Croatia: Health and Employment
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Tammy Boyce and Jadranka Mustajbegović
Abstract
Being in good health and improving health benefit individuals, employers, wider society and the national economy. A significant problem in Croatia is the large number of people not working because of health-related problems. Work-related physical and mental disorders represent an increasing burden to the health-care system and employers with mental disorders as the main cause of disability. In Croatia long working hours, a perceived higher level of job insecurity and poor work–life balance contribute to high stress levels. Integrated comprehensive policies targeting the structural characteristics of organizations are more effective and cost-effective in addressing work-related health issues. Key stakeholders are: national, regional and local government policy-makers; ministries; employers; unions; and nongovernmental organizations. The most effective interventions aim to improve work quality, employee health and occupational health support; promote active labour market programmes and sustainable and equitable economic growth; and integrate lifelong learning into work and health policies.

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Contributors

Authors

Tammy Boyce
WHO Consultant, WHO European Office for Investment for Health and Development, Venice, Italy

Jadranka Mustajbegović
Professor, WHO Collaborating Centre for Occupational Health, Zagreb, Croatia
Abbreviations

ALMP  active labour market programme
EU    European Union
ILO   International Labour Organization
NGO   nongovernmental organization
Executive summary

Being in good health and improving health is beneficial for individuals, employers and the wider society, as well as to the nation’s economy. Although many European Union (EU) countries face similar problems related to high youth unemployment and an ageing population, in Croatia a more significant problem is the large number of people not working owing to health problems. A healthy workforce is more productive and resilient, with reduced absenteeism and presenteeism. In 2015 the financial costs to employers of occupational health support for work-related illness and injuries in Croatia were double those of the government (604.6 million vs 297 million Croatian kuna). Poor working conditions are associated with higher rates of stress, raised blood cholesterol, musculoskeletal disorders and mental health consultations with medical practitioners. These result in increased costs to Croatia’s health-care system and represent a large burden for employers.

Since 2010 the majority of persons with disability have not found work. The availability of jobs for people with disabilities varies across Croatia’s regions. The total number of participants in active labour market programmes (ALMPs) has fluctuated since 2011. However, the percentage of people with disabilities participating in ALMPs declined between 2014 and 2016.

Mental disorders, including depression and anxiety, are the main cause of disability and early retirement in almost every country in Europe, and are a major burden to economies. This is also the case in Croatia. On average, people in Croatia work longer hours compared with other EU countries. They perceive a higher level of job insecurity and have a poorer work–life balance, contributing to high stress levels. Integrated comprehensive policies and approaches are more effective and more cost-effective than single interventions in addressing issues related to work and health.

Many key stakeholders are involved in implementing and developing policies to improve health and well-being and work, including national, regional and local governments, along with various ministries, employers, unions, and nongovernmental organizations (NGOs). These stakeholders can select from a range of policies and interventions. Effective interventions include those aimed at:

- improving the quality of work;
- improving the health of employees;
- shifting to more ALMPs;
- promoting sustainable and equitable economic growth;
- integrating lifelong learning into work and health policies; and
- improving and expanding the range of occupational health support.

Policies targeting the structural characteristics of organizations are likely to be more effective than those concentrating on the individual behaviour of employees.
Objectives of the report

The report aims to support Croatia in developing a strategic approach to (i) promote health at work and (ii) improve the health, social welfare and well-being of all in society through:

1. examining the current situation in Croatia and the challenges, gaps and opportunities in relation to employees’ health protection;
2. identifying recommendations and policies for future activities in Croatia; and
3. providing examples of similar national experiences related to developing national occupational health and safety programmes and promoting and maintaining good health at work.
The relationship between health, work and productivity

*Improving health = improving productivity*

Health and work are fundamentally linked in two ways: work can harm, and work can protect and promote good health. A healthy workforce is more productive and resilient, with reduced absenteeism and presenteeism. Poor health affects individuals, health-care systems, employers and the nation’s economy (1).

- In 2015 the financial costs to employers of occupational health support for work-related illness and injuries in Croatia were double those of the government (604.6 million vs 297 million Croatian kuna).
- An EU-funded project estimated the cost of work-related depression to be €617 billion annually (in Europe alone) (2):
  - employer costs: absenteeism and presenteeism, €272 billion; loss of productivity, €242 billion;
  - health-care costs: €63 billion; and
  - social welfare costs (disability benefit payments): €39 billion.

Poor working conditions are associated with higher rates of stress, raised blood cholesterol, musculoskeletal disorders and mental health consultations with medical practitioners (3). Therefore, good health and improvement in health are beneficial for individuals, employers and the wider society, as well as for the nation’s economy.

- Cardiovascular disease mortality rates show that improving health leads to growth in the gross domestic product.
- Retention of employees is better when their well-being is better – if employees do not feel that an employer values their health and well-being, then they are four times more likely to leave (4).
- In the United Kingdom, organizations with a high level of employee well-being have outperformed the stock market by 2–3% per year over a 25-year period (5).

The International Monetary Fund states that investing in human capital is crucial for a country’s long-term growth and recommends investing in equitable access to health and education to:

- improve access to disadvantaged groups; and
- ensure universal access to health services (by reducing/waiving user charges for those in low-income households) (6).
Health and work

Employment and good working conditions have powerful effects on health and health equity. Poor working conditions reduce physical and mental health through exposure to organizational hazards such as long working hours and shift work, in addition to physical, chemical and biological hazards. Psychosocial factors at work are the key causes of stress-related diseases. Work-related stress has the following main causes.

- **Effort/reward imbalance:** employees feel a lack of control, lack of autonomy, conflict, and poor job satisfaction (7). When people have some control over their social and work environments, they are more likely to take action to improve their circumstances and feel able to assume or share responsibility for what happens to them.

- **Poor employment conditions:** poor pay, inconsistent and/or insufficient hours, uncertain or insecure work (precarious work), job insecurity, risk of redundancy, and jobs where the amount of responsibility and effort exceeds the rewards.
  - On average, people in Croatia work longer hours than people in other EU countries. They perceive a higher level of job insecurity and have a poorer work–life balance (8).
  - A national survey of Croatian workers found that many are exposed to occupational hazards. The most common occupational hazards are psychosocial and organizational, such as low earnings, long working hours and poor working conditions (experienced by 83% of employees) (8).

Illness has a larger impact than injury on morbidity and mortality (9). Therefore, the health of Croatia’s workforce will become more important as its retirement age increases. Although Croatia’s life expectancy is high, its healthy life expectancy is one of the lowest in the EU (Box 1).

**Box 1. Life expectancy for men and women in Croatia, 2016**

Women: life expectancy, 84 years; healthy life expectancy, 70 years.
Men: life expectancy, 81 years; healthy life expectancy, 70 years.

Source: Eurostat, 2019 (10).

Temporary and precarious work

Croatia was heavily impacted by the economic crisis, which resulted in a significant increase in non-standard or precarious employment (short- and fixed-term contracts and part-time work) and unemployment. According to a report by the Institute for Development and International Relations,
the most widespread form of non-standard employment in Croatia is fixed-term work (16.9% in 2014) (11). In 2015 more than 95% of all new employment in the country was fixed-term work, overshadowing all other forms of non-standard employment. Furthermore, some categories of workers (such as youth) were disproportionally affected by the increase in fixed-term employment.

The number of people in temporary and precarious work is growing, and accounts for approximately 15% of Europe's workforce (3). Such jobs are more common among women, manual workers, immigrants and workers with low educational attainment. The problems related to temporary and precarious work are as follows.

- Temporary workers report a higher incidence of work-related stress and greater exposure to physical health risk factors at work, with less autonomy, fewer learning opportunities and less support from their colleagues (12).
- A review of 27 studies found the most consistent associations of temporary work were adverse effects on mental health (3).
- Temporary and precarious workers (often from agricultural and producer cooperatives) are usually excluded from contribution-based benefits and the respective social protection, and their earnings (if any) are poorly regulated (3).
- Temporary work does not usually lead to permanent work, with workers becoming trapped in insecure and precarious jobs.

**Mental health at work**

Mental health challenges are among the greatest health challenges across the WHO European Region.

- Mental health problems, including depression and anxiety, are the main cause of disability and early retirement in almost every country in Europe, representing a major burden to national economies (13).
- People with mental health problems have a two-fold greater risk of losing their jobs and are disproportionately out of work compared with the working population (14).
- Work-related stress is higher for employees with lower educational qualifications and for those in low-skilled jobs or working in locations where there are limited alternative employment opportunities (3).

**Employment, unemployment and disability in Croatia**

The unemployment rate in Croatia is continuing to fall: in May 2017 15.5% of women and 11% of men were recorded as unemployed. However, the number of people in work is also falling, suggesting that people are not finding jobs but are instead either emigrating or reaching pensionable age.

Government spending on disability benefits (including disability pensions) is higher in Croatia compared with other EU countries (3.6% versus 2.0%; data for 2013) (15). In addition, the proportion
of retired people receiving a disability pension is much higher in Croatia compared with the EU average: one quarter of Croatia’s retired population receives disability pension compared with 14% in the EU (16).

In May 2017 7107 (3%) of people registered as unemployed had a disability (56% of men, 44% of women). In 2016 in Croatia the most common reason for claiming disability rights via the Croatian Pension Insurance Institute was diagnosis of a mental disorder (39% of claimants) (16). Since 2010 most people with disability have not found work (Fig. 1).

**Fig. 1. Number of people with disabilities, unemployed and employed, 2010–2015**

![Graph showing number of people with disabilities, unemployed, and employed from 2010 to 2015.](image)

*Source: Croatian Employment Service, 2017 (17).*

Long-term unemployment continues to be a significant problem in Croatia, as it is in many nations in Europe. In 2015 almost half of the 22 million unemployed in the EU were long-term unemployed (18). Long-term unemployment among young people has far-reaching effects (subsequent lower pay, higher unemployment, more mental health problems) (19) because career prospects are largely determined in the first 10 years of working life (20).

Unemployment is high for people with disabilities and the employment rate for people with disabilities varies across Croatia’s regions (Box 2). Table 1 shows the number of people with disabilities who found work in 2015. Varaždinska was the best-performing region: 3.3% more people with disabilities had found jobs than were unemployed. The worst-performing regions were those with the highest percentage differences between unemployed and employment people. Note that four regions (Dubrovačko-Neretva, Ličko-senjska, Šibensko-krninska and Virovitičko-Podravska) had fewer than 100 people in either category.
Box 2. Human rights for all people with disabilities

Since 2007 the Croatian Government and legal system have adopted international standards, translated them into law and undertaken a number of reforms and national programmes regarding the rights of people with disabilities. In August 2007 Croatia became the fourth country in the world to ratify the United Nations Convention on the Rights of Persons with Disabilities (21, 22). In addition, through its Constitution, the Republic of Croatia has committed to providing special protection and care for people with disabilities and encouraging their integration into society.

However, despite this policy leadership, Croatia has not met its obligations under the international treaty: legislation remains inconsistent, implementation continues to be irregular and a lack of coordination among the responsible governmental bodies leaves many people with disabilities without much-needed support (23). The United Nations Human Rights Council, the European Commission, civil society organizations and national human rights institutions have all stated that Croatia is not doing enough to improve the lives of people with intellectual disabilities and mental disorders or to bring the country’s laws, policies and practice into line with international requirements and standards (23).

Table 1. Number of people with disabilities who were unemployed and found employment, by region, 2015

<table>
<thead>
<tr>
<th>Region</th>
<th>Unemployed (%)</th>
<th>In employment (%)</th>
<th>Difference (unemployed vs employed; %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varaždinska</td>
<td>3.8</td>
<td>7.1</td>
<td>−3.3</td>
</tr>
<tr>
<td>Međimurska</td>
<td>2.5</td>
<td>4.4</td>
<td>−1.9</td>
</tr>
<tr>
<td>Krapinsko-Zagorska</td>
<td>3.9</td>
<td>5.4</td>
<td>−1.5</td>
</tr>
<tr>
<td>Istarska</td>
<td>2.3</td>
<td>3.5</td>
<td>−1.2</td>
</tr>
<tr>
<td>Dubrovačko-Neretvanska</td>
<td>1.3</td>
<td>2.2</td>
<td>−0.9</td>
</tr>
<tr>
<td>Šibensko-krinska</td>
<td>1.1</td>
<td>1.7</td>
<td>−0.6</td>
</tr>
<tr>
<td>Bjelovarsko-bilogorska</td>
<td>4.9</td>
<td>5.4</td>
<td>−0.5</td>
</tr>
<tr>
<td>Zadarska</td>
<td>1.9</td>
<td>2.2</td>
<td>−0.3</td>
</tr>
<tr>
<td>Brodsko-Posavska</td>
<td>4.7</td>
<td>5.0</td>
<td>−0.3</td>
</tr>
<tr>
<td>Virovitičko-Podravska</td>
<td>1.1</td>
<td>1.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Ličko-senjska</td>
<td>0.5</td>
<td>0.5</td>
<td>0.0</td>
</tr>
<tr>
<td>Vukovarsko-Srijemska</td>
<td>3.6</td>
<td>3.5</td>
<td>0.1</td>
</tr>
<tr>
<td>Koprivničko-Križevačka</td>
<td>3.2</td>
<td>2.8</td>
<td>0.4</td>
</tr>
<tr>
<td>Požeško-Slavonska</td>
<td>2.3</td>
<td>1.8</td>
<td>0.5</td>
</tr>
<tr>
<td>Zagreb (city)</td>
<td>20.9</td>
<td>20.4</td>
<td>0.5</td>
</tr>
<tr>
<td>Karlovačka</td>
<td>3.2</td>
<td>2.6</td>
<td>0.6</td>
</tr>
<tr>
<td>Zagrebačka</td>
<td>8.7</td>
<td>7.9</td>
<td>0.8</td>
</tr>
<tr>
<td>Sisačko-Moslavčka</td>
<td>5.9</td>
<td>4.6</td>
<td>1.3</td>
</tr>
<tr>
<td>Primorsko-Goranska</td>
<td>6.3</td>
<td>4.3</td>
<td>2.0</td>
</tr>
<tr>
<td>Osječko-Baranjska</td>
<td>10.3</td>
<td>8.2</td>
<td>2.1</td>
</tr>
<tr>
<td>Splitsko-Dalmatinska</td>
<td>7.7</td>
<td>5.6</td>
<td>2.1</td>
</tr>
</tbody>
</table>

Source: Croatian Employment Service, 2017 (17).
Since 2009 the number of people with disabilities who are in work has increased; however, so too has the number of people with disabilities who are unemployed. It is difficult for people with disabilities to secure employment in Croatia (21). A number of policies have been implemented to improve the employment prospects of people with disabilities, such as the quota system, which requires any organization with more than 20 employees to hire a certain number of persons with a disability. However, 54% of organizations, including government departments, have opted out of the quota system and pay a fee rather than employ a person with disabilities (24). Employers need more support (both financial and guidance) in employing people with disabilities. The International Labour Organization (ILO) provides extensive advice, for example, Managing Disability in the Workplace provides specific guidance on developing a disability strategy and making adjustments for people with disabilities, and their recruitment, promotion and retention (25).

**Education and employment**

Years of education (or educational level) significantly affects the chance of employment. In EU countries, the employment rate is 48% among those with fewer years in education (lower-secondary education) and 84% among those with the highest number of years in education (tertiary education, with a university degree) (26). A similar, but much more marked, association is seen between likelihood of employment and educational level for people with disabilities in Croatia (Fig. 2). Whereas 30% of people with one to three years of secondary education are unemployed in the general population, the percentage rises to 63% in those with a disability. It is possible that most people with disabilities have one to three years of secondary education, and this is the reason why so many are included in this category. The pattern of high unemployment in this group has existed since 2014, when records for this were made publicly available.

**Fig. 2. Employment rate by educational level, 2014–2016**

![Bar chart showing employment rates by educational level from 2014 to 2016.](chart.png)

*Source: Croatian Employment Service, 2017 (17).*
Multiple active employment measures are in place in Croatia. The total number of participants in ALMPs has fluctuated since 2011. By selecting a single month (January) to represent the differences, Fig. 3 shows the number of ALMP participants between 2011 and 2016.

**Fig. 3. Number of ALMP participants, 2011–2016.**

Despite real increases in their scope and funding, ALMPs remain insufficiently targeted in Croatia. In particular, ALMPs do not adequately reach older persons, the low-skilled and those with disabilities. Participation in ALMP measures and expenditure on ALMPs have increased in recent years but, compared to European countries, remain quite low. Although the total number of ALMP participants has varied, the percentage of participants with disabilities and participated in the ALMP has declined since 2014 (Table 2). In May 2017 2% ($n = 353$) of the 22 311 people participating in ALMPs had a disability.

**Table 2. ALMP participants, total and people with disabilities, 2014–2016**

<table>
<thead>
<tr>
<th>ALMP participants</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>23 178</td>
<td>33 021</td>
<td>26 890</td>
</tr>
<tr>
<td>People with disabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>number ($n$)</td>
<td>555</td>
<td>565</td>
<td>340</td>
</tr>
<tr>
<td>percentage (%)</td>
<td>2.4</td>
<td>1.7</td>
<td>1.3</td>
</tr>
</tbody>
</table>

*Data for January of each year.  
Source: Croatian Employment Service, 2017 (17).

The active employment policy measures implemented between 2010 and 2013 resulted in increased spending, but these policies were often of short duration and implemented inconsistently. The Croatian Institute of Public Finance recommended improvement of “the transparency and relevance...
of measures and to make them as targeted and customized to each group of the unemployed as possible” (27). The Government of the Republic of Croatia has adopted the Guidelines for the Development and Implementation of Active labour Market Policy for the period 2015–2017, and the revised policy emphasized the importance of promoting employment, training, start-ups, education, workplace training, employment in public works and employment maintenance for all people (17).

It is unclear whether ALMPs improve the employment (permanent or temporary) prospects of people with disabilities.
Policies and interventions to promote health in employment and unemployment in Croatia

Two major issues need to be addressed in order to improve the effects of health and work in Croatia:

- work-related mental disorders; and
- employment for people with disabilities.

Both people with work-related mental disorders and people with disabilities are stigmatized and have difficulty securing employment.

Integrated comprehensive policies and approaches are more effective and more cost-effective than single interventions in addressing issues related to work and health. Croatia’s existing legislation (the National Strategy for Mental Health Protection 2011–2016 (28) and the National Health Care Strategy 2012–2020 (29)) addresses issues related to the mental health, occupational health and general health of people with disabilities (Box 3). These existing policies make the shift to more equitable policies easier: the first steps have been achieved but the delivery of and commitment to these policies is needed.

Box 3. Defining disability

Across Europe different countries define disability differently; in Hungary, ministries, laws and regulations have adopted different definitions of disability. The Social Welfare Act (30) defines persons with disabilities according to the definition in the United Nations Convention on the Rights of Persons with Disabilities (22): “a person with disabilities is a person having long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with persons without disabilities”.

Disability is more than a health problem (25): it is the interaction between features of a person’s body and features of the society in which he or she lives. Overcoming the difficulties faced by people with disabilities requires interventions to remove environmental and social barriers. ILO defines a person with disability in relation to work as “[a]n individual whose prospects of securing, returning to, retaining and advancing in suitable employment are substantially reduced as a result of a duly recognized physical, sensory, intellectual or mental impairment” (31).
Improving the mental health of employed and unemployed people

Key points

- Good mental health is essential for maintaining a sufficient and productive workforce (32).
- Good mental health is a necessary part of an individual’s employability and a step towards labour market entry for those who are unemployed (33).
- The actions of employers can reduce or exacerbate mental health problems among working age populations (34).
- Evidence-informed workplace interventions to promote mental health could help save up to €135 billion per year by reducing absenteeism and early retirement (35). Between 2007 and 2012 Croatians’ sense of job security decreased (8).

The fastest way to improve the mental health of both employed and unemployed people is to comply with the recommendations of the existing National Programme on Occupational Health and Safety for Persons Employed in Health Care for the period 2015–2020 (36).

Key stakeholders

The key stakeholders are:

- employers
- local and regional governments
- Ministry of Construction and Spatial Planning
- Ministry of Finance
- Ministry of Health
- Ministry of Labour and Pensions
- occupational health services
- unions.

Recommendations and examples of successful policies

- Develop a mental health strategy in workplaces, promote awareness of mental health and work, improve the provision of rehabilitation in the workplace, and develop guidance for employers and employees to improve mental health and reduce stress at work.

- Provide incentives to encourage and support employers to address mental health at work, including interventions at three levels:
  - **prevent**: interventions to lessen, reduce or entirely avoid mental stress (through examining working environments, workflows, the quality of cooperation and the relationship between personal effort and recognition received);
  - **promote**: interventions to promote and boost resilience and resources for good mental health.
These can be:
- organizational (e.g. higher levels of autonomy, better quality of employee-centred management);
- social (e.g. social support among employees and between employees and managers); and
- personal (e.g. qualifications, health literacy, sense of self-worth);

- **support and reintegrate**: support employees with mental health problems in everyday working life and manage their reintegration back into work. Provide equitable access across Croatia to outpatient treatments and community-based services.

- Ensure equitable access to health and preventive services in Croatia. The percentage of the population reporting an unmet need for medical examination due to travel distance is one of the highest in the EU (15), with particular problems for those living in rural areas (8). Reforms to occupational health services are needed to include specific initiatives to meet the needs of those living in all parts of Croatia. For example, introduction of the e-health initiative in 2011 appeared to improve the perceived quality of health and access to health services (see Case study 1).

- Increase the number of and empower mental health professionals, with a focus on reducing stress and addressing anxiety people in work and increasing coverage of screening for mental conditions such as depression.

- In many cases, stressful work is preventable. A few companies have adopted strategies for mental health prevention and promotion (32). The Stress Prevention at Work Checkpoints app could also be implemented (37).

- Better access to high-quality green spaces and to viable modes of transport in the areas where people live and work improves both mental well-being and physical health. Populations in the greenest areas have the lowest risk of poor mental health (38). Access to high-quality green space is associated with positive health outcomes, including improvements in mental health and well-being by reducing depression, stress and dementia (39).

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**Case study 1. Screening and online support in the Netherlands**

In a large Dutch hospital, nurses and allied health professionals were screened for the symptoms of stress, burnout, depression and anxiety (40). Staff members testing positive received personalized online feedback. This intervention was successful in improving work function and work-related fatigue, along with a small but meaningful reduction in stress levels. Preventive interventions at the workplace have repaid their costs within a year because the costs of interventions are more than compensated for by reduced levels of absenteeism and presenteeism.
Existing policies and legislation

- WHO European Mental Health Action Plan (13)
- Croatian Health and Safety Act (41)
- National Health Care Strategy 2012–2020 (29)
- Croatian Institute for Health Protection and Safety at Work’s project on health and safety at work (launched in 2015) (42).

The Croatian Institute for Health Insurance and the bodies and institutions involved in the work of the Communication Working Group in the Occupational Health System, which include the Croatian Institute for Health and Safety at Work, have started a project to promote health and safety at work in certain types of jobs. The project seeks to strengthen the workplace prevention culture, reduce the number of injuries at work and raise the level of health and safety at work through collaboration with employers in hospitals, shops and universal postal services. Case study 2 gives an example of a Finnish initiative to reduce stress in the workplace.

United Nations Sustainable Development Goal 3, target 3.4 is to, by 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment, and promote mental health and well-being (Fig. 4).

Case study 2. Decreasing stress in Finland

The Finnish Institute of Occupational Health leads the work on improving mental health in Finland (3). Employers are required to continually monitor the working environment and to demonstrate improvements where needed. A special focus is harassment and the threat of violence at work. A further innovation concerns preventing work-related stress with the help of occupational health care.

Fig. 4. Health, employment, unemployment and the Sustainable Development Goals

<table>
<thead>
<tr>
<th>Cause of poor health</th>
<th>Risk factors</th>
<th>Policy intervention</th>
<th>Relevant SDGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Poor-quality employment</td>
<td>Employment legislation (e.g. rights for temporary workers)</td>
<td>1 MD PRIORITY</td>
</tr>
<tr>
<td></td>
<td>Stress</td>
<td>Support to return to work after poor mental health (e.g. occupational health)</td>
<td>3 NO POVERTY</td>
</tr>
<tr>
<td></td>
<td>Poor working conditions (hours, wages)</td>
<td>ALMPs for all</td>
<td>4 QUALITY EDUCATION</td>
</tr>
<tr>
<td>Unemployment</td>
<td>Unemployment</td>
<td>Equitable and good-quality education, including lifelong learning</td>
<td>5 GOOD HEALTH, GENDER EQUALITY</td>
</tr>
<tr>
<td></td>
<td>Poor access to support (occupational, health, mental health)</td>
<td></td>
<td>8 DECENT WORK AND ECONOMIC GROWTH</td>
</tr>
</tbody>
</table>
Improving the quality of work and health of employees

The benefits of work are only fully realized where the quality of work is taken into account (Fig. 5). Poor-quality work can be worse than having no job at all for those with mental health conditions (19). Higher employment rates are associated with higher job quality (43). Good quality work and employment provides protective and positive effects on health and well-being (3), including:

- better financial security and rewards (regular wages, paid holidays, social protection benefits such as sick pay, maternity leave, pensions);
- improved social status (personal development, social relations, self-esteem); and
- reduced exposure to physical and psychosocial hazards (long/irregular work hours, discrimination/harassment).

Fig. 5. Definition of good work

Key points

- Labour policies should reflect the changing employment conditions. Across Europe middle-skill/middle-pay jobs are declining (44), with increasing numbers of high- and low-skill jobs. In Croatia, most of the increase in part-time work is involuntary, reflecting a shortage of opportunities for full-time employment. Informal work rarely leads to high-quality jobs and is hard to escape; this is especially the case for women, older workers and low-skilled workers (19).

- Having higher levels of control and reward at work leads to better health (45).

- In Croatia workers work long hours and perceive high levels of job insecurity and a poor work–life balance (8).

- Unemployment benefits help maintain recipients' quality of life (by meeting their personal needs) and provide an opportunity to search for new employment (46).

- Social protection policies for those of working age reduce material hardship, thereby reducing stress and improving mental health (47). People whose benefits are disallowed (i.e. are taken off a register) report a deterioration in mental health, quality of life and well-being (48). The equitable provision of medical assessments in the pension insurance system is necessary to ensure that all benefit applicants are treated fairly.
Key stakeholders

The key stakeholders are:

- employers
- European Social Fund
- international development organizations
- Ministry of Demographics, Family, Youth and Social Policy
- Ministry of Economy, Entrepreneurship and Crafts
- Ministry of Finance
- Ministry of Health
- Ministry of Labour and Pensions
- Ministry of Regional Development and EU Funds
- Ministry of Science and Education
- occupational health services
- unions
- WHO.

Recommendations and examples of successful policies

- Follow the Organization for Economic Co-operation and Development’s job strategy to improve the quality and quantity of jobs by:
  - curbing informal work (19);
  - improving flexibility in work schedules without compromising security;
  - improving workers’ key skills and investing in lifelong learning; and
  - scaling up ALMP.

- Provide higher-quality childcare.

- Reintegrate people with illness or disabilities into work and employment by the use of appropriate rehabilitation measures (3).

- Avoid national policies with a one-size-fits-all approach (49). Target specific regions and populations, and design interventions with workers (not for workers) by including them in planning and implementing the measures. As an example:
  - in job security councils in Sweden, social partners play an active role in providing assistance to workers who will be laid off and tailoring the assistance offered to the specific needs of the affected workers, while unions help ensure that labour market adjustments are made more smoothly (43).

- Improve social protection for temporary workers and labour market flexibility by allowing workers to access reasonable social benefits and supporting workers with short-term or temporary employment (50). Make social protection more transferable from one job to the next by addressing the needs of the changing job market (i.e. towards more temporary jobs). As examples:
• Denmark’s so-called flexicurity policy, which provides flexible benefits for employers and job security benefits for employees (Case study 3) (3).

- Target policies to keep older workers in employment. As an example:
  
  • the Nordic countries are leaders in developing and implementing programmes that aim to maintain a large proportion of older people in paid work. Policies include flexible retirement, enhanced part-time options and regulations to protect highly stressed occupational groups of older age (3).

- Understand that taking people off the employment register is associated with increases in health inequalities and poverty. Ensure that those removed from the employment register have an adequate income.

Case study 3. ALMPs in Denmark

Denmark’s flexicurity policy aims to promote employment security over job security (51). It ensures that employers have a flexible labour force and that employees have the safety net of an unemployment benefit system and an active labour market policy. In total, 1.5% of Denmark’s gross domestic product is spent on ALMPs. Approximately 25% of Danish private sector workers change jobs each year.

A large percentage of Denmark’s employers, particularly Danish employers, are involved in ALMPs; this percentage is higher than for other European nations (52). Local job centres are responsible for delivering ALMPs. Reforms to Denmark’s ALMP in 2013 aimed to bring more people with disabilities back into the labour force. The reforms targeted people with complex problems and provided individual support to meet their distinct needs (53).

Training provision is a fundamental aspect of the Danish labour policy: in 2014 37% of Danish employees aged 18–74 years had participated in training courses in the last four weeks (53).

Existing policies and legislation

- ILO: Decent Work Country Programmes (54), Guidelines on Occupational Safety and Health Management Systems (55)

- United Nations: Convention and Protocol on the Rights of Persons with Disabilities (22)

- Croatia: active employment policy (56,57).
Transforming from passive support policies to ALMPs

The Government of the Republic of Croatia has adopted the Guidelines for the Development and Implementation of Active Labour Market Policy for the period 2015–2017. Although the revised policy emphasizes the importance of promoting employment, training, start-ups, education, workplace training, employment in public works and employment maintenance, it could go further and become more effective (58).

Key points

In European countries with more developed active labour market policies, work environments are more conducive to health (58).

- ALMPs have a positive impact on reducing work-related mental health problems (49). Countries with well-established ALMPs have lower average levels of stressful work than countries with less well-developed policies (49).
- ALMPs have the greatest health impact for those with lower education levels and skills. ALMPs are particularly effective for women and low-skilled and long-term unemployed people (59).
- Countries with the lowest long-term unemployment rates (Austria, Denmark, Finland, Germany, Luxembourg, the Netherlands and Sweden) are among those with the highest level of participation in ALMPs (60).

Key stakeholders

The key stakeholders are:

- Croatian Employment Service employers
- Ministry of Education
- Ministry of Finance
- Ministry of Health
- Ministry of Labour and Pensions
- Ministry of Regional Development and EU Funds
- regional governments.

Recommendations and examples of successful policies

- ALMPs that include outreach counselling, support for coping skills, training in job seeking, and mentoring are highly effective, with a high impact (61).
- Subsidized private sector labour programmes are very effective in the short and longer terms; in contrast, public employment programmes are far less effective. Public employment contracts are usually short term and rarely lead to further employment (62).
- In its role as the employer in ALMPs, the health sector provides employment at local levels and in regions where unemployment is high.
- Working with lifelong learning, health literacy and personal skills provides new employment opportunities.
Through a targeted approach, ALMPs provide services to people with disabilities at local or regional levels (see Case study 3). Smaller-scale schemes appear to be more effective and reflect the local context (63). Localized services draw on local knowledge and resources and build support and services that are relevant to local needs (64,65). As an example:

- targeted, personalized support and peer support improve the ability of people to find employment, particularly those with long-term mental and physical health conditions (64,66).

**Existing policies and legislation**

- European Commission: European Regional Development Fund (67), European Social Fund (68)

**Promoting sustainable and equitable economic growth**

**Key points**

- Healthy work and employment policies and conditions are central to a sustainable economy (3).
- A high employment rate promotes an inclusive society.
- All people, including marginalized groups (people with disabilities, older people, migrants), should be helped back into employment as quickly as possible (19).
- The unemployment rate in Croatia is higher for women (15.5%) than for men (11%). In 2011 the proportion of women participating in the labour market was 47%, significantly below the EU average of 58% (69).
- The proportion of workers aged 55–64 years in the workforce will increase to 30% in 2030 in many European countries (70). In Croatia, early retirement is common (71). Across Europe the retirement age is increasing, and many workers will have a longer working life. As a result, additional effort will be needed to ensure a safe, healthy working environment and good health and well-being throughout the working life.
  - In Denmark the statutory retirement age was recently increased from 65 to 69 years with the aim of improving the long-term sustainability of public finances (53).

**Key stakeholders**

The key stakeholders are:

- employers
- European Social Fund
- Ministry of Economy, Entrepreneurship and Crafts
- Ministry of Finance
- Ministry of Health
- Ministry of Labour and Pensions
- Ministry of Regional Development and EU Funds
occupational health services
unions
WHO.

Recommendations and examples of successful policies

- Prioritize economic growth with an environmental and sustainability strategy. Reduce poverty and unemployment rates, and improve educational levels by investing in training, improved infrastructure and technology and by extending access to employment and good quality of work throughout major sectors of the workforce.

- Shift employment policies to more active measures, in particular those facilitating job creation and increasing employability through education and training courses (8). Reduce occupational illnesses and injuries by enforcing national regulations and strengthening preventive efforts. Target vulnerable groups, such as workers with disabilities.

- Support women’s economic empowerment by promoting equal pay for equal work, flexible work, education, training and counselling, childcare, and women entrepreneurs (72).

Existing policies and legislation

- European Commission: Lisbon Strategy (73,74), Europe 2020 Strategy (75).

Integrating lifelong learning into work and health policies

Key points

- More years of education is associated with better self-rated health, quality of life and life satisfaction (76).

- Higher participation rates in lifelong learning and higher investments in rehabilitative services are associated with obtaining better-quality work (77).

- A study of 10 European countries found that lifelong learning produces a range of benefits (78), including improvements in:
  - health and well-being;
  - locus of control;
  - self-efficacy and having a sense of purpose in life; and
  - tolerance and social engagement.

- People who keep learning:
  - have greater levels of satisfaction and optimism; and
  - report having greater well-being, ability to cope with stress, and feelings of self-esteem, hope and a sense of purpose (79).

- People with fewer years of education particularly benefit from adult education (79).

- A large proportion of the working age population does not participate in the labour market, commonly due to early retirement.
Key stakeholders

The key stakeholders are:

- employers
- libraries
- Ministry of Demographics, Family, Youth and Social Policy
- Ministry of Health
- Ministry of Labour and Pensions
- Ministry of Science and Education
- NGOs
- public health services
- schools.

Recommendations and examples of successful policies

- Support learning programmes target older workers to remain in work (80).
- Increase awareness and acceptance of adult education (see Case study 4).
- Promote better partnerships between employers and health systems, government and employees (82).
- Encourage people to volunteer, especially those who have never volunteered (86% of people aged 65 years and over) (8).

Case study 4. Lifelong learning in Norway

Lifelong learning and adult education opportunities are important principles of Norwegian education policy. Over 60% of adults participate in learning activities in Norway (81). The goal of adult education in Norway is to provide every person with the possibility of improving their competencies and developing their skills throughout life.

Every year, approximately 10 000 adults receive formal education at primary and lower-secondary levels, mostly at adult education centres in local municipalities. In addition, 20 000 adults participate in upper-secondary education and training courses each year, 15 000 students attend continuing education courses at public universities and university colleges, 70 000 adults participate in supplementary training courses and 500 000 adults attend non-formal courses run by NGO-based adult education associations.
Existing policies and legislation

- European Commission: Adult education strategy (83).

Improving and expanding occupational health care

Key points

Despite significant advances in occupational health support, mental, physical, chemical and biological work-related hazards still lead to large numbers of work-related diseases and fatalities (45).

- Better quality and transparent occupational health data will enable policies to be more effective and better targeted, prioritized and integrated (9).

Key stakeholders

The key stakeholders are:

- academics
- employers Ministry of Health
- Ministry of Labour and Pensions
- occupational health services
- public health services.

Recommendations and examples of successful policies

- Improve access to mental health care and treatment, both locally and at work. Develop appropriate human and financial resources for occupational safety and health services.

- Integrate occupational health services into a package of labour and social policies such as social protection and active training, mentoring and apprentice schemes.

- Interventions may be more effective when targeted at the structural characteristics of organizations, rather than concentrating on the individual behaviour of employees (45). Examples include:
  - changing work processes and work conditions with a participatory approach; and
  - making changes to shift schedules.

- Support data collection capable of tracking the causes of illness and injury by industry. Understand the effectiveness of current policies such as the Ordinance on establishing quotas for the employment of persons with disabilities (84). Implement alternative policies if current policies do not increase the number of people with disabilities in employment.

Selected existing policies and legislation

- EU: occupational safety and health acts (85)
- Croatia: National Programme on Occupational Health and Safety for Persons Employed in Health Care for the period 2015–2020 (36)
Recommendations

People with disabilities work in all sectors of the economy and in all types of roles. With the right opportunities and adjustment to a job or the work environment (when required), they make a valuable contribution to the world of work and the economic development of Croatia.

The opportunities to actively promote policies to improve workers' mental health and the employment rate for persons with disabilities are as follows.

- Adopt a single definition of disability in line with the Convention on the Rights of Persons with Disabilities (all government ministries) (22).
- Align education, labour, tax and employment policies and legislation to enable flexible labour markets.
- Continue to implement the current occupational health and safety legislation, with equitable coverage and accessibility across all parts of Croatia.
- Improve the quality of mental health programmes for all workers and unemployed people by integrating these policies into national health strategies, health sector reforms and plans for improving the performance of health systems.
- Make ALMPs more inclusive and increase the participation of people with disabilities. As an example:
  - ensure that social protection and social policies are aligned to enable people with disabilities to be in work and stay in work.
- Develop a national programme to ensure employment and occupational rehabilitation for all persons with disabilities. Croatia is a signatory of the WHO Global Disability Action Plan 2014–2021 (86), which calls for Member States to:
  - remove barriers and improve access to health services and programmes;
  - strengthen and extend rehabilitation, assistive devices and support services, and community-based rehabilitation; and
  - improve the collection of relevant, internationally comparable data on disability and research on disability and related services.
References


The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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