comes to PSRs and their effective management. Sectoral representatives noted the absence of practical and accessible guidance materials as a key barrier, leaving managers without concrete tools to identify, assess, and address these risks. Interviewees stressed the

need for clear, user-friendly resources aimed at both managers and employees, complemented by broader awareness-raising campaigns. They also emphasised the importance of stronger oversight and monitoring mechanisms to ensure that PSRs are treated as a genuine priority across workplaces.

Beyond regulatory aspects, the interviews also pointed to the labour market context as a driver of change. A representative from the manufacturing sector explained that competition for skilled workers and specialists, particularly engineers, is becoming increasingly intense. Start-ups and technology companies often provide more attractive working conditions, putting pressure on traditional industries to improve their work environments in order to retain and recruit talent. The shortage of qualified specialists emerged as a recurring theme across interviews, reinforcing the view that enhancing workplace well-being, including psychosocial dimensions, is not only a matter of compliance but also of competitiveness and long-term sustainability.

5.4 Psychosocial safety climate

The project survey results also provide insights into the psychological safety climate within workplaces, that is, the degree to which employees believe their organisation and leadership are genuinely committed to preventing and addressing PSRs. A strong psychological safety climate is widely recognised as a critical factor in promoting employee well-being, enabling open communication, and fostering trust across all organisational levels (Dollard & Bakker, 2010).

Overall, the data indicate a mixed perception of the psychological safety climate, with responses showing uncertainty and variation across different aspects. When asked whether senior management demonstrates support for stress prevention through involvement and commitment, about one-third of respondents (35.9%) agreed or strongly agreed, while a similar share (31.0%) disagreed. Another third (33.2%) remained neutral. These results suggest that for a considerable proportion of employees, the visibility and clarity of leadership's commitment to stress prevention may not be consistently evident.

Similarly, when asked whether senior management considers employee psychological health to be as important as productivity, responses were mixed: 39.1% agreed, while 32.7% disagreed and 28.3% remained neutral. The proportion of neutral responses may indicate uncertainty among employees about whether psychological well-being is genuinely prioritised or merely acknowledged without meaningful follow-through.

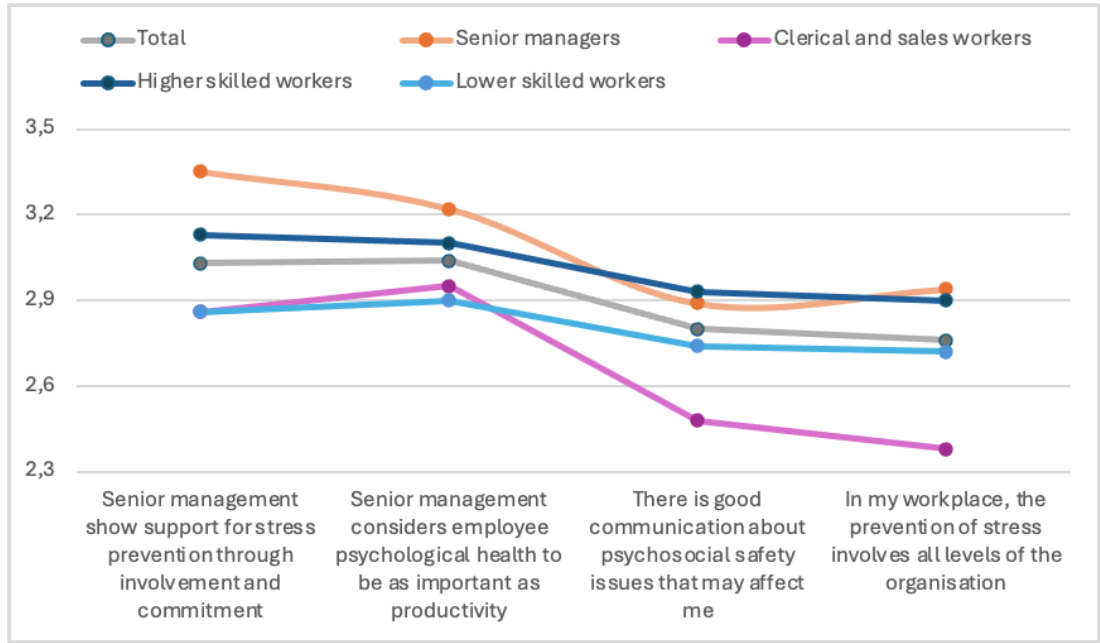
Communication, a core element of psychological safety, received relatively low levels of agreement among respondents. Only 29.5% of them agreed that good communication exists around psychosocial safety issues that may affect them, while 42.5% disagreed. These findings suggest that many employees experience gaps in how information related to PSRs is shared and discussed within their organisations, which could weaken overall sense of psychological safety.

The weakest area identified in the survey concerned the extent to which stress prevention involves all levels of the organisation. Only 27.1% of respondents agreed or strongly agreed with this statement, compared to 42.8% who disagreed and 30% who were neutral. This indicates that employees often do not perceive stress prevention as a shared responsibility, and that coordinated organisation-wide approaches to managing PSRs may be lacking. Sectoral interviews also highlighted that PSR management should operate across different organisational

levels; however, at present, initiatives remain limited and the necessary knowledge to support such a comprehensive approach is often lacking.

The results also indicate clear differences between occupational groups in their perception of the psychological safety climate (Figure 5). Senior managers consistently expressed more positive views than other groups, particularly regarding leadership involvement in stress prevention and the priority given to psychological health. Higher-skilled production and construction workers tended to align more closely with the overall average, whereas lower-skilled workers generally reported somewhat less favourable perceptions. Taken together, the findings suggest a hierarchy in perceptions of psychological safety: the more senior the position, the more positively stress prevention and psychosocial safety are evaluated.

Figure 5. Mean values of Psychological Safety Climate Perceptions across occupations (measured on a 5-point Likert scale)



The results highlight that perceptions of psychological safety climate remain fragmented, with leadership commitment, communication, and shared responsibility often viewed as insufficient. Differences across occupational groups—where senior staff view stress prevention and psychosocial safety more positively than lower-level employees—underline the importance of considering these differences when formulating and implementing strategies to improve the psychosocial work environment.

5.5 Practices and Measures for the Prevention of Psychosocial Risks

Findings from the project questionnaire indicate that employees are aware to certain measures to prevent PSRs as being in place, although their implementation varies across workplaces (Table 6). Among the more frequently reported practices were greater autonomy in how employees organise their work and adjustments to reduce demands and workload. Awareness-raising

activities and the provision of OSH information suggest that some initiatives to address PSRs are already being implemented at workplace level.

However, other measures appear to be less common. Fewer employees reported access to counselling or psychological support services, or interventions aimed at reducing excessively long or irregular working hours. Formal procedures to address bullying, harassment, or external threats were mentioned less frequently, as were training activities focused on well-being, stress management, and conflict resolution. Consultation with employees about stressful aspects of their work and the use of formal action plans to prevent work-related stress were among the least reported measures. Overall, the findings suggest that while some preventive actions are in place, these tend to be fragmented and limited in scope. More comprehensive and structured approaches to PSR prevention, focusing on both individual support mechanism and organisational policies, are not yet widespread in Estonian workplaces.

Table 6. Employees' Perceptions of Workplace Actions to Prevent Psychosocial Risks

	Measures for psychosocial risk prevention	Yes	No
1.	Allowing employees to take more decisions on how to do their job	63.4%	36.6%
2.	Reorganisation of work in order to reduce job demands and work pressure	53.2%	46.8%
3.	Awareness raising or other activities to provide information on health and safety	53.1%	46.9%
4.	Intervention if excessively long or irregular hours are worked	36.6%	63.4%
5.	Access to counselling or psychological support	32.9%	67.1%
6.	Procedure or action plan to deal with possible cases of bullying or harassment	30.9%	69.1%
7.	Information and training on well-being and coping with stress	28.1%	71.9%
8.	Procedure or action plan to deal with possible cases of threats, abuse or assaults by clients, patients, pupils or other external persons	27.4%	72.6%
9.	Consultation of workers about stressful aspects of work	25.1%	74.9%
10.	Procedures or action plan to prevent work-related stress	18.8%	81.2%
11.	Training on conflict resolution	17.3%	82.7%

Interviews revealed that mental health is increasingly discussed in workplaces, it is still predominantly framed at the individual level as a matter of personal mental well-being, rather than as the part of PSR factors at the organisational level. Several interviewees noted that the term 'mental health' is more tangible and easier for both employers and employees to relate to, whereas the concept of PSRs is perceived as more abstract, less familiar as well as less widely understood. As a result, many measures reported in relation to PSRs management continue to focus on individual-level interventions, such as counselling, psychological support, or training in resilience and stress management. While these initiatives can play an essential role in supporting employees, they place the responsibility largely on the individuals rather than addressing the organisational and structural challenges, such as workload, management practices or work organisation.

Although counselling is becoming more common in general, indicated by both some interviewees and ESENER 2019 data (EU-OSHA, 2022), these practices are less established in male-

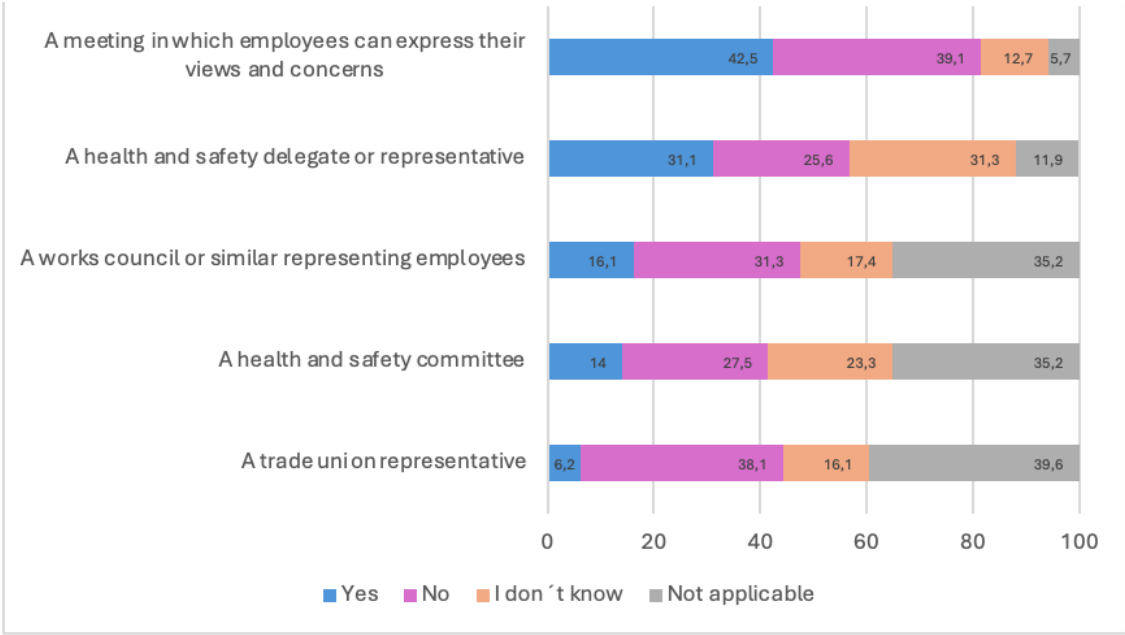
dominated sectors. Sector-specific representatives confirmed that such measures are known and occasionally used, but they remain relatively uncommon due to limited availability, higher costs, and persistent stigma surrounding mental health, which discourages employees from seeking counselling or participating in related training. Some interviewees also noted that the management of PSR factors is not approached strategically, in the sense of being addressed at different organisational levels. Instead, measures are often reactive, focusing on solving specific problems once they arise rather than aiming to prevent them.

Based on the project questionnaire, employees evaluated employers' efforts to manage PSRs with considerable pessimism. Nearly one-third of respondents (30.4%) stated that their employer's actions and initiatives were not successful at all, while a similar share considered that they were successful only to some extent. A little less than one-third of respondents (28.4%) acknowledged that measures had been taken but emphasised that there was still room for improvement. Only a small minority (10.7%) regarded their organisation's approach as genuinely successful. Overall, the findings suggest that employees view current actions on PSR management as insufficient, fragmented, or only partially effective.

5.6 Employee Involvement in Psychosocial Risk Management

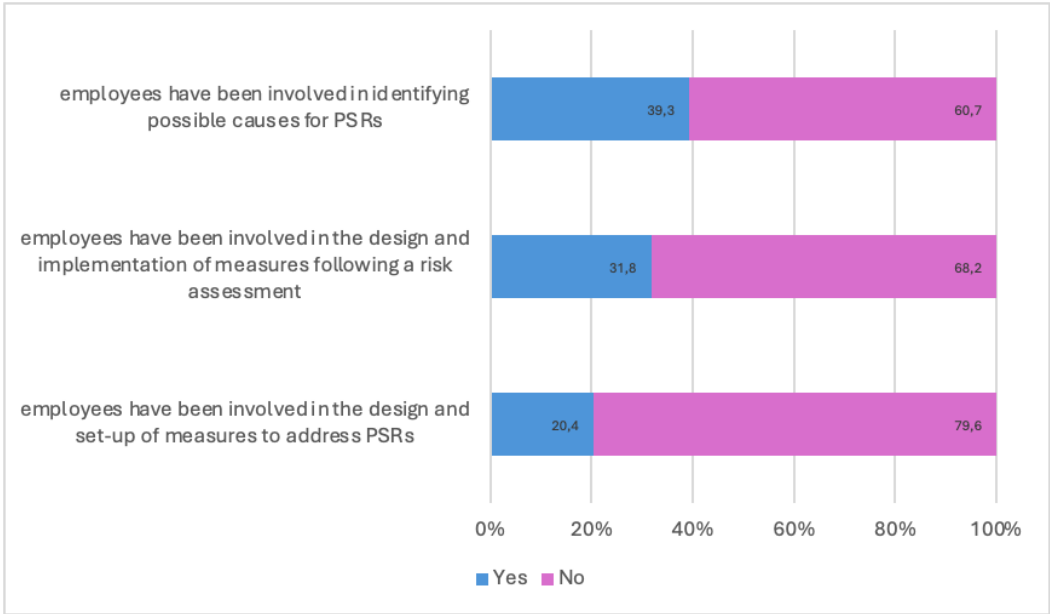
Employee involvement has previously been identified as a challenge, including by ESENER 2019, which found that less than half of employees were engaged in identifying PSRs (Heylen et al., 2024). Findings from the project questionnaire reflect a similar pattern. While some respondents indicated that they have opportunities to raise concerns in meetings or through health and safety delegates, many reported the absence of such mechanisms. Health and safety committees were also mentioned less frequently, and trade union representation was reported by only a small share of employees (Figure 6). In addition, a considerable share of employees stated that they did not know whether any form of employee representation is involved in discussions concerning PSR in their workplace. This may reflect the low visibility of existing mechanisms or a lack of clear communication about them, suggesting that employee participation structures are not widely established or well recognised.

Figure 6. Employee Representation in Discussions on Psychosocial Risks and Well-Being (in %)



The project questionnaire indicated that only a limited number of employees are involved in identifying PSRs or contributing to their management (Figure 7). Around 40% of respondents reported that employees take part in recognising possible causes of work-related stress, but fewer noted involvement in the design and implementation of measures following a risk assessment. The least common form of participation was engagement in the development of specific measures to address PSRs.

Figure 7. Employee Participation in the Identification and Management of Psychosocial Risks (in %)



Overall, the findings suggest that, although opportunities for participation exist, employees' involvement in PSR management remains limited and is often confined to problem identification rather than to the development of preventive or strategic measures.

5.7 Vulnerable groups

Sectoral interviews identified temporary agency workers and foreign labour as vulnerable groups within the manufacturing and construction sectors. These forms of labour are widely used to address skills shortages and to provide companies with flexibility in uncertain market conditions. By relying on temporary agency contracts rather than directly employment, companies often reduce long-term commitments and obligations, including those related to social protections and working conditions.

Although Estonian OSH legislation requires that temporary agency workers should receive the same level of protection, both physical and psychosocial, as directly employed workers, in practice their well-being often receives less attention. Interviewees acknowledged that temporary employees are frequently viewed more as a short-term resource than as full members of the workforce. Consequently, their PSRs are at greater risk of being overlooked, and some stakeholders voiced concern that their health and safety may not be adequately safeguarded. Trade union representatives also noted that migrant workers are typically not unionised, often due to a lack of engagement or interest on their part, leaving the Labour Inspectorate as their main channel for assistance.

Another vulnerable group emerging in these sectors is women entering traditionally male-dominated fields such as construction and manufacturing. Interviewed sectoral representatives generally presented this trend as positive: women were described as bringing “softer values,” contributing to a more balanced workplace culture, and demonstrating high levels of precision and competence, sometimes even serving as role models for male colleagues. Overall, this change was described as natural and beneficial for the sectors.

Nevertheless, challenges persist. One sectoral interviewee emphasised that in highly male-dominated environments, women, particularly in supervisory or managerial positions, may struggle to adapt to established work cultures and face greater difficulties in asserting authority. This can be especially challenging for women in supervisory or managerial roles, where they may need to work harder to gain authority. These perspectives are reflected in the project questionnaire results (Figure 2). For example, 55% of female respondents reported problems with poor communication or cooperation within the organisation, compared to 37.5% of male respondents. Additionally, 13.1% of women indicated they had experienced harassment or bullying, more than double the rate reported by men (5.6%). These figures suggest that female employees in traditionally male-dominated sectors may face greater challenges related to interpersonal dynamics, inclusion, and organisational culture.

5.8 Self-Reported Health and Common Health Issues

The project questionnaire also examined employees' self-assessment of their health and the health problems they had encountered in the previous year. Overall, employees evaluated their health rather optimistically. Nearly half of respondents (44.7%) rated their health as good, and a

further 14.3% described it as very good. About one-third (33.8%) considered their health to be fair, while only a small minority reported it as bad or very bad (7.3%).

In the questionnaire, employees had the opportunity to report health problems they had experienced during the previous year. The most frequently mentioned issues were overall fatigue, headaches or eyestrain, and bone, joint, or muscle problems. Stress, depression, or anxiety were also reported by more than half of respondents, while sleep problems were mentioned by roughly one-third. By contrast, relatively few employees reported infectious diseases or accidents and injuries. Overall, the findings suggest that employees are more likely to experience health concerns linked to PSRs and physical strain, highlighting the importance of preventive measures that, among other aspects, address psychosocial factors in the workplace.

Table 7. Prevalence of health problems reported by employees across occupational groups (% of respondents)

	Stress, depression or anxiety	Bone, joint or muscle problems or pain	Infectious diseases	Headaches or eyestrain	Accident or injuries	Overall fatigue	Sleep problems
Senior managers	63,2	63,2	18,4	60,5	7,9	57,9	44,7
Clerical and sales occupation	61,2	51,5	11,9	67,2	9,0	68,2	50,0
Higher-skilled workers	53,6	58,6	20,0	62,4	9,4	71,2	39,4
Lower-skilled workers	40,9	72,0	11,7	55,9	14,9	67,0	36,3

According to regulation, employees in Estonia are required to undergo regular occupational health checks, during which occupational health physicians should also assess employees' mental health and potential PSRs in the workplace. However, several stakeholder interviews highlighted concerns about the quality and consistency of these health checks. In many cases, PSRs are not systematically considered, and where mental health assessment tools are used, their application may be voluntary rather than mandatory. Furthermore, interviewees noted that employers often do not receive sufficiently clear or practical feedback from occupational health checks to support employees effectively or to implement targeted improvements in the work environment. Overall, many interviewees representing sectoral level did not consider the current system of health checks to provide significant value in PSR management, but they saw clear potential if the process offered more meaningful feedback and recommendations, including personalised guidance that would allow addressing these issues at an individual level.

5.9 Digitalisation

With the increasing use of technology in workplaces, digitalisation has gained growing attention in relation to PSRs. Reflecting this trend, EU-OSHA updated the ESENER 2024 survey to include additional questions on digitalisation. The initial results show that, on average across the EU, fewer than half of establishments (43%) have incorporated digital technologies into their risk assessments, while 42% report providing training on the use of digital technologies (EU-OSHA,

2025b). Compared to ESENER 2019, these numbers indicate some progress, yet they remain modest given that digital technologies have become an unavoidable part of working life.

Based on stakeholder interviews, digitalisation was widely perceived as being closely linked to PSR factors in the workplace. At the legislative level, there is an awareness of these risks; however, no concrete measures have been introduced so far, with national actors largely awaiting initiatives and guidance from the EU level. A representative of the Labour Inspectorate emphasized the potential downsides of digitalisation, noting that it can increase mental workload and heighten the risk of burnout. Specific concerns included the expectation of constant availability and the blurring of work–life boundaries, as well as the continuous pressure to develop new skills and adapt to changing technologies. Similarly, a representative of the Ministry of Social Affairs highlighted the phenomenon of technostress, explaining that digitalisation adds complexity to work tasks and increases the need for adequate recovery. Additional challenge mentioned was insufficient training, as new technologies are often introduced with the expectation that employees will adapt quickly or engage in self-directed learning.

According to trade union representatives, discussions on digitalisation have mainly taken place at the EU level, where the topic has been addressed and new directives are being prepared. Trade unions stressed that regulation in this area is necessary, as without it the challenges related to digitalisation and PSRs are unlikely to be adequately addressed. In Estonia, the issue has partly been raised within trade unions, particularly in relation to the use of robots and employee monitoring, both of which are seen as potential sources of stress. However, no specific training initiatives or concrete measures have yet been planned in Estonia to directly address digitalisation as PSR factor.

Employer representatives noted that digitalisation is transforming work processes, creating uncertainty, and eliminating simpler tasks, leaving employees with more complex responsibilities that may increase the risk of burnout. At the same time, sectoral employers emphasized the positive aspects of digitalization. They highlighted that automation helps to address labour shortages, which are particularly acute given the difficulty of finding skilled workers, and that it can also improve occupational safety by reducing employees' exposure to physical risks. However, some groups of workers, especially older employees and those in companies located in more rural areas, were less willing to engage with automation and facing greater difficulties in adapting to new technologies.

While companies are investing in training to support employees during this transition, the process remains challenging. One interviewee stressed that automation is generally received positively when employees understand its purpose and experience direct benefits, such as reduced workload. In contrast, when automation is perceived as a threat to job security, it is met with greater resistance. Beyond automation, stakeholders also mentioned the use of drones in the construction sector and the adoption of artificial intelligence mainly as a tool for consultation to support employees' decision-making.

Overall, digitalisation is advancing in organisations in these sectors. The main challenge is ensuring that employees can adapt and update their skills, while employers must provide sufficient training and support when new technologies are introduced. However, based on the interviews, digitalisation is not yet perceived as a particularly significant PSR factor in these sectors, even though it may influence workload, learning demands, and employee well-being.

6. Conclusions

This national case study has analysed the prevention and management of PSRs in Estonia, with particular focus on male-dominated sectors such as construction and selected branches of manufacturing. By combining desk research, stakeholder interviews, and an employee questionnaire, the study provides a comprehensive overview of how PSRs are currently recognised and addressed at policy, sectoral, and workplace levels.

Findings demonstrate that Estonia has taken important legislative and strategic steps toward integrating PSRs into OSH. The Occupational Safety and Health Act now explicitly covers PSRs, while national strategies such as the Health Development Plan 2030 and the Welfare Development Plan 2030 prioritise their importance.

The Labour Inspectorate has supported these developments through counselling and awareness-raising campaigns. However, PSRs are not consistently prioritised in workplaces. OSH practice remains largely focused on traditional physical risks, while psychosocial challenges continue to be addressed reactively or at the individual level, through counselling or resilience training, rather than via systemic, preventive and organisational measures.

The employee survey revealed high levels of PSR-related health problems, including fatigue, stress, anxiety, and musculoskeletal pain. Furthermore employees expressed scepticism about their employers' efforts: only a small minority considered current measures effective. The perceived psychological safety climate was weak, with less than half of respondents believing that management values psychological health on par with productivity. Communication on PSRs and shared responsibility for stress prevention were identified as particularly poor. Moreover, managers rated the situation more positively than frontline employees, reflecting a disconnect between leadership perspectives and employees' daily experiences.

Persistent cultural and structural barriers continue to constrain progress. Mental health stigma remains strong, discouraging open discussion, while managers often lack the necessary expertise, training and resources to address PSRs effectively. Sectoral associations and trade unions have only limited capacity to foster systemic change, and low union density continues to restrict employees' influence, limiting their ability to shape workplace policies. Vulnerable groups, including temporary agency workers, migrant labour, and women entering male-dominated sectors, face additional risks, with their well-being and representation not always adequately safeguarded.

Digitalisation represents another critical dimension. While technological development can mitigate labour shortages and improve safety, it also generates new psychosocial pressures, such as technostress, the need for continuous upskilling, intensified monitoring, and blurred work-life boundaries. The dual reality underscores the necessity for proactive approaches that balance innovation with employee well-being.

Taken together, the study identifies core challenges for Estonia. Firstly, PSRs although recognised, are not prioritised in practice to the same extent as traditional OSH risks. Secondly,

social dialogue on PSRs is weak, constrained by low union density and limited sectoral engagement. Thirdly, workplace initiatives remain uneven, often reactive, and focused more on individual coping strategies than on systemic prevention. Finally, persistent stigma and limited awareness as well as expertise continue to restrict open discussion and effective management of PSRs.

Estonia has established the legislative and institutional foundations for tackling PSRs in the workplace. The next step is to translate these frameworks into coherent and systematic practice, supported by inclusive social dialogue and meaningful employee participation. Recognising PSR management as an integral part of OSH policy is key not only to protecting workers' health and well-being, but also to strengthening organisational resilience, productivity, and the long-term sustainability of Estonia's economic development.

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Deliverable 3.1

National case study report - Italy

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Diletta Porcheddu

July 2025



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1. Introduction

The present document, drafted as a deliverable for [the PSYR-IR - The opportunities for industrial relations to prevent and manage psychosocial risks in post-pandemic workplaces](#) project (hereinafter referred to as 'the Project') has the objective of providing a general overview of the state of play concerning mental health and workers' well-being in the Italian context, by identifying the broad challenges and issues at play, as well as their underlying drivers. Furthermore, the project will consider the interplay between psychosocial risks and mental health and well-being. This document addresses Italian stakeholders interested in retrieving extensive information on the issue of mental health at work in the Italian context.

1.1 Methodology

In order to achieve the goals described in the previous paragraph, the research team carried out desk and field research activities.

As for desk research, the authors carried out a literature review of the most relevant academic and grey literature related to the topics prior to the Project. Special attention has been attributed to the post-COVID-19 context, the identified at-risk groups, and the identification and/or description of those job characteristics and sociodemographic factors that influence the emerge and persistence of psychosocial risks in Italian workplaces.

Furthermore, a brief analysis of the regulatory framework concerning mental health in the Italian context was completed with a specific focus on its key institutional and workplace-level actors. This analysis was complemented with a synthetic overview of the structure and main actors of the Italian industrial relations system, which the authors deemed functional to the subsequent review of relevant social partners' practices linked to mental health promotion and protection – including (but not limited to) collective bargaining provisions and supplementary healthcare funds.

Lastly, the report includes a chapter specifically dedicated to exploring the role of industrial relations in preventing and managing psychosocial risks in the Italian healthcare sector. In terms of desk research, the authors carried out a brief analysis of the main social partners active in the Italian healthcare sector, together with a review of the main sectoral collective agreements which they negotiated and are currently applied.

The field research activities served to gather first-hand information on the Italian context, so as to complement the information retrieved through the various phases of the desk research. To this end, 8 respondents were involved in a round of semi-structured interviews aimed at gaining a deeper understanding of the dynamics and general views related to mental health and its interplay

with psychosocial risks in Italian workplaces.¹ The interview outline was divided into four sections. The first section included questions aimed at understanding the respondents' perspectives on mental health within their sector/company. The second section focused on actions aimed at preventing and managing emerging mental health issues in the workplace. The third section allowed for an in-depth discussion on the role of social dialogue in ensuring mental health in the workplace. Finally, the fourth section gathered participants' opinions on future prospects regarding the prevention of psychosocial risks and the protection of mental health in the workplace. The outline was slightly adapted to the respondent's characteristics (e.g., activity in the health sector; institutional role; belonging to a social partners' organisation, etc.).

Moreover, the present report also includes the results of an online questionnaire directed at workers employed in the Italian healthcare sector (255 respondents) aimed at gathering first-hand information from workers on mental health issues.

The online questionnaire consists of five sections. The first section collects all the socio-demographic variables of respondents such as gender, age, trade union affiliation, professional profile as well as the specific sector and size of the company in which they are employed. The second and third section are devoted to workers' exposure to psychosocial risks and to the level of cultural awareness of the organisation they are employed by. The fourth and fifth section instead focus on gathering information on OSH practices present in the respondent's organisation and the actors involved in those practices. Finally, in the last section, the respondent is asked further information about their health and wellbeing.

¹ The interview respondents are identified as follows: RI1 (HR representative), RI2 (HR representative), RI3 (Company-level workers' representative), RI4 (Company-level workers' representative), RI5 (Sectoral-level trade unionist), RI6 (Psychologist active in the healthcare sector), RI7 (Occupational doctor), RI8 (Managerial figure in the Italian National institute for Occupational health and safety), RI9 (HR representative). Interviews involving respondents RI1, RI2, RI3, RI4, RI5 have been carried out in the context of another EU co-funded project ADAPT is currently involved in (Increme-n-tal, n. 101143366). Considering that the topic of the Increme-n-tal project (The role of industrial relations and social dialogue in managing mental health at work) and the targets of the field research are very similar to those of the PSYR-IR project, the authors opted to include results from those interviews in the present paper. From a methodological point of view, it is to be noted that the interview outline used to carry out interviews involving respondents RI1, RI2, RI3, RI4, RI5 overlaps in full with the outline used to carry out interviews involving respondents RI6, RI7, RI8 and RI9 thus ensuring comparability of results.

2. Context: the history of OSH in Italian workplaces

At the beginning of the 1990s, the debate on the occupational health of Italian workers revealed, thanks to the work of the press and social literature, the suffering caused by certain employers and industries that ignored their social responsibility to provide a safe and healthy environment for their employees (Avallone, 2011). Work organisation aimed solely at achieving the highest possible productivity for the company, paying no attention to the working environment or the health of workers. Workers were regarded as passive elements who responded exclusively to economic stimuli and were merely asked to adapt to changes in the technological system. It was not until the 1930s and 1940s that the impact of factors associated with work-related injuries and illnesses began to be observed. During this period, support tools were introduced for workers injured at work, and committees and bodies (both governmental and non-governmental) were established to monitor and improve working conditions (Ilgen & Swisher, 1989). During this period, the focus of intervention was on the individual, and a mechanistic conception with linear causality prevailed, whereby the focus of studies was limited to assessing working conditions that could potentially cause injury. In the 1950s and 1960s, a more active view of the worker emerged, considering their complex interactions with their working environment. Health and safety aspects also began to be studied in relation to job design, education, training, and employee selection. During this period, the focus of intervention remained on the care of the individual, but attention also began to be paid to the psychological consequences of work, such as fatigue, stress and psychosomatic disorders. From the 1970s to the 1980s, the focus shifted from care to preventive training, and studies aimed at improving workplace safety increased in number. During this period, the importance of workplace safety became a collective concern, prompting the participation of all stakeholders in the world of work, including trade unions. It was also during this time that the importance of psychological and social factors, as well as biological factors, was recognised (Avallone & Papiromatas, 2005). Indeed, the concept of wellness and Occupational Health Promotion was introduced in the 1980s, shifting the focus from preventing occupational accidents and diseases to actively preserving health. Prior to these studies, health was simply considered the absence of disability or illness (Glasgow & Terborg, 1988).

2.1 State of play of psychosocial risks and mental health

Psychosocial risk management in the workplace has been one of the main concerns of and health (OSH) in Europe over the last decades. In Italy, the term ‘work-related stress’ was first introduced into the policy framework in June 2008, following the translation and implementation of the European Framework Agreement on Work-related Stress into Legislative Decree 81/2008, which updated the occupational health and safety regulations. Prior to this, the national policy contained only general provisions with no specific reference to psychosocial risks. The European Union Strategic Framework on OSH 2021-2027 calls for cooperation between Member States and social partners to anticipate emerging risks linked to changes in the world, and psychosocial risks are recognised as one of the main priorities for the future of work (§3).

The focus on ‘fair and sustainable well-being’ in the Italian context has emerged in recent years in economic and financial planning, with the aim of identifying indicators that contribute to the ‘well-being of citizens’ and that can become priorities for political action. In this context, the quality

of work is established as strategic, not only as a driving force for the revitalisation of the economic system, but also for other purposes; corporate social responsibility plays an important role: among labour practices, we talk about favourable working conditions, risk prevention through training and the adoption of safety devices, attention to work-life balance needs, etc.; ensuring safe working conditions is also defined, among others, as a parameter of decent work (Buoso, 2019). In this context, the importance of psychosocial risks in the workplace is steadily increasing, as the mental well-being of workers has become a key priority for stakeholders in the occupational field (Chirico & Giorgi, 2023).

Emerging risk factors brought about by the socio-economic crisis, global climate change, such as the COVID-19 pandemic, have a profound impact on work organisation and may also contribute to increasing levels of mental and physical stress in the working population. New forms of work organisation (e.g. agile or smart working) and new information and digital technologies pose additional challenges to the health and well-being of workers in the workplace (Chirico, 2017). This form of stress, which increased during the COVID-19 pandemic, is particularly prevalent among those who work remotely. This particular form of stress ('technostress') was described in 1984 by the American psychologist Craig Brod as a disorder characterised by an inability to cope with modern information technology (computers and software). Since then, numerous studies have linked this type of stress to the use of new technologies and described it as an emerging psychosocial risk factor in both the work and non-work environment.

Technostress is realised when the worker perceives his or her work experience, which is characterised by the intensive use of technological tools necessary to perform his or her job, in a negative way. This brings technostress closer to the construct of work-related stress, defined by EU-OSHA as a worker's perception of an imbalance between the job demands he or she receives, and the individual capabilities possessed and needed to meet those demands. The main psychosocial risk factors identified in technostress include work overload, role ambiguity and job insecurity.

In addition to organisational working conditions (Tiraboschi, 2022), psychosocial risks may include individual characteristics of workers that make them potentially vulnerable in the context of current labour market dynamics (Tiraboschi, 2023a): the ageing of the population, the increase in chronic diseases, migratory flows and the internationalisation of markets. These are examples that will have a major impact on the composition of the workforce in public, private and non-profit organisations, which will need to plan a paradigm shift in order to manage the impact of these changes on the labour market.

The complex interplay between organisational factors and individual characteristics highlights the continuing difficulty in defining psychosocial factors; such risks are often defined by listing, or rather listing some manifestations of distress such as stress, burnout, bullying, harassment and negative behaviour. Cox defines them as 'those aspects of work design, work organisation and work management, and their social and organisational contexts, that have the potential to cause psychological or physical harm' (Cox, as cited in Clarke & Cooper, 2004, p. 3).

The concept of psychosocial risk should be broader and embrace any risk to safety, health and well-being: psychosocial risks are those that, as the word implies, result from psychosocial phenomena, that is the phenomena that exist when a set of people interact (Di Bisio, 2009). When these interactions occur dysfunctionally, a possible negative outcome is stress or mobbing, which is a phenomenon and a legal construct based on four constituent elements: a series of persecutory behaviours carried out systematically by the employer or a person in a position of authority, the event of harm to the health or personality of the employee, the link between the behaviours and the harm suffered by the victim, and the persecutory intent unifying the various behaviours (Pedrazzoli, 2007; Nunin, 2019; D'Aponte, 2019). Another possible example is burnout, an emotional exhaustion syndrome that can occur in professional relationships that are both engaging

and particularly exhausting, as happens in many helping professions such as healthcare or teaching (Vianello, 2019). Several definitions of burnout can be found in the literature, most of which originate from clinical observations. In response, Maslach and Schaufeli (1993) sought to identify common elements among these various definitions and highlighted the following:

- A predominance of fatigue-related symptoms, such as mental and emotional exhaustion, tiredness, and discouragement.
- The presence of non-specific physical stress symptoms (e.g., asthenia, easy fatigue, apathy, insomnia, nervousness, and irritability) as well as somatic symptoms (e.g., headache, dyspepsia, cardiac arrhythmias, sexual and eating disorders).
- A clear association between burnout symptoms and specific working conditions.
- The manifestation of symptoms even in otherwise healthy individuals without any diagnosed psychopathology.
- A reduced sense of effectiveness at work and diminished abilities, often linked to negative attitudes and behaviours in the workplace (e.g., emotional detachment, etc.).

In 1982, in the text *Burnout – The Cost of Caring*, Maslach elaborates the definition that is still the most widely used to define the phenomenon, namely a chronic stress syndrome characterised by three dimensions:

- Emotional exhaustion: feeling of exhaustion and depletion of one's emotional resources.
- Depersonalisation: angry detachment in the relationship with users, resulting from a process of 'dehumanisation'.
- Reduced personal accomplishment: feeling of incompetence and lack of results in one's activity.

In general, the diagnosis of burnout is also based on the results of the widely used Maslach Burnout Inventory questionnaire by Maslach and Jackson (1986), for which there are national calibrations and cut-off values. In order to fully understand the phenomenon, it is necessary to make a distinction between stress and burnout; in fact, the element that allows a differential diagnosis between the two phenomena is related to the quality of the relationship with work: stress is determined by excessive commitment and the subject may feel a strong overload, accompanied by a sense of urgency and haste to work, accompanied by loss of energy and anxiety. They are aware of their condition. Burnout, on the other hand, leads the subject to experience a strong detachment from work: feelings of emptiness and worthlessness; deprivation of strong emotions and no hope of changing the situation; lack of motivation and emotional complications such as the development of depression. Another difference with stress is that there is often no awareness of what is happening. The WHO - World Health Organisation - is the first international health organisation to recognise work-related burnout as a syndrome, adding it to its long list of medical conditions. In May 2019, burnout was recognised as a syndrome and as such was listed in the 11th revision of the International Classification of Diseases (ICD), the global reference text for all diseases and health conditions.

Finally, among the organisational dysfunctions, stress is considered by some to be 'mild mobbing', which refers to an isolated and non-recurring action whose effects persist over time, and by others to be 'episodic mobbing', i.e. lacking the characteristic of continuity, 'but not necessarily a source of less serious damage' (Garofalo, 2016).

Recently, Jain and colleagues (Jain, Torres, Teoh & Leka, 2022) highlighted that national legislation is associated with more organisations implementing action plans to prevent work-related stress, which was associated with providing more job resources but not with reducing job demands. In addition, job resources were found to be associated with less reported work-related stress in European countries with specific legislation on work-related stress and psychosocial risks, such as Italy. A recent study (Ronchetti, Russo, Di Tecco & Lavicoli, 2021) builds on these findings and, focusing on Italy, extends Jain's research by exploring the role of key OSH policy

principles as motivators for organisational action on work-related stress. The study strongly supports the relationship between key OSH policy principles embedded in Italian legislation and organisational action on work-related stress. Legislation creates an OSH climate that encourages organisations to take action on stress.

However, the findings suggest that while legislation and OSH principles motivate action, they are not sufficient to guide organisations towards effective interventions or the implementation of preventive approaches to address psychosocial risks and work-related stress. Despite the mature policy context in Italy, with specific legislation, tools and guidelines, organisations tend to focus on secondary and tertiary level interventions, such as improving workers' stress management skills and providing rehabilitation for stress-related health problems, rather than on primary level interventions that address the causes of work-related stress, such as work organisation and the creation of a healthy psychosocial working environment. Organisations often perceive interventions at the primary level as complex or time-consuming, or they may lack the skills to effectively translate risk assessment results into appropriate actions at the organisational level. While OSH legislation aims to identify and reduce risks to workers' health, safety, and well-being, more efforts are needed to educate organisations on the benefits of managing psychosocial risks. This could encourage greater investment in creating healthy work environments, rather than just focusing on individual coping strategies.

2.2 The impact of the COVID pandemic

The COVID-19 pandemic has created a situation of high uncertainty and instability, resulting in a 'shock' to the careers of many people around the world (Akkermans, Richardson & Kraimer, 2020).

There are some sectors that have been particularly exposed to the shocks caused by the pandemic, including the healthcare sector. In Italy, by early March 2020, hospital intensive care units had already reached a quarter of their total capacity and 20% of healthcare workers were infected (Remuzzi & Remuzzi, 2020). Previous studies (Goulia, Mantas, Dimitroula, Mantis & Hyphantis, 2010) have already shown how the spread of disease on a large scale affects not only the mental and physical health of healthcare workers, but also their work performance, as it requires an adjustment of their functions, roles and competencies.

In the case of the COVID-19 pandemic, healthcare workers were faced with many new challenges, often with very little time to adapt. Among these, empirical evidence has highlighted the shortage of medical equipment (Wang, Zhang & He, 2020) and personnel, the high exposure to the risk of infection (Zhang et al., 2020; Zhao et al., 2020). The public health emergency has had a major impact on health care organisations, both logistically and organisationally (Leite, Lindsay & Kumar, 2020): to meet the increased demand for health care, hospitals have had to significantly increase their capacity, measured in terms of the availability of health care facilities, beds (including intensive care), and human and financial resources (William, King, Jeffery & Bienz, 2020). At the same time, non-emergency care was often interrupted, the use of telemedicine was encouraged where possible, and the use of private facilities was exploited to increase the response (Leite et al., 2020). The pandemic also forced healthcare organisations to rethink their procurement and supply chain model and to strengthen their planning, demand management and patient care capabilities (Bohmer, Pisano, Sadun, & Tsai, 2020).

A study carried out in 2020 (De Girolamo, Cerveri, Clerici, et al., 2020) on mental health services in the Lombardy region of Italy - a region heavily affected by the pandemic - showed how the organisational changes imposed by the pandemic have also drastically affected the quality of the relationship with patients: in many hospitals, entire wards, including some psychiatric wards, have been reorganised to accommodate patients with COVID-19, and many doctors and nurses have been transferred to wards dedicated to the management of such patients. Most day-care facilities

for patients with psychiatric disorders have been temporarily closed, while patients in residential facilities, who are usually free to come and go during the day, have been confined indoors with very limited or no exit permits. Many outpatient clinics have restricted visits to the most urgent cases, and home visits - a common practice in most departments - have been drastically reduced, with potentially detrimental consequences for patients' well-being.

The authors of the cited study point out that the organisational changes implemented during the pandemic highlighted the fragility of the health system in relation to mental health: mental health departments should be able to take the lead in the psychosocial management of disaster-like situations. This aspect requires the acquisition of new skills that will be useful to health personnel in dealing with emergency situations: the ability to properly inform the population about risks, to train and disseminate effective prevention and emergency management procedures, to support health personnel and rescuers, and to offer support to the bereaved.

2.3 Insights from EU-OSHA surveys

Grey literature provides important information concerning the situation of mental health in Italian workplaces. Namely, in recent years EU-OSHA has included questions and indicators concerning mental health in its periodic surveys issued to companies and workers and aimed at assessing the general health and safety levels in European workplaces.

Based on the findings from the Third and Fourth European Survey of Enterprises on New and Emerging Risks (ESENER 2019 and 2024),² Italian establishments report psychosocial risks at consistently lower rates than the EU-27 average.

Only 37% of establishments report risks associated with difficult customers, patients, or pupils, compared to an EU average of 59%. Similarly, just 19% identify time pressure as a risk, far below the EU average of 45%. Other risks, such as long or irregular working hours, are reported by 9% of Italian establishments, against an EU average of 21%. Poor communication or cooperation within Organisations is flagged by 8% of establishments in Italy, while the EU average is 18%. Finally, 9% of Italian establishments recognise job insecurity as a risk, aligning more closely with the EU average of 11% (EU-OSHA, 2019).

Moreover, the survey shows how Italian establishments have implemented several measures to mitigate psychosocial risks, although their adoption rates are often lower compared to the EU-27 average. In Italy, 49% of establishments allow employees to make more decisions about how to perform their work. This is significantly below the EU-27 average of 68%, suggesting that Italian workplaces could do more to promote employee autonomy.

The reorganisation of work, another key measure, is reported by 41% of Italian establishments, close to the EU-27 average of 43%. However, the provision of confidential counselling for employees is implemented by only 21% of Italian establishments, which is well below the EU average of 42%. Similarly, training on conflict resolution is provided in just 26% of Italian workplaces, compared to an EU average of 34%. Intervention in cases of excessively long or irregular working hours is relatively rare in Italy, with only 24% of establishments taking this measure. This is also below the EU-27 average of 29% (EU-OSHA 2019).

The results from ESENER 2019 show how Italy faces a wide range of challenges in addressing psychosocial risks.

1. Reluctance to talk openly about these issues: In Italy, 54% of establishments reported this as a significant barrier, compared to the EU-27 average of 60%. This indicates a slightly lower level of discomfort in discussing psychosocial risks, though it remains a prominent obstacle.

² At the date of publication of the present Report, only the preliminary findings of the ESENER 2024 survey have been published. Therefore, the largest part of the reported data has been retrieved from the third wave of the ESENER survey (2019).

2. lack of expertise or specialist support: This barrier was cited by 35% of Italian establishments, lower than the EU average of 45%, suggesting that Italian workplaces may have comparatively better access to or reliance on available expertise.
3. Lack of awareness among staff: About 43% of Italian establishments noted this as a challenge, close to the EU-27 average of 44%. This reflects a need for increased training and awareness programmes to enhance understanding among employees.
4. Lack of awareness among management: Italian establishments reported this at a slightly higher rate (38%) compared to the EU average of 33%, indicating room for improvement in management's recognition and understanding of psychosocial risks.

These findings show that while Italy performs relatively better than the EU average in some areas, such as access to mental health expertise, challenges related to awareness, both at the employee and management level, and openness to discussing psychosocial risks remain substantial barriers (EU-OSHA, 2019).

Approximately half of the establishments reported conducting employee surveys that included questions on work-related stress within the past three years, aligning closely with the EU-27 average of 44%. While this demonstrates that Italy is comparable to the broader European context in this practice, it lags behind Nordic countries, where 84% of establishments in Sweden, 81% in Finland, and 72% in Denmark conduct such surveys. Furthermore, only 46% of Italian establishments actively involve employees in identifying potential causes of work-related stress, such as time pressure or dealing with difficult clients, in line with EU-27 average. This figure reflects trends observed in southern and eastern European countries, where employee involvement tends to be lower. In contrast, Nordic countries such as Switzerland (65%), Sweden (64%) and Germany (63%), report much higher levels of employee participation (EU-OSHA, 2019).

Additionally, when it comes to providing training on how to prevent psychosocial risks, 49% of Italian establishments reported offering this type of training, which is above the EU-27 average of 34% (EU-OSHA, 2019). While this demonstrates a relatively stronger focus on addressing psychosocial risks compared to other EU countries, it still highlights the need for further improvements. Italian workplaces show a growing recognition of the importance of equipping employees with the tools and knowledge to manage these risks, though this remains an area where greater emphasis and resources could be directed.

These findings underscore areas where Italy could improve by fostering greater employee engagement and adopting more proactive and participatory approaches to managing workplace stress. The findings retrieved from the fourth ESENER survey will help to acquire a more comprehensive and recent overview on mental health in Italian workplaces.

It is to be noted, however, that ESENER surveys are only directed to company-level OSH experts - both on the worker and management side.

The OSH Pulse survey concerning occupational safety and health in Post-Pandemic Workplaces, carried out between April and May 2022, was instead directed at a sample of around 27 000 'regular' European workers, therefore showcasing a different perspective on the topic.

The results of the OSH Pulse survey show how mental health remains a sensitive topic in Italian workplaces. In Italy, 64% of respondents believe that disclosing a mental health condition could negatively impact their career, significantly higher than the EU-27 average of 50%. This places Italy among the countries with the strongest stigma around mental health disclosures, alongside Cyprus (66%), Greece (66%), and France (68%), in contrast to Nordic countries like Iceland (21%), which exhibit more accepting workplace cultures. Furthermore, only 56% of Italian respondents feel comfortable discussing their mental health with their manager or supervisor, a figure below the EU average of 58%. This level of openness is far lower than in Denmark (78%), Sweden and Finland (75%), which lead in fostering supportive workplace environments. These

findings highlight the dual challenge Italian workplaces face: reducing the stigma of mental health disclosures and creating a culture where employees feel safe discussing these issues (EU-OSHA, 2022).

The COVID-19 pandemic has had a mixed impact on stress and mental health management in Italian workplaces. According to the survey, 64% of respondents in Italy agree (combining 'strongly agree' and 'agree') that the pandemic has made it easier to talk about stress and mental health at work. This is higher than the EU-27 average of 51%, positioning Italy alongside Spain (64%) and Malta (72%) as one of the leading countries in terms of progress in fostering open discussions on mental health during the pandemic. However, the pandemic has also exacerbated work-related stress for many. 46% of Italian respondents report that their work stress has increased as a result of the COVID-19 pandemic, slightly above the EU-27 average of 44%. This indicates that, while Italy has made progress in facilitating conversations about stress and mental health, the overall stress levels among workers remain a significant concern (EU-OSHA, 2022).

Moreover, according to the OSH Pulse survey, Italy shows limited availability of initiatives to address workplace stress and mental health. Only 33% of Italian respondents indicated that workers are consulted about stressful aspects of their work, compared to the EU-27 average of 43%. Similarly, 37% of respondents in Italy reported access to information and training on well-being and stress management, which is slightly below the EU-27 average of 42%. Access to counselling or psychological support is available in just 29% of Italian workplaces, falling short of the EU-27 average of 38%. Finally, only 16% of Italian respondents reported the presence of other measures to address workplace stress, significantly below the EU-27 average of 26%. These figures suggest that while some initiatives are present, Italian workplaces lag behind the European median in providing comprehensive support for managing workplace stress and mental health (EU-OSHA, 2022).

2.4 Field research results: interview data

In order to gather deeper insights on mental health in Italian workplaces, the authors of the present report carried out 8 interviews involving workers, workers' representatives, HR representatives and members of Italian institutions focusing on occupational health and safety (see par 1.1).

2.4.1 Overall assessment of mental health status among Italian workers

Interviewees have firstly been asked to provide a general evaluation of the mental health status of Italian workers, and whether it underwent significant changes in the last years.

Firstly, respondents highlight how societal transformations occurred in recent years have the potential of strongly influencing workers' mental health status, also given the system's difficulties in adapting promptly to these changes (RI8).

"We live in a society that has transformed rapidly, sometimes even tumultuously. This transformation has generated opportunities for growth, but also multiple forms of distress. The speed of change has reshaped patterns of personal, family and community life, and it is difficult for the system to react promptly. [...] This is true in general for occupational diseases, but it is even more evident for less visible ones, such as those of a psychosocial nature. Signs of distress are not always easy to identify and arise from a complex interweaving of macro (social and economic) and micro (relating to the individual and the work environment) factors." (RI8)

In parallel, however, discussions concerning psychological distress in the workplace are reported to have gained significant traction in the public and academic debate - especially after the COVID

pandemic - which is considered to be a positive outcome (R17, R19). On an institutional level, this topic is considered “*strategic [...], object of investments such as the creation of multidisciplinary teams tasked with tackling the problem*” (R18).

However, the current initiatives and adopted measures are still being considered insufficient to effectively tackle the issue (R16) especially when it comes to psychosocial risks prevention (R18).

2.4.2 Main psychosocial risks in Italian workplaces

When asked about the main psychosocial risks present in Italian workplaces, employers' side interviewees highlight the difficulties in identifying which mental health issues stem from the work environment and which from the workers' personal life.

“The pandemic has had a significant impact, but the causes of mental health distress are multiple, being related to both personal and working life. It is difficult to separate these two aspects. It is normal for events in personal life to influence work life and vice versa.” (R11)

“People often have to deal with personal and professional problems simultaneously, with no clear separation between the two areas. This makes it more difficult to say whether a mental well-being problem stems from the work context or the personal context, because the two are increasingly interconnected.” (R12)

Among psychosocial risk factors stemming from societal transformations, interviewees listed globalisation - which can make workers more insecure about the stability of their job - and isolation, causing scarce support systems (R18).

With concern to psychosocial risks linked to work organisation, interviewees listed workplace harassment, difficult relations with clients and patients (R17), work overload, conflict between expectations, training backgrounds and concrete aspects of the job, feeling of impotence due to scarce organisational resources (R16), insufficient separation between professional and private life (R19). These aspects have been strongly highlighted by interviewees active in the healthcare sector (see §5).

“Some jobs are particularly emotionally demanding, precisely because of the relationship between the person doing the work and what that kind of work requires. I’m thinking, for example, of care work: not just the work done in hospitals, but also, and perhaps even more so, care work within facilities for the elderly.” (R17)

“Think about those cases in which caregivers have to manage people who [...] exhibit behaviours that are difficult to cope with, perhaps related to cognitive impairment or early signs of dementia. This requires not only technical skills but also strong emotional resilience on the part of caregivers. The problem is that the facility and staff are not equipped - either in training or in tools - to deal with these situations, which would require very specific psychological and social skills. The result is a widespread sense of helplessness among the operators.” (R16)

2.4.3 Links between digitalisation and mental health

Technological change - despite being considered as crucial for social and economic development - has also been listed by interviewees as a factor which impacts workers' mental health.

“Technological innovation is necessary to remain competitive. The problem is that there is a time lag between the speed with which innovation spreads and the slowness with which we are

able to understand and manage the side effects it has on people. So, we are faced with a paradoxical situation: professionals who are more competent and better equipped to deal with change are at the same time more fragile, precisely because change does not impact everyone equally. [...] Those who are better trained or more sensitive may still feel more alone, and this sense of isolation is often one of the conditions that can generate psychosocial distress.” (R18)

The most frequently mentioned psychosocial risk factors associated with digitalisation are reduced social interaction (R18) and excessive porosity between private and working life, which can lead to an unhealthy ‘always-on’ culture (R17). Company-level workers’ representatives however also stress issues such as increased working hours, difficulty in asking for support from colleagues, increasing sense of inadequacy among workers - related to the need of constant digital upskilling (R13, R16) - and the increasingly hectic pace of work (R14).

“Workers end up overloaded with tasks, but continuous multitasking and task changes reduce productivity. The result is an increasing sense of unproductivity despite the longer hours worked.” (R14)

“When technological tools are introduced in the workplace, organisational difficulties arise: it is taken for granted that the introduction of these tools facilitates work digitisation and therefore makes work easier. But this also implies the need for workers to constantly update their skills abandoning established practices [...] that perhaps worked for them [...]. Moreover, new tools are often introduced in the workplace without prior training or support [...] leaving operators alone to deal with any problems which might arise.” (R16)

Lastly, fear of job loss due to digitalisation is listed among factors which might impact workers’ mental health (R17).

“Think of people working in the service sector: every day the media talk about the possibility that they will be replaced by artificial intelligence. Similarly, people working in call centres who often hear people repeat that ‘call centres will disappear because they will all be automated’ experience real anxiety about their future. And we cannot assume that this does not have an impact on their mental health.” (R17)

2.4.4 Vulnerable groups

When asked about particularly vulnerable groups, interviewees identify younger people, older people, and workers engaged in non-standard work contracts as more exposed to psychosocial risks, albeit for different reasons.

“The groups most exposed to mental health problems are young people, who often find it difficult to fit into the work environment without support and experience a strong sense of inadequacy, and workers with limited skills, considering how the labour market is becoming increasingly specialised and those without the required skills risk social exclusion. In addition, older workers must adapt quickly to new technologies and therefore experience anxiety and stress.” (R13)

“The relationship between older and younger workers represents a potentially critical field, especially when it comes to work organisation. You can have a conflict among very different backgrounds and approaches.” (R16)

“The feeling of precariousness - i.e., the possibility to suddenly lose one’s job and not being able to find another - can weigh down workers: it is often perceived as a constant state of threat, which can have a devastating impact on their mental health.” (R17)

At the same time, younger generations appear to have a higher level of awareness with concern to mental health and wellbeing at work, considered on a general level (R19).

“There are categories of people with a greater sensitivity to these issues. In particular, younger people - I would say under 40 - have a very different view of work than previous generations. Today it is normal to receive CVs from people who have changed jobs every two years. Only a few years ago I would have considered this a sign of unreliability, whereas now I realise that it is often the result of a continuous search for better working conditions - not only economic, but also in terms of work-life balance and well-being.” (R19)

2.4.5 Obstacles to psychosocial risks prevention and management

Despite the increased attention on mental health following the COVID-19 pandemic, the lack of awareness concerning the topic at company-level has been identified as an obstacle to preventing and managing psychosocial risks by interviewees both on the company and trade union side. Respondents identify the reasons for this in the lack of a corporate culture that makes workers aware of the importance of using available mental health protection tools (R11), difficulties in identifying mental health risks given the lack of middle management training on the subject (R14) and the limited support of institutional bodies such as INPS (National Social Security Institute) or INAIL (National Occupational Health Institute) (R15).

“Cultural and organisational differences play an important role: in some business contexts, the topic of mental health is strongly considered, in other sectors, the topic is still little dealt with or even ignored” (R12)

“In some companies, communication, listening, targeted growth paths, corporate welfare strategies, organisational wellness, smart working have become central aspects of work organisation. However, in general, we are still far behind. In many realities, the topic of well-being in the workplace is still perceived as an unnecessary burden.” (R19)

“There is still a lack of awareness among employers. Although initiatives such as those for work-related stress are quite widespread, so far the focus has been more on physical risks than on psychological ones. Generally speaking, there is a tendency to play down the problem, thinking that it is only related to factors concerning the workers’ personal life (e.g., family).” (R11)

Respondents underlined how the size of the companies significantly influences the quality of working conditions and the effectiveness of workers’ rights, including that to mental health (R17, R18).

“Generally speaking, in medium to large companies [...] there is more organisation, more investments, a more relevant presence of the union component and thus a greater attitude of these companies to [...] discuss together with respect to what to do in certain contexts.” (R17)

Stigma has also been identified as a relevant obstacle to mental health protection, especially by company-level workers’ representatives, who report that many workers do not talk about their problems for fear of being judged or penalised in their career (R13), which however end up having a negative impact on their private life (R14). This view is however also shared by national-level

institutional representatives (RI8) and healthcare workers (RI6) interviewed in the context of the PSYR-IR project.

"If compared to other countries [...] Italy is characterised by a very backwards approach to the issue of psychosocial distress. There is a 'cultural wall' to break down: expressing one's discomfort and confronting qualified professionals should be natural, but it is still perceived as a sign of weakness [...] In some more sensitive and advanced contexts-which your association is familiar with-there are good projects in place, but in many realities, a worker may fear repercussions if he or she makes public his or her own fragile state. Mitigating this problem requires a lengthy sensitisation effort." (RI8)

"Although prejudices still exist, I'm noticing some opening signals on the companies' side: they are still not openly referring to 'mental illnesses', but they are using 'lighter' terms, such as 'emotional difficulties'. Psychological support services are also popping up here and there [...] But to make sure that they are really used, you have to create the conditions to talk about mental health openly. It is not enough to allude to the problem." (RI6)

2.4.6 Tools and practices to protect and promote workers' mental health

Regarding potential tools to protect and promote workers' mental health, only one respondent stresses the importance of institutional-level initiatives aimed at awareness-raising, suggesting the issuing of guidelines for companies and workers concerning mental health (RI1). The other interviewees instead focus mainly on company-level initiatives, such as the creation of a healthier working environment (e.g., through good work-life balance and the provision of flexible working arrangements) (RI1), the monitoring and reporting concerning employees' psychological well-being (RI3), the setting up of a psychological help desk - managed by a third party - and of structured pathways for the reintegration of workers with psychological problems (RI4).

"Companies monitor physical injuries, but not workers' mental health. We need data, specific criteria and indicators to understand whether the situation is getting better or worse." (RI3)

"In some European countries (e.g., Austria) mixed training courses are organised, where 30% of the participants are people who have experienced difficult situations (illnesses, family difficulties), while the remaining 70% are workers without such problems. This type of approach allows a gradual and natural reintegration in the workplace, avoiding stigma." (RI4)

"Workers must be made to understand that support tools exist and must be used. Many resources, such as support programmes for families or people with disabilities, are not sufficiently promoted and workers often have to seek them out themselves." (RI4)

"It is necessary to create a corporate culture that promotes diversity and inclusion. In order to put in place effective tools for this, collaboration between workers, trade unions and companies is needed." (RI4)

2.4.7 Company-level policies to protect workers' well-being

As with concern to practices currently present in Italian workplaces aimed at preventing and managing psychosocial risks at the workplace, the HR representative (RI2) and the workers' representative (RI3) active in a large multinational IT company report on the availability of an Employee Assistance Programme (EAP), which offers psychological support to employees and their families by putting them in contact with a local psychologist and covering up to 10 free sessions. Moreover, company workshops are organised twice a year, with experts covering topics

such as stress management, work-life balance and support for parents. However, despite the entire process being anonymous and confidential, both respondents report a low membership to the programmes (less than 2% of the workforce) and link this outcome to the stigma attached to mental health management.

Another HR representative, instead, mentioned a similar initiative which had more success, despite not involving mental health professionals (R19).

“In my organisation, listening sessions with human resources personnel have been organised. In these meetings, people expressed needs, underlined their skills, shared their aspirations, all in an informal atmosphere, not bound by a rigid scheme. We offered 45-minute slots, all of which were filled.” (R19)

Another workers' representative (R14) mentions the presence of a psychological support service available in the company, created during the pandemic as a result of collective bargaining and reinstated as a company benefit in the following years. It is to be noted that one of the HR representatives interviewed during the field research phase underlines how psychological counselling services provided by the companies in which he has worked have always been the result of unilateral company policies, and not of a dialogue with the trade union (R12).

Mental health is an issue that is being addressed particularly in the field of supplementary healthcare as specified by a sectoral-level trade unionist.

“Among the current initiatives is the MetaSalute Health Fund, which covers about 1.2 million workers and 550,000 family members, and is exploring responses to psychological problems, in particular related to addictions, autism, and eating disorders. Another initiative is the PMI Salute Fund, which is testing a protocol to measure the cognitive ageing of workers.” (R15)

One respondent underlines how psychological therapy sessions are usually not covered by supplementary healthcare funds (R13).

2.4.8 Professional figures for mental health

Interviewees were also asked to identify which specific professional roles at company level could be most beneficial in addressing workers' mental health issues. Respondents often mention the RLSs (Workers' Safety Representatives) as *‘a useful channel for monitoring broader trends within the company with regard to workers' mental health’* (R12). Occupational doctors have also been identified as strategic figures to identify work-related mental health issues (R15). However, both figures are reported to be usually inadequately trained on the subject (R13, R15, R17): institutional initiatives aimed at tackling this issue are currently underway (R18).

“Company-level occupational doctors - which are present in most Italian workplaces - usually deal with aspects related to physical health. However, they should also focus on psychological aspects, and to do that, they'd need a holistic approach to their patients' health.” (R17)

“INAIL has just issued a €24 million call for proposals for training workers and specialists. One of the four thematic areas concerns psychosocial risks. We are talking about thousands of workers who will have access to targeted training that can help them identify, read and deal with psychosocial distress.” (R18)

It also needs to be noted how small and medium enterprises often do not dispose of dedicated healthcare personnel. According to one interviewee, *“territorial or multi-employer models should*

be created, in order to strengthen the role of territorial representatives for occupational health and safety³ – especially in sectors such as commerce, agriculture, craftwork” (RI8).

Company psychologists are also considered potentially crucial figures to tackle psychosocial risks factors in Italian workplaces, given their specific skills on the matter: however, interviewees report structural shortages of dedicated mental health personnel, caused by cuts and investment reductions in the Italian national healthcare system (RI6).

2.4.9 Social partners’ role in protecting and managing workers’ mental health

Lastly, interviewees have also been asked their opinion on the role of social partners in tackling the issue of psychosocial risks in the workplace.

Currently, mental health appears not to cover a central role in trade unions’ agenda – being often mentioned only in connection with issues such as work-life balance or the right to disconnect (RI3) or sparking only a superficial level of interest (RI6).

“Mental health problems are often regarded as individual issues and not as collective problems.” (RI3)

“It looks like workers’ representatives’ focus is primarily on other aspects of work – e.g. working hours, wages, union rights. Mental health is treated as a marginal problem, which, in my opinion, is quite limiting.” (RI6)

One HR representative, however, reported a slight change in trade unions’ perspective on the topic. (RI9)

“Social partners are gradually approaching these issues, albeit with some delay. I have been involved in labour relations for a long time, and I can say that, in the past the unions looked at corporate welfare measures with diffidence, almost as if they were some sort of trap for workers. In the last five or six years, however, something has changed. In my organisation, for example, company-level collective agreements on corporate welfare measures and remote work have recently been signed [...] So, there is a growing awareness, which is developing both at company and at trade union level.” (RI9)

However, all respondents agree that social partners can play a very important role in supporting workers’ mental health, through lobbying activities involving national stakeholders, training workers and their representatives on the topic (RI4, RI6), facilitating contacts with territorial healthcare facilities (RI6) and designing awareness-raising and sensibilisation initiatives (RI5, RI8).

“Trade unions have the task of raising awareness among companies, governments and employers on these issues, demonstrating that investing in mental health brings benefits to everyone, by improving both company productivity and social environment.” (RI4)

“Once you open a gap, you have to expand it. Take work-life balance as an example: ten years ago, it was an elitist topic, now it is an integral part of bargaining. The same could happen with mental health, if you could raise awareness among companies and workers.” (RI5)

³ According to art. 47, par. 3 of Legislative Decree 81/2008, the territorial workers’ representative for occupational health and safety is tasked with exercising the prerogatives of company-level workers’ representatives for occupational health and safety (RLS) in every company/establishment of a designated territory where RLS have not been elected.

“Today, there is a shared perspective concerning the fact that workers’ mental health represents a common goal for companies and trade unions. This is a first step for overcoming stigma on the topic, but there is still a long path ahead.” (R18)

Collective bargaining is also considered a fundamental tool to protect workers’ mental health: according to the respondents, its flexibility (R17) allows to provide solutions *‘in a quicker and more adaptable way compared to national legislation’* (R15).

When asked about at which level should social partners intervene, some respondents identify the national level as the most suitable to *‘making mental health protection and promotion initiatives accessible to medium-sized companies’* (R13) *‘envisaging training targeted on mental health’*, *‘providing tools for monitoring the real well-being of workers’* (R14).

“I think it should all start [...] at the stage of drafting the national collective agreement [...] The territorial organisations are active, some more, some less, depending on how strong the vertical link with the national level is. But they all operate within the perimeter outlined by the national contract. Therefore, if at the national level there is an opening, even if only in the form of guidelines, then it becomes easier to reinforce and decline those guidelines at the territorial level, according to local specificities.” (R19)

Moreover, the national collective agreement is considered as strategic to identify new figures dedicated to dealing with workers’ well-being and mental health (R15).

“The national collective agreement should identify a figure dedicated to the well-being of workers within the RSUs (Unitary Workplace Union Structure) assigning him or her an hour’s leave per month to act as a link between workers and the health fund. Formally recognising this figure would mean enhancing a role that is already played today, but without adequate tools.” (R15)

Opinions about company-level bargaining diverge: some respondents consider it a *‘less effective means’* (R13) to provide *‘concrete and measurable actions’* (R14), while others identify social dialogue action at collective level as a fundamental tool to adapt psychosocial risk prevention and management to the specific characteristics of each workplace (R17).

“Psychosocial factors have an ambivalent nature: factors that can be considered positive in some contexts, can be considered negative in others. [...] For this reason, you cannot adopt the same approach used to tackle physical risk factors [...] but you need an approach based on dialogue among different interested actors. This dialogue can start from general principles defined at national level, but it then needs to be adapted to the reality of each company.” (R17)

Lastly, synergies among legislators, institutional actors and social partners are deemed necessary to reach effective psychosocial risk prevention and management across Italian workplaces (R18).

“Clearer legislation that recognises psychosocial distress as a genuine occupational disease, on a par with fractures or respiratory diseases, is urgently needed [...]. Moreover, to reach all workplaces, we need to proceed step by step, prioritising the sectors most at risk, and work on two levels. Internally, we need effective collective agreements and industrial relations, and externally, we need a network of specialists such as psychologists, social workers and sociologists that need to be reintegrated into the system. Institutions must provide strategies,

guidelines, controls and funding, and the social and contractual network must be active and widespread.” (R18)

3. Regulatory framework on psychosocial risks and workers' health and well-being

3.1 Legislation and policy

In the Italian legal system, the protection of workers' health is firmly rooted in constitutional principles. A recent amendment to Article 41 reaffirms that while private economic initiative is free, it must not conflict with social utility or cause harm to health, the environment, safety, personal freedom, or human dignity. By explicitly mentioning health, the Constitution elevates it to a core constitutional value, placing it on equal footing with other fundamental principles. Moreover, the law establishes specific programmes and regulatory frameworks to ensure that both public and private economic activities are structured to support social and environmental goals (Tritto, 2022).

Among the constraints outlined in Article 41, the reference to health is particularly significant due to its direct connection to Article 32, which recognises health as a fundamental right. This right receives absolute protection - not only in the relationship between individuals and the State but also in private relations (Mazzola, 2021).

The Italian Constitution adopts a broad understanding of health, encompassing physical, psychological, social, and environmental well-being. This interpretation aligns with the World Health Organisation's definition and reinforces the constitutional vision of health as essential to equality, freedom, and personal development (Ludovico, 2022).

This perspective is further supported by Articles 2 and 3, which frame health as a key instrument for promoting equality, safeguarding individual freedom, and fostering both personal and social development (Montuschi, 1976).

The recent explicit inclusion of health as a limitation in Article 41 reflects its increasing constitutional relevance, particularly in protecting workers' rights and enhancing societal well-being. This amendment confirms the primacy of health over economic interests in cases of conflict, embedding it within a broader commitment to sustainability and environmental protection.

Italian occupational health and safety (OHS) regulations are rooted in the Civil Code, particularly Article 2087, which states: 'The employer is required to adopt, in the exercise of the enterprise, the measures which, based on the specific nature of the work, experience, and technical advancements, are necessary to protect the physical integrity and moral personality of workers.'

Article 2087 serves as a broad and flexible legal safeguard, obligating employers to adopt all necessary measures to ensure workplace safety - even in the absence of detailed or specific legislation. It functions as a gap-filling provision, allowing safety standards to evolve in response to changing work conditions, advancements in technology, and accumulated professional experience.

Italian case law has expanded the interpretation of this article. Courts have held that under Article 2087, workers need only demonstrate that harm occurred and that there is a causal link to their work, while the burden of proof shifts to the employer. The employer must then prove that all reasonable and preventative measures were taken to avoid such harm (Cassazione Civile, 8 February 1993, n.1523). Employers are also required to maintain ongoing supervision and ensure that employee behavior does not compromise safety protocols. If necessary, disciplinary measures - including dismissal - must be taken to preserve a safe working environment.

Thus, Article 2087 positions the employer as the primary guarantor of workplace safety, requiring the adoption of the highest available technical, organisational, and procedural standards (Squeglia, 2017).

Importantly, Article 2087 explicitly protects both the physical and moral integrity of workers, extending its applicability to psychological well-being and mental health protection.

The Italian Supreme Court has further clarified this interpretation, affirming that employers have a general duty to foresee and address potential negative outcomes resulting from imbalances in work organisation and personnel management. This includes recognising that even lawful workplace behaviors - when they cause stress or discomfort, especially in conjunction with other factors - can contribute to psychological harm. In such cases, the legality of the conduct is irrelevant when determining eligibility for compensation (Cassazione Civile, 7 February 2023, n. 3692). Any behavior that undermines an employee's psychological integrity may be considered a psychosocial risk factor.

This evolving judicial interpretation reflects a growing recognition of psychological risks in the workplace and underscores the employer's responsibility to prevent and mitigate both physical and mental health hazards (De Marinis, 2023).

Within the Italian legal framework, the European Framework Agreement on Work-related Stress was transposed by the social partners through the Interconfederal Agreement of June 9, 2008, and is explicitly referenced in Article 28, paragraph 1 of Legislative Decree No. 81/2008 (commonly known as the *Testo Unico per la Sicurezza sul Lavoro* - TUSL). This provision mandates that risk assessments for workers' health must include risks affecting specific groups, particularly those related to work-related stress, in accordance with the European Agreement of October 8, 2004.

In fact, this requirement was already implicit in other provisions of the *Testo Unico*. The decree defines health as a 'state of complete physical, mental, and social well-being, not merely the absence of illness or infirmity' (Art. 2, par. 1, lett. o) and requires a 'comprehensive and documented assessment of all risks to workers' health and safety' (Art. 2, par. 1, lett. q).

A pivotal development in this area came from the Court of Justice of the European Union, which in 2001 condemned Italy for failing to correctly transpose Framework Directive 89/391/EEC. The Court clarified that the directive obliges employers to assess all risks to workers' health, including psychosocial risks stemming from work organisation (Court of Justice of the European Union, 2002, 246).

Although Article 28 of the *Testo Unico* refers to the European Framework Agreement, it does not provide a specific definition of work-related stress. Similarly, the European Agreement lists several contributing factors but lacks a detailed definition. To fill this gap, Legislative Decree No. 106 of August 3, 2009, added paragraph 1-bis to Article 28, assigning the Permanent Advisory Commission on Health and Safety at Work - based at the Ministry of Labour and Social Policies - the task of developing specific assessment criteria (Ludovico, 2022).

In response, the Commission issued operational guidelines on November 18, 2010, which became mandatory for all employers as of December 31, 2010. These guidelines provide a methodological framework establishing a 'minimum level of implementation' for the employer's obligation to assess work-related stress risks. While they set out essential requirements, they also allow for more detailed assessments tailored to the specific characteristics of each workplace.

The risk assessment process consists of two phases:

1. objective evaluation, based on direct observations and checklists;

2. subjective evaluation, involving structured questionnaires, focus groups, or interviews that capture individual perceptions of stress. The subjective phase measures dimensions such as job satisfaction, psychophysical distress, emotional exhaustion, and burnout.

The Advisory Commission's guidelines reinforce that the assessment of work-related stress is a non-delegable duty and forms an integral part of the overall risk assessment. This responsibility lies directly with the Employer (Article 17, paragraph 1, letter a), who must conduct the assessment in collaboration with the Head of the Prevention and Protection Service and the Competent Doctor (Article 29, paragraph 1), and in consultation with the Workers' Safety Representative (Article 29, paragraph 2) (Squeglia, 2017).

3.2 Key actors

Within the Italian legal framework, various key figures play essential roles in ensuring risk prevention, worker protection, and compliance with Legislative Decree 81/2008. These professionals operate in a coordinated manner, each assuming specific responsibilities according to their role within the organisation.

Employers are the primary guarantors of workplace safety and bear the highest level of responsibility. They are required to conduct comprehensive risk assessments, organise the Prevention and Protection Service (SPP), appoint the Head of the Prevention and Protection Service (RSPP), and draft the Risk Assessment Document (DVR). In the public sector, the employer role may be held by a manager or, in their absence, by a senior official with managerial and financial autonomy.

The Manager, delegated by the employer, is responsible for organising work activities and overseeing safety compliance, sharing the responsibility of implementing protective measures. The Supervisor serves as the intermediary between workers and management, ensuring that safety directives are enforced effectively. This role is often performed by department heads, office heads, team leaders, or site managers.

The Head of the Prevention and Protection Service (RSPP) is a technical expert appointed by the employer to coordinate all prevention and protection activities. This figure plays a strategic role in workplace safety through risk assessment and the implementation of protective measures. Supporting the RSPP, the Prevention and Protection Service Assistants (ASPP) help to execute the company's safety policies in a consistent and effective manner.

The Competent Doctor is a mandatory presence in companies where health surveillance is required. This professional works closely with the employer during the risk assessment process and monitors workers' health to determine their fitness for specific tasks. Introduced into workplace safety legislation in 1956, the role has evolved significantly under the TUSL, which now assigns the Competent Doctor the responsibility of managing and maintaining medical records for all workers under surveillance.

The Workers' Safety Representative (RLS) is elected or appointed by employees to represent them on issues of health and safety at work. The RLS has access to the Risk Assessment Document (DVR), receives information from the employer, and is responsible for reporting any identified risks. This figure plays a critical liaison role between the workforce and management, ensuring that workers' safety concerns are communicated and addressed.

The Safety Trainer is tasked with organising and delivering workplace safety training, which is mandatory for all employees under Article 37 of the TUSL. Trainers must meet specific academic and professional criteria and possess specialised knowledge in occupational health and safety.

In addition to these internal company roles, two national institutions play a vital part in protecting the physical and mental health of workers in Italy: INAIL (National Institute for Insurance against Accidents at Work) and INPS (National Institute for Social Security). These organisations

contribute to the broader national system of worker protection through initiatives that support prevention, care, and financial assistance.

INAIL is a public, non-economic body responsible for managing compulsory insurance against workplace injuries and occupational diseases. Over the years, its mission has expanded to include a comprehensive approach to worker protection, not only by offering financial compensation, but also through activities related to risk prevention, medical care, psychological support, and reintegration into work and social life. This integrated model of care addresses both physical and psychological damage caused by work-related incidents.

INAIL is a public, non-economic entity responsible for managing compulsory insurance against occupational injuries and diseases. Over time, its mission has expanded beyond financial compensation to include risk prevention, medical care, psychological support, and reintegration into both work and social life. This integrated approach allows INAIL to address not only physical injuries but also psychological harm caused by work-related incidents. Its commitment to mental health was especially evident during the COVID-19 emergency, when it partnered with the National Council of Psychologists (CNOP) to launch a national psychological support programme for frontline healthcare workers, offering clear, accessible tools for activating local services.⁴

In 2023, this collaboration was formalised through a memorandum of understanding, aimed at strengthening psychological services for workers affected by illness or injury, as well as their families. This agreement introduced regional registries of accredited psychologists whose services are fully funded by INAIL and integrated these professionals into multidisciplinary support teams. It also promotes standard models of care and joint initiatives for the prevention of psychosocial risks, based on the OASI approach - Observe, Listen, Support, Intervene.⁵

INAIL has also developed a specific methodology for the assessment and management of work-related stress, which was updated in 2017 and again in 2025. This methodology includes tools designed to evaluate the impact of technological changes and remote work on employee well-being, enabling companies to identify stress-related risks and implement targeted improvement measures (Inail, 2025; Curi, 2024).

INPS complements these efforts by providing financial support to individuals experiencing mental health challenges. Among its key initiatives is the 'Bonus Psicologo,' a subsidy aimed at helping those suffering from anxiety, stress, or depression access psychotherapy services. INPS also provides disability pensions for individuals unable to work due to severe psychological or physical conditions.

Together, INAIL and INPS contribute to building a comprehensive, though complex, system that increasingly recognises mental health as a central component of worker protection. Their work reflects a growing institutional awareness that psychological well-being is essential not only to health and safety but also to dignity and full participation in working life.

Workplace safety in Italy is thus a shared responsibility, requiring the cooperation of all involved parties. Each figure, like the components of a finely tuned mechanism, must work in harmony to prevent risks, reduce workplace accidents, and maintain a safe and healthy working environment. This includes not only the physical dimension of safety but also the psychological, affirming that mental well-being is a fundamental part of occupational health.

⁴ More information available at the following link: <https://rb.gy/d79hzb>

⁵ Full text available at the following link: https://ordinepsicologi.tn.it/wp-content/uploads/2025/04/CNOP-INAIL-protocollo-dintesa-ottobre-2023_compressed-1.pdf

4. Industrial relations system and regulatory framework on social dialogue

4.1 Industrial relations system and its key actors

The industrial relations system in Italy is structured around a two-tier collective bargaining framework, combining industry-level and company-level agreements. Sectoral negotiations play a key role in aligning wages with inflation trends, ensuring that salary increases reflect anticipated price changes. In addition to wage matters, these agreements cover a broad range of issues, including working hours, holidays, leave entitlements, information rights, and work organisation (ETUI, n.d.).

Over recent decades, labour relations reforms have increasingly promoted the strengthening of company-level bargaining, aiming to introduce greater flexibility into labour agreements (ETUI, n.d.). This trend intensified in the mid-2000s when employers began advocating for more decentralised negotiations and a stronger role for enterprise-level agreements. However, the trade union movement has been divided on this issue. CISL and UIL have supported the expansion of company and territorial bargaining, while CGIL has remained cautious, arguing that sectoral agreements are essential for maintaining uniform labour standards across the country.

Currently, around 35% of Italian workers are union members, with the majority of them concentrated in the public sector (ETUI, n.d.). The three main union confederations - CGIL, CISL, and UIL - have historically reflected different political orientations. In recent years, however, independent and autonomous unions have gained ground. By 2017, these unions accounted for approximately 14.9% of union membership, highlighting a growing detachment of younger and non-standard workers from traditional union structures (Pulignano, 2018).

Overall, union density has declined in recent decades. This trend is often attributed to an aging workforce and the lower propensity of younger generations to join unions (Pulignano, 2018). Nonetheless, CGIL, CISL, and UIL continue to represent the majority of unionised workers, though at reduced levels compared to the past.

On the employers' side, the most prominent organisation is Confindustria, which represents companies across a broad spectrum of industrial and service sectors. As of recent data, Confindustria counted approximately 150,000 member companies, employing over 5.39 million workers. However, employer representation in Italy is highly fragmented, with numerous organisations catering to different sectors, company sizes, and in some cases, distinct ideological traditions (Armaroli, 2024). Notable employer associations alongside Confindustria include Confapi (representing small and medium-sized enterprises), Confartigianato and CNA (for artisans), Confagricoltura (for large agricultural enterprises), and Confcommercio and Confesercenti (for the commerce and tourism sectors).

At the workplace level, representation is primarily exercised through unitary workplace union structures (RSUs). Introduced in 1993 to replace the earlier workplace union representatives (RSAs), RSUs are elected by all employees and serve a dual function: they act as trade union representatives and as general bodies of employee representation. RSUs hold the right to nego-

tiate company-level agreements and are a central component of Italy's decentralised labour relations system.

4.2 Social partners' involvement in the prevention and management of psychosocial risks

Although social partners and workers' representatives are not assigned specific roles in the management of psychosocial risks, the organisational nature of these risks has led to the development of several agreements aimed at addressing them. These initiatives build upon the prior commitment of social partners to implement the European Framework Agreement on Work-Related Stress (§1.1), most notably through the signing of the Cross-Sectoral Interconfederal Agreement on Work-Related Stress (Accordo interconfederale sullo Stress Lavoro-Correlato) on June 9, 2008.

The primary aim of this agreement is to raise awareness, encourage attention, and simultaneously provide a framework for identifying, preventing, and managing issues related to work-related stress (Art. 2). Its approach is inclusive, recognising that stress may also originate outside the workplace, potentially leading to behavioural changes and decreased efficiency on the job. It also identifies a range of potential causes, such as work content, deficiencies in work organisation or environment, and poor communication, and lists relevant indicators, including high absenteeism, staff turnover, interpersonal conflicts, and worker complaints.

The agreement outlines a variety of measures to address work-related stress, categorising them as collective, individual, or mixed; specific or integrated; and preventive or remedial. These measures focus on information, consultation, training, and communication, but also include actions related to the organisation and management of work processes, working conditions, and the physical work environment. While employers retain primary responsibility for implementing these actions, their effectiveness depends on the active participation and collaboration of workers and/or their representatives.

The signing of this agreement holds particular importance within the Italian industrial relations system, as it revitalised the interconfederal agreement as a key instrument of labour relations and demonstrated the commitment of social partners to addressing emerging challenges in workplace well-being (Gottardi, 2008).

4.2.1 Mental health-related provisions in company-level collective agreements

At the organisational level, many companies are increasingly prioritising the mental health of their employees. This growing attention has led to the development of good practices in corporate agreements.

A notable example is the Parmalat agreement (2021), which introduces a detailed procedure for assessing work-related stress risks. This process involves all employees through a questionnaire, followed by analysis in regular meetings that include occupational health doctors.

Another example is the GFT agreement (2021), which tackles work-related stress by committing - under Article 4 - to monitoring potential risk indicators. The company also pledges to provide employees with access to anonymous support from external mental health professionals.

Broadening the scope to include mental health more generally, the Peroni agreement (2023) offers psychological support services to its workforce.

Similarly, Chiesi Farmaceutici (2021) addresses employee stress by promoting work-life balance, aligning with the European Agreement on Work-Related Stress (October 8, 2004).

Beyond these examples, some agreements go further by establishing joint committees or commissions focused on health, work-life balance, and organisational well-being. Examples include

agreements from FCA (2019), Aon (2020), Parmalat (2021), Leonardo (2021), Electrolux (2021), and Heineken (2023) (Tiraboschi, 2023b).

This trend is further confirmed by more recent company-level agreements (stipulated between 2023 and 2024), retrieved from the ADAPT database on collective bargaining in Italy.⁶ These agreements, distributed across several different sectors, show a growing integration of mental health measures into company-level policies.

In 2023, MBDA Italia, the Italian branch of a multinational defense and aerospace company, distinguished itself by providing employees with access to digital health and wellness platforms aimed at promoting an active and healthy lifestyle. These platforms offered discounted memberships to a wide network of gyms and sports centers, access to apps focused on physical and mental well-being, guided meditation sessions, and parenting workshops. Additionally, the company introduced a work-Life Balance programme, featuring policies and initiatives designed to help employees better manage their personal and professional lives.⁷

In the same year, Gefran, an Italian multinational specialising in the design and production of sensors, systems, and components for industrial automation and control, reaffirmed its commitment to employee mental health. The company offered training courses on psychological well-being and shared preventive content through its internal portal, kenFLY. These materials addressed topics such as substance abuse, gambling addiction, post-COVID vulnerabilities, and neuroses. Additionally, Gefran expressed interest in exploring a potential partnership with a specialised organisation to provide anti-violence support services for employees.⁸

Feralpi, among the leading steel producers in Europe, reaffirmed the importance of its 'Listening Desk for Cases of Work Discomfort,' a service dedicated to identifying and managing work-related stress, supervised by the occupational physician and supported, when necessary, by the HR Department and the Prevention and Protection Service.⁹

Ducati, active in the automotive industry, launched mental and physical health prevention campaigns in collaboration with the workers' representative body (RSU) and established a 'Nutrition and Wellness Committee' tasked with monitoring canteen services and promoting a healthier, more inclusive work environment.¹⁰

Similarly, ERG Group, building on initiatives already active in its Genoa offices, signed an agreement to extend psychological well-being services to all employees, including access to a network of gyms and digital resources such as meditation sessions, healthy eating courses, and mental wellness programmes, thus offering a good practice for the energy sector.¹¹

Mental health in remote work arrangements was specifically addressed, in the space and telecommunications sector, by Telespazio and E-Geos, which ensured that smart working practices protect both physical and mental health. Their agreement emphasised that the workplace - whether in the office or at home - must comply with safety regulations and safeguard privacy and psychological well-being.¹²

6 Further information available at www.farecontrattazione.it

7 Company-level agreement signed by MBDA Italia, the trade unions Fiom-Cgil, Fim-Cisl, and Uilm-Uil, company representatives, and the employers' association UNINDUSTRIA Roma, on December 21, 2023.

8 Company-level agreement signed by Gefran SpA and Gefran Soluzioni Srl, the trade unions Fiom-Cgil and Fim-Cisl, company representatives, and the employers' association Confindustria Brescia, on August 5, 2023.

9 Company-level agreement signed by Feralpi Siderurgica, the trade unions Fim-Cisl and Uilm-Uil, and company representatives, on July 23, 2024.

10 Company-level agreement signed by Ducati, the trade unions Fiom-Cgil, Fim-Cisl, and Uilm-Uil, and company representatives, on June 26, 2024.

11 Company-level agreement signed by ERG SpA and ERG Power Generation SpA, and the trade unions Filctem-Cgil, Flaei-Cisl, and Uiltec-Uil, on February 6, 2024.

12 Company-level agreement signed by Telespazio and E-Geos, the trade unions Fim-Cisl, Fiom-Cgil, and Uilm-Uil, and the employers' association UNINDUSTRIA Roma, on March 21, 2024.

On the same front, with regard to the tourism sector, Alpitour reaffirmed the importance of preventing cognitive fatigue by recalling the legal provision that workers using display screen equipment are entitled to a 15-minute break every 120 minutes, as outlined in Article 175 of Legislative Decree 81/08.¹³

Corporate agreements have also tackled more complex psychosocial issues such as harassment and discrimination. The banking group Banco BPM explicitly recognised that any discriminatory act, violence, or harassment represents a threat to individual dignity and can compromise health in its broadest sense - physical, mental, and social. The agreement promotes a respectful and professional work environment that values diversity and equal opportunity and includes measures to support victims of such behaviors, building on the work already carried out by the joint committee on gender equality.¹⁴ Similarly, the GPI Group, operating in the field of digital health, committed to protecting the dignity of employees, preventing and sanctioning any form of harassment, and preparing a training plan for all staff, including management, on the protection of personal freedom and dignity.¹⁵

Other companies have focused on early psychological intervention and proximity. The pharmaceutical company Menarini introduced individual online psychological support sessions with qualified professionals, to be implemented during the validity of the agreement.¹⁶ As for what concerns the insurance sector, Assimoco encouraged the use of its psychological support platform to help counter emotional stress and isolation, particularly during periods of absence, as part of a broader approach titled 'Proximity to the Person'.¹⁷ Hera, one of the leading Italian multi-utilities, launched a comprehensive 'return to work' programme for employees with chronic illnesses, lasting twelve weeks and including sessions with psychologists, nutritionists, medical staff, and mindfulness experts, aimed at improving overall well-being and work ability.¹⁸ Lastly, the banking group Intesa Sanpaolo introduced specific tools for assessing psychosocial risks in the workplace, including work-related stress.¹⁹

These agreements highlight how collective bargaining is increasingly adopting a holistic approach to employee well-being, recognising mental health as a core component of occupational health - not a secondary concern. Through a variety of initiatives - including support services, preventive measures, training programmes, and organisational improvements - companies are working to cultivate a workplace culture rooted in dignity, inclusion, and psychological well-being.

4.2.2 Bilateral initiatives: supplementary healthcare funds

An increasingly important tool developed by social partners are supplementary health funds, which have taken on a growing role in recent years. By 2017, these funds had already surpassed six million members, and their expansion has continued - largely driven by significant investments made through collective bargaining.

13 Company-level agreement signed by Alpitour, assisted by the Industrial Unions of Turin and Pesaro, and the trade unions FILCAMS-CGIL, FISASCAT-CISL, and UILTUCS, on February 14, 2024.

14 Company-level agreement signed by Banco BPM, and the trade unions FABI, FIRST-CISL, FISAC-CGIL, UILCA, and UNISIN Falcri Silcea Sinfub, on October 10, 2024.

15 Company-level agreement signed by the GPI Group, and the trade unions FILCAMS-CGIL, FISASCAT-CISL, and UILTRASPORTI.

16 Company-level agreement signed by the Menarini Group, and the trade unions FILCTEM-CGIL, FEMCA-CISL, and UILTEC-UIL, along with the Territorial Secretariats and the Workplace Union Representatives (RR.SS.UU.) of the Group's companies where present, on January 29, 2024..

17 Company-level agreement signed by the Assimoco Group, and the company-level trade union representatives of FIBA-CISL, FISAC-CGIL, FNA, and UILCA-UIL, on June 5, 2024.

18 Company-level agreement signed by the HERA Group, and the trade unions FILCTEM-CGIL, FP-CGIL, FEMCA-CISL, FLAEI-CISL, FIT-CISL, UILTEC-UIL, UILTRASPORTI-UIL, FIADEL, and CISAL-FEDERENERGIA, on June 19, 2024.

19 Company-level agreement signed by Intesa Sanpaolo S.p.A., and the trade unions FABI, FIRST-CISL, FISAC-CGIL, UILCA, and UNISIN, on December 4, 2024.

These funds are especially notable within the industrial relations system, as they were among the first initiatives to promote a modern, holistic concept of workplace health. The first of these, Faschim, was established in 2004. Their creation reflects a shared commitment by employers and unions to protect workers' well-being in a broader sense, going beyond the traditional focus on workplace injuries or narrowly defined illnesses.

Supplementary healthcare funds typically provide a wide range of medical services to workers - and often to their families - addressing both physical and mental health needs. As workers' needs evolve, these funds are increasingly adapting to include support for psychological well-being, complementing the services offered by the National Health Service.

Among Italy's supplementary healthcare funds, several stand out for their mental health support initiatives:

- MetaSalute (for employees in the metalworking sector) offers annual psychotherapy sessions in specific cases, including support for adolescents with eating disorders, individuals recovering from serious oncological conditions, and postpartum psychological consultations.
- FASDAC (for managers in trade, transport, and services) reimburses both in-person and remote psychotherapy sessions. Coverage is extensive and thresholds are expanded in special cases, such as for individuals with autism.
- Fondo Est (serving commerce, tourism, and service sector workers) provides reimbursement for psychological services only in cases of certified disability and requires a medical prescription with proper documentation.
- Sanifonds Trentino (regional fund for artisans and other workers) promotes the SANlinMENTE programme, which partially reimburses costs for individual and family psychotherapy.
- CADIPROF (for employees of professional firms) includes psychological counselling and psychotherapy in its benefits, extended to underage children of members through its 'Family Package.' (Tiraboschi, 2023b).

This increasing focus on mental health shows how healthcare funds can complement the National Health Service, creating a more integrated support network for comprehensive well-being. As such, they represent a valuable resource for protecting and promoting mental health across diverse sectors of the Italian workforce.

5. Sectoral deep dive: industrial relations and psychosocial risks in the healthcare sector

5.1 Industrial relations system and its key actors

As already described in §4.1, the Italian collective bargaining system can be defined as multi-level, taking place both at sectoral and territorial/company level, and centrally organised (Leonardi and Pedersini, 2018). The Italian health sector follows this pattern, being covered by different sectoral-level collective agreements, negotiated at national level, regulating the employment relationship of most workers in the sector. These agreements delegate the regulation of certain topics (e.g. performance-based bonuses) to decentralised bargaining.

For workers active in the public sector (Sistema sanitario nazionale – National health system) the sectoral collective agreement of reference (CCNL Sanità), is signed by ARAN (National agency representing the public administration in collective negotiations activities) and FP-CGIL, FP-CISL, UIL FPL, FIALS, Nursind and Nursing up (trade union federations). This agreement covered 548,283 workers in 2022. Its last renewal occurred in 2022, exception made for the section covering workers active in research in the healthcare field, which was renewed in 2024.

For that concerns to private healthcare facilities, two separate sectoral collective agreements are currently in force. The first one is applicable to non-medical personnel employed in private hospitals (CCNL per il personale non medico dipendente degli IRCCS e delle strutture sanitarie ospedaliere iscritte ad Aiop e Aris) and is signed by ARIS and AIOP (employers' associations) and FP-CGIL, FP-CISL, UIL FPL (trade union federations); in 2023, it covered 146,322 workers (69% were women) and was applicable to 2,203 establishments. The second collective agreement is instead applicable to workers active in private nursing homes and rehabilitation centres (CCNL per il personale dipendente da residenze sanitarie assistenziali e centri di riabilitazione), is signed by ARIS (employers' association) and FP-CGIL, FP-CISL, UIL FPL (trade union federations); in 2023, it covered 16,496 workers and was applicable to 159 establishments (CNEL, 2024).

As it can be deduced from the previous paragraph, the trade union federations active in the healthcare sector affiliated to the three main Italian trade union confederations (FP-CGIL, FP-CISL, UIL FPL) sign both the collective agreement covering public sector workers and those covering private healthcare facilities. This shows the intention of coordinating strategies for the whole healthcare sector, in order to harmonise working conditions standards for public and private healthcare workers.

With concern to decentralised bargaining, official data for the healthcare private sector is unavailable,²⁰ while, according to the National Council for Economy and Labour (CNEL), more than 5,000 establishment-level collective agreements have been signed in the healthcare public sector from October 2015 to March 2025 (CNEL, 2025).

²⁰ This is due to the lack of a mandatory deposit system with concern to decentralised collective agreements in the private sector. Art. 40-bis of Leg. Decree 165/2001 instead compels public administrations to deposit sectoral and decentralised collective agreements at the National Council for Economy and Labour, which organises and classifies them according to signing date, sector, and territory of applicability.

5.2 Field research results: survey data

As mentioned in the 'Methodology' section of the present report (§1.1) from March to June 2025 the authors administered a survey aimed at exploring the impact of psychosocial risks on Italian healthcare workers, together with their perception of the role and the actions of social partners, policymakers and other actors (e.g. employers, civil society organisations, external/internal services for prevention and protection at work) in addressing psychosocial risks in their work environment. Through the support of the project coordinator, 255 complete responses belonging to the targeted group have been gathered.²¹

The following paragraph provides an analysis of the results of the survey.

5.2.1 Information on organisations and respondents

As for what concerns the demographic characteristics of the respondents, it is to be noted how the majority of them are women (58%). This data reflects the composition of the Italian - and European - healthcare sector, which is primarily composed by women.²²

With regard to the age of respondents, it is notable that the largest age brackets represented in the pool of respondents are those including workers aged 25-34 (25%) and 35-44 (24%). However, around 7% of respondents declare that they are over 65 years of age, which is a relatively high number considering the physical and mental demands which characterise healthcare professions.

In terms of occupations declared by the respondents, it is interesting to note that 35% declare themselves to be in professional occupations (e.g. doctors, engineers, therapists and scientists), while 4% describe themselves as being in technical occupations or associate professional roles (e.g. nurses, technicians, doctor's assistants, health inspectors, paramedics and physiotherapists). The majority of the respondents is part of a permanent employment contract (65%), works in the public healthcare sector (49% - compared to 39% in the private healthcare sector) in a workplace with more than 250 employees (48%).

As far as trade union density is concerned, 36% of respondents declare to be part of a union. This data appears in line with overall data concerning trade union density in Italy, especially concerning the large share of public sector workers among respondents (§4.1).

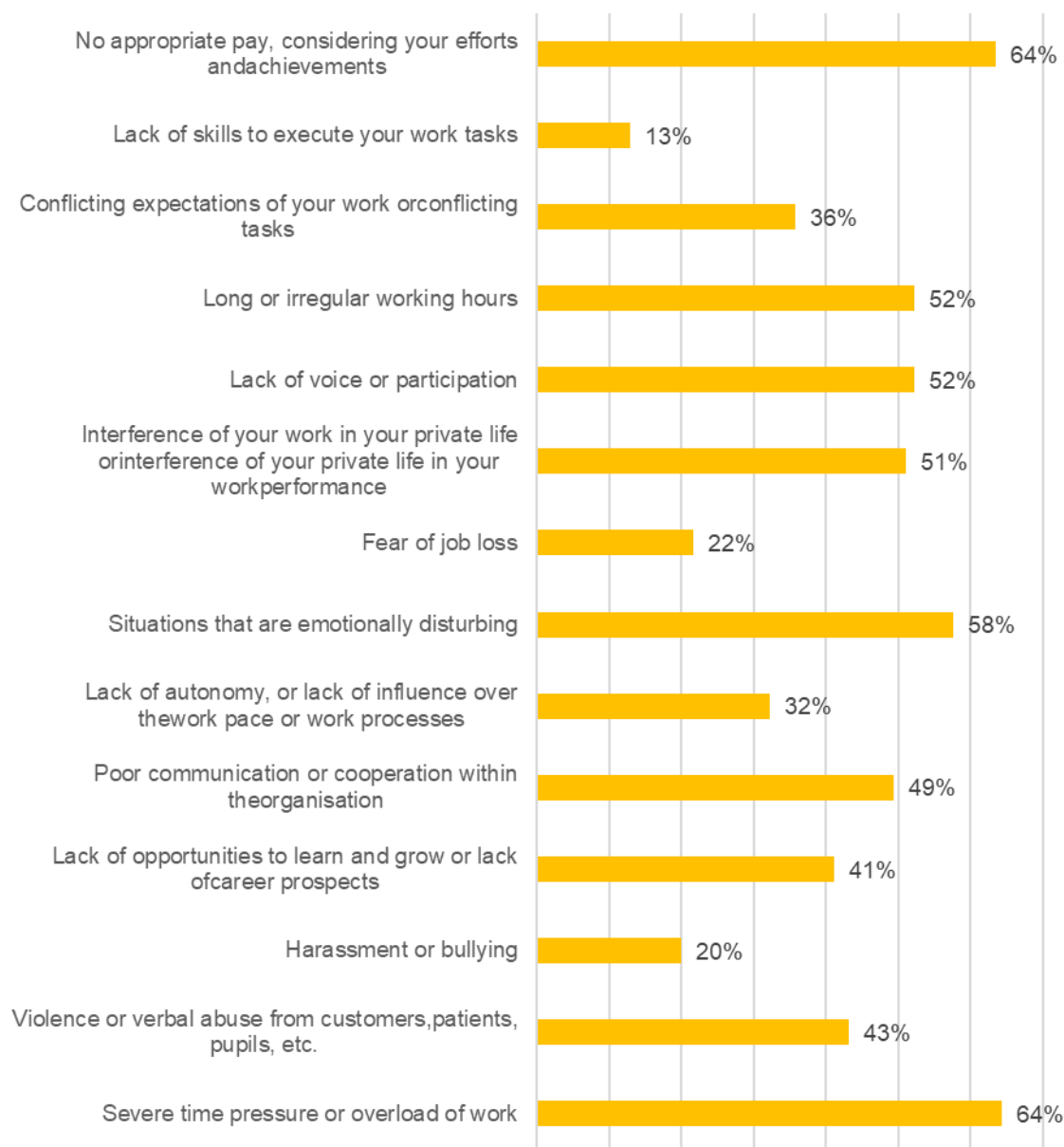
5.2.2 Exposure to psychosocial risks at work

When asked about the psychosocial risks they feel exposed to in their job, Italian healthcare workers highlight severe time pressure and work overload (64%), lack of appropriate pay (64%), emotionally disturbing situations (58%), lack of voice or participation (52%), long or irregular working hours (52%) and work-life interference (51%) as the main risks. The less frequently mentioned risks were fear of job loss (22%), harassment or bullying (20%), and lack of skills to execute their tasks (13%).

²¹ The total number of respondents who provided complete answers to the survey is 277. However, since 22 respondents affirmed to not being active in the healthcare sector, their answer were not analysed in the present report.

²² Eurostat (2021), Majority of health jobs held by women <<https://ec.europa.eu/eurostat/web/products-eurostat-news/-/edn-20210308-1>>

Figure 1. Exposure to psychosocial risks



Source: own analysis of PSYR-IR survey data among Italian healthcare workers

When analysing the answers provided by female respondents only, it is notable that the perception of exposure to psychosocial risks increases for almost all of those listed in the survey. Notably, the greatest increases can be observed in responses relating to time pressure and work overload (experienced by 70% of surveyed female workers), violence and verbal abuse (50%), lack of professional growth opportunities (50%), poor communication or cooperation (55%), emotionally disturbing situations (63%), conflicting expectations or tasks (42%). Surprisingly, the percentage of female workers affected by work-life interference shows a slight decrease (51%) if compared to the general figure of 52%.

Some healthcare workers who took part in the survey mention additional psychosocial risks they feel particularly vulnerable to, such as unrealistic expectations from the public, disorganisation and internal contrasts with colleagues – often deemed to be insufficiently skilled.

“After 10 years working with terminal patients, I feel emotionally tired and oppressed.” (R11248)

“People have growing expectations towards us: more often than not, they tend to want ‘everything and now.’ (R22050)

5.2.3 OSH practices and culture in organisation

Coming to the survey section concerning OSH practices and culture in their organisations, respondents have been asked about the attitude of their senior management towards mental health. Responses are mildly negative, with only 27% of respondents reporting that senior management shows support for stress prevention through involvement and commitment, and only 31% that they consider employee psychological health to be as important as productivity. Similarly, just under a third (28%) of respondents report good levels of communication about psychosocial safety issues that may affect them and the involvement of all levels of their organisation in stress prevention.

Additionally, 61% of respondents identify a lack of awareness among management concerning mental health as an obstacle to dealing with psychosocial risks within their organisation. According to the majority of respondents, a lack of expertise in providing special support also appears to be an issue (56%), as does a reluctance to talk openly about these issues (54%). Furthermore, 46% of respondents report a lack of awareness among staff.

Figure 2. Obstacles to dealing with psychosocial risks



Other obstacles to managing psychosocial risks include frequent dehumanisation of workers, an unfavorable work environment, uncertainty about job roles, fear of talking openly about the subject, constant understaffing and a lack of time and resources - and, in some cases, the will - to cater to workers' psychological needs.

“Psychosocial risk management is often only a subject of discussion on paper.” (R10275)

“After an episode of harassment, my organisation has not been able to protect me. I had to take the issue into my own hands.” (R20119)

“Healthcare personnel are considered only as a ‘number’ to fill shifts and roles.” (R20306)

Respondents were then asked to indicate how much they agreed with a series of statements concerning their organisation's culture and practices with regard to mental health prevention.

As highlighted by previously mentioned surveys (§2.3), it is worth noting that stigma surrounding mental health issues appears to be quite common in Italian workplaces. Indeed, 50% of Italian healthcare workers state that disclosing a mental health condition would negatively impact their career (32% agree - 18% strongly agree), and 36% that they would not feel comfortable discussing their mental health with their manager or supervisor (13% strongly disagree - 23% disagree).

In general, respondents appear not to be inclined to discuss any kind of health and safety issue with their immediate supervisors (38%).

When asked if they are encouraged to report health and safety issues (not necessarily related to mental health), survey results show a more even distribution among respondents who are (37%) and those who aren't (34%). Solidarity among workers concerning the reporting of dangerous OSH situations appears to be stronger: 75% of respondents report to ask their colleagues to 'stop work which they believe is performed in an unsafe manner', and 53% are confident that their colleagues would do the same. 63% of respondents declare to report 'any dangerous situations they see'.

Table 1. OSH management practices in the company, percentages

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	I don't know/prefer not to answer
Health and safety problems are addressed promptly in my workplace	14%	22%	31%	22%	9%	2%
Disclosing a mental health condition would impact negatively on my career	2%	17%	27%	32%	18%	3%
I would feel comfortable speaking to my manager or supervisor about my mental health	13%	23%	28%	23%	9%	4%
There are good measures to protect workers' health in my workplace	15%	22%	29%	22%	9%	4%
Workers are encouraged to report safety and health issues in my workplace	13%	21%	26%	26%	11%	3%
I would rather not discuss health and safety issues with my immediate supervisor	6%	22%	30%	23%	15%	4%
My colleagues will stop me if I work unsafely	5%	13%	26%	39%	14%	3%
I ask my colleagues to stop work which I believe is performed in an unsafe manner	2%	5%	16%	38%	37%	2%
I report any dangerous situations I see	1%	7%	26%	41%	22%	2%

The survey investigates characteristics of work organisation in the Italian healthcare sector and how the respondents reacted to them individually.

Overall, workers' perception of their attitude towards flaws in their workplace organisation and their ability to manage work-related issues/changes appears to be quite positive.

The majority of respondents affirm that they often cope well with heavy long-term workloads (38%) and effectively respond to work-related crises (40%). 49% of surveyed workers state that they often learn from their mistakes and improve their work methods, and 49% that they often analyse their work performance to improve it. Respectively, 18% and 16% of respondents state that they always put similar mechanisms in place. According to 41% of respondents, they often take feedback at work well, including criticism (33% - sometimes, 16% - always). 39% of respondents often ask for help when they need something for work (18% - always), and 38% often see work-related changes as an opportunity to develop (13% - always).

Opinions concerning work organisation as a whole are slightly more negative.

The majority of respondents emphasise that people only sometimes persevere until a problem is solved (33%). The options 'rarely' and 'often' were selected by 25% and 23% of surveyed workers, respectively. Similar answers were given in relation to the following statements: 'in our organisation, there are enough opportunities to cope with unexpected changes' (22% rarely, 36% sometimes, 25% often), 'when key employees are absent from work, there are always people who can fill their role' (25% rarely, 33% sometimes, 23% often), 'we have confidence that in a crisis, our organisation is well managed' (22% rarely, 36% sometimes, 22% often). According to the respondents, only a few Italian healthcare workplaces are known innovative organisations, with 43% of respondents selecting options 'never' and 'rarely'.

Lastly, respondents have been asked to indicate their level of agreement with general statements concerning health and safety levels in their organisation, and how promptly issues on the matter are addressed. Only 9% of respondents strongly agree that their workplace presented good measures to protect workers' health and safety, while 15% strongly disagree. Similarly, only 9% of respondents strongly agree that health and safety issues are addressed promptly in their workplace, while 14% strongly disagree.

Table 2. Attitudes of workers in dealing with stressors (resilience), percentages.

	Never	Rarely	Sometimes	Often	Always
I successfully cope with a heavy long-term workload	5%	14%	35%	38%	8%
I handle work-related crises effectively	2%	10%	40%	40%	9%
I learn from my mistakes and then improve my work methods	1%	6%	25%	49%	18%
I analyse my work performance and make my work better and better	1%	6%	27%	49%	16%
I take feedback at work well, including criticism	2%	8%	33%	41%	16%
I ask for help when I need something for work	3%	12%	28%	38%	18%
I see work-related changes as an opportunity to develop	3%	9%	36%	39%	13%
In our organisation, people don't give up until the problem is solved	7%	25%	33%	23%	11%
In our organisation, there are enough opportunities to cope with unexpected changes	9%	22%	36%	25%	7%
When key employees are absent from work, there are always people who can fill their role	8%	25%	33%	23%	11%
We have confidence that in a crisis, our organisation is well managed	11%	22%	36%	22%	9%
We are known as an innovative organisation	13%	30%	29%	18%	10%

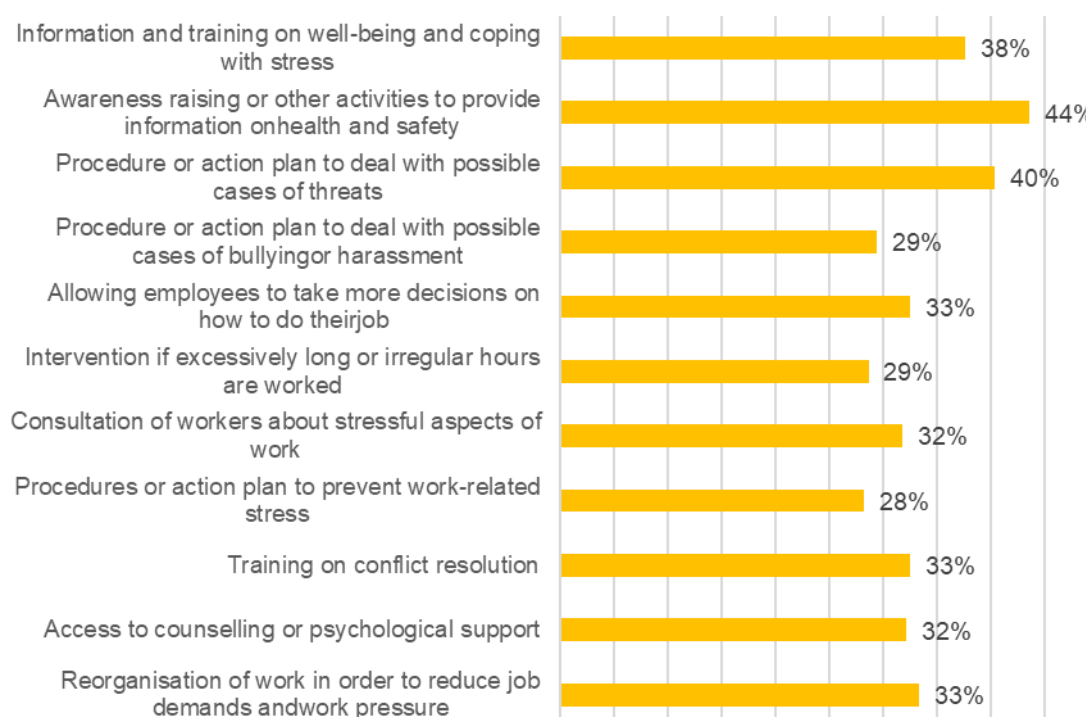
5.2.4 OSH practices and relevant actors present in the organisation

One of the most critical questions of the survey was dedicated to OSH practices related to mental health present in respondents' organisations. At a first glance, it is worth noting that none of the practices listed by the creators of the survey is indicated as 'present' by the majority (50%) of Italian healthcare workers, showing a generalised scarcity of measures aimed at preventing and/or managing the insurgence of psychosocial risks.

The measure most frequently reported as being present is raising awareness or carrying out other activities to provide information on health and safety (44% of respondents). It is to be mentioned, though, that periodic OSH training is required by Italian OSH legislation (§3). Therefore, the fact that only 44% of respondents indicate this resource as 'present' is nonetheless quite alarming.

More than 35% of respondents indicate the presence of procedures or action plans to deal with possible cases of threats (40%) and of information and training on well-being and coping with stress (38%). All other measures (e.g., reorganisation of work in order to reduce job demands and work pressure, access to counselling or psychological support, training on conflict resolution, consultation of workers about stressful aspects of work, intervention if excessively long or irregular hours are worked, allowing employees to take more decisions on how to do their job) fall below the 35% threshold, with the less frequently present measures being procedures or action plans to prevent work-related stress (28%) and intervention if excessively long or irregular hours are worked (29%).

Figure 3. OSH practices available in the organisation



Source: own analysis of PSYR-IR survey data among Italian healthcare workers

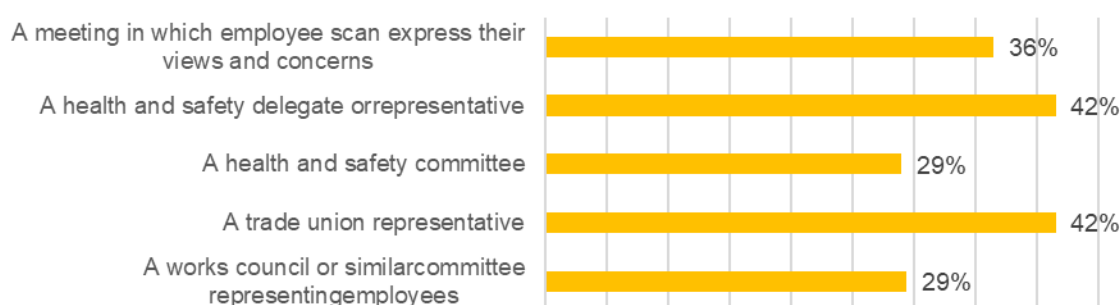
It is worth noting that respondents active in the private sector more frequently report - if compared to overall data - the presence of all listed measures related to mental health protection, while public sector workers report these measures to be less frequently present. Wider discrepancies can be observed in the following areas: reorganisation of work in order to reduce job demands and work pressure (present according to 56% of private sector workers, and according to 20% of public sector workers), possibility of increased autonomy in their job (present according to 50% of private sector workers, and according to 22% of public sector workers), procedures and/or action plans to prevent work-related stress (present according to 43% of private sector workers, and according to 21% of public sector workers).

Considering the size of the establishments where respondents work, it seems that measures related to mental health protection are more prevalent in microenterprises (1-9 employees) and small enterprises (10-49 employees) than in medium-sized enterprises (50-249 employees) and large enterprises (250+ employees). For instance, access to counselling or psychological support is available in 34% of microenterprises, 44% of small enterprises, 30% of medium-sized enterprises, and 31% of large enterprises. Awareness-raising and training activities on mental health appear to be the most evenly distributed measures across enterprises of different sizes.

Respondents have then been asked about the involvement of employees and/or their representatives in discussions concerning psychosocial risks in the workplace.

Individual representatives, e.g. trade union representatives or health and safety delegates, appear to be more frequently involved in such discussions (42% of respondents), compared to collective bodies or meetings. According to 29% of respondents, works councils and health and safety committees are consulted, while 36% of respondents report meetings where employees can express their views and concerns on the topic.

Figure 4. Work groups or representatives



Source: own analysis of PSYR-IR survey data among Italian healthcare workers

With concern to the direct involvement of workers in psychosocial risks prevention, 31% of respondents affirm they are involved in identifying possible causes for work-related stress, such as time pressure or difficult clients, 29% in the design and implementation of measures following a risk assessment, 27% in the design and set-up of measures to address psychosocial risks.

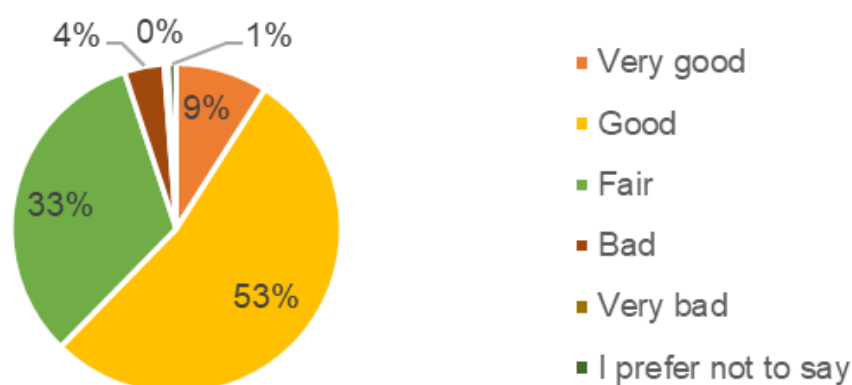
When asked about the success of these actors and/or initiatives in reducing stress and psychosocial risks, 33% of respondents answer negatively and 29% report they are only partially successful. 20% of respondents answer positively but express nonetheless the need for improvement.

5.2.5 Health and well-being

The last section of the survey inquires about Italian healthcare workers' health levels.

When asked to rate their general level of health, the vast majority of respondents rates it 'fair' (33%) or 'good' (53%).

Figure 5. Overall perception of health, percentages



Source: own analysis of PSYR-IR survey data among Italian healthcare workers

However, when asked more detailed questions, a large percentage of workers identify health problems that are caused or exacerbated by their work in the last 12 months. The most common answers are overall fatigue (71%), headaches and eyestrain (61%), bone, joint or muscle problems or pain (51%), sleep problems (51%) and stress, depression or anxiety (49%).

When analysing the responses of workers in professional (e.g. doctors) or technical (e.g. nurses, technicians, doctor assistants, health inspectors, paramedics, physiotherapists) occupations, it seems that those in professional occupations are generally more susceptible to work-related health problems than those in technical occupations. For instance, 73% of professional workers report overall fatigue, and 53% experience sleep problems, compared to 35% and 49% of technical workers, respectively.

Other work-related physical and mental health issues reported by respondents include weight gain, back pain, hypertension, night-shift-related insomnia, panic attacks, and chronic fatigue.

"I sought professional psychological help due to work-related stress caused by my employers. The workload is so challenging that I am forced to work from home outside of normal working hours." (R20052)

"I have been close to burnout due to difficult relationships with patients and issues with conflict resolution." (R20473)

"I have experienced anxiety, low self-confidence and fear caused by my colleagues. I have doubts about myself and my abilities." (R20637)

Despite these symptoms of mental health issues, healthcare workers report a positive attitude towards their job. 39% of respondents state that they often feel bursting with energy at work (35% sometimes), and that they feel enthusiastic about it (27% sometimes). Answers concerning concentration and immersion in work activities reveal an even higher proportion of positive responses, with 74% of workers stating that they often or always feel immersed in their work.

Consistently, only 29% of respondents reported sometimes having trouble staying focused at work; the most frequently selected answers were 'never' (20%) and 'rarely' (36%). Similarly, only 31% of respondents reported sometimes struggling to feel enthusiastic about their job; the most frequently selected answers were 'never' (15%) and 'rarely' (28%). Another rarely experienced symptom appears to be an inability to control emotions at work (24% sometimes, 43% rarely, 24% never). Mental exhaustion appears to be the most common symptom experienced by Italian healthcare workers instead, with 23% of respondents experiencing it 'often' and 42% 'sometimes'.

Table 3. Burnout risk items, percentages

	Never	Rarely	Sometimes	Often	Always	No answer
At work, I feel mentally exhausted	7%	21%	42%	23%	5%	1%
I struggle to feel any enthusiasm for my work	15%	28%	31%	17%	9%	1%
At work, I have trouble staying focused	20%	36%	29%	11%	2%	2%
At work, I feel unable to control my emotions	24%	43%	24%	5%	2%	2%

Source: own analysis of PSYR-IR survey data among Italian healthcare workers

Finally, respondents have been asked if they had any additional comments on the survey topic.

One respondent emphasises that Italian institutions should pay more attention to the nursing profession, given that nurses experience a variety of issues that can have a detrimental effect on their long-term health and that their wages are exceptionally low.

Other respondents highlight that long working hours are commonplace in the healthcare sector and that the constant need to be contactable by patients after working hours has a significant impact on their personal lives.

Some workers suggest ways to improve working conditions in healthcare facilities, such as organising training courses dedicated to stress management and patient-worker relationships, and/or working groups involving mental health professionals to tackle problematic cases.

One respondent states that Italian workplace culture, which - in their opinion - is based on exploitation and discrimination, had led them to seek career opportunities abroad.

6. Conclusions

The investigation of psychosocial risks in the Italian context highlighted the strengths and weaknesses of the system, which, through a multi-level approach, aims to ensure the wellbeing of workers in Italy. The country's regulatory framework is relatively advanced, and the protection of health, understood as a holistic psycho-physical well-being, is widely addressed in the Constitution and supported by laws regulating health in the workplace (Legislative Decree No. 81/2008, Article 2087 of the Civil Code). However, Italian legislation currently does not present any explicit mention of psychosocial risks; the only references can be found in provisions that oblige employers to consider all risks related to work and employees' duties, including those that may affect their psycho-physical health. Among these is work-related stress, the national definition of which is based on the European Framework Agreement on Work-related Stress (2004), emphasising the importance of the role of social partners in the evolution of this topic.

Desk research activities and regulatory framework analysis also clarified the role of social partners, who, according to Italian legislation, can act at different levels to promote specific initiatives and raise awareness among stakeholders about the evolution of OSH, taking into account changes affecting work organisation and content, as well as emerging needs. It is also to be noted how, thanks to the Italian structured industrial relations landscape, characterised by an above EU average unionisation rate and collective bargaining coverage, social partners could potentially have the strength to play a significant role in promoting collective measures dedicated to mental health prevention.

The importance of the role of social partners in tackling psychosocial risks has also been underlined by relevant stakeholders interviewed in the context of the PSYR-IR project (HR representatives, workers' representatives, members of Italian institutions dedicated to OSH, workers active in the healthcare sector). Interviewees stressed the need for psychosocial risk prevention to become a higher priority on social partners' agendas. Specific initiatives were recommended, such as lobbying national stakeholders, training workers and their representatives, facilitating connections with local health services, and designing awareness campaigns - making use of sectoral, territorial and company-level collective agreements and bilateral tools like supplementary health funds.

Lastly, through the administration of a targeted questionnaire, the authors were able to gather a more specific insight on the perspectives of workers active in the Italian healthcare sector, who were thus able to share their perceptions of the impact of psychosocial risks in their workplaces. What emerged is that over half of the respondents feel particularly exposed to relevant psychosocial risks factors, such as severe time pressure and work overload, lack of appropriate pay, emotionally disturbing situations, which in many cases leads to mental and physical distress. This highlights the importance of participatory company procedures aimed at improving the working environment.

However, despite growing attention and sensitivity towards mental health issues in the post-COVID-19 context, employees report that senior management frequently lacks awareness of this topic and is often reluctant to go beyond legal compliance. Survey results, in fact, indicate a wide-

spread lack of measures aimed at preventing and managing the emergence of psychosocial risks in Italian healthcare workplaces.

Furthermore, employees and/or their representatives are rarely involved in discussions of such measures, and, when they are, their involvement is not particularly effective.

Company culture and working environment directly influence employees' wellbeing, who struggle to dedicate time and resources to this aspect. Survey results show how stigma related to mental health issues appears still quite present in Italian workplaces: the resistance to openly discuss these topics represents one of the main barriers to the creation of effective prevention strategies.

A cultural shift in healthcare workplaces is therefore desirable - one that embraces initiatives to support employee well-being through education, training, and access to support services.

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