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Background

The workplace is an important arena for health promotion since many people spend a great time of their life there. The ideas behind workplace health promotion (WHP) are based on the salutogenic perspective and imply that employee health may be a product of individual behaviour as well as a product of the work environment. Consequently, managers can promote employee health both by strengthening personal health practices and resources by offering various health-specific programmes, activities, and measures, and by forming a well-functioning work organization in general, beneficial for productivity, well-being, and health. Research concerning how well this corresponds in practice has so far been performed to a limited extent. This study investigated the extent to which differences in employee health and sickness absence between Swedish municipalities in the social care sector are related to general psychosocial work conditions and WHP.

Method

In a random sample of 60 out of 290 municipalities in Sweden, 15,871 municipal social care employees working with elderly and disabled clients were sent a questionnaire concerning psychosocial work environment, leadership, WHP, and self-rated health. The responses (response rate 58.4%) were complemented by register data on sickness absence.

Results

A structural equation modelling analysis using employer-level data demonstrated that employers with more favourable employee ratings of the psychosocial work conditions, as well as of specific health-promoting measures, had better self-rated health and lower sickness absence levels among employees.

Conclusions

The results from this representative nationwide sample of employers within one sector corroborate recent theories about health consequences of general psychosocial work conditions. However, traditional health-specific measures directed to individuals, such as fitness activities and stress counselling, still stand out as essential and justify their use in a comprehensive workplace health approach.

Burnout among medical professionals-social and economic dimensions

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Bulgarian medical professionals are working in conditions of health system reform more than 20 years. Workload is a key dimension of organizational life. From the organization's perspective, workload means productivity. From the individual's perspective, workload means time and energy. Finding a compromise between the two perspectives is a fundamental challenge in maintaining a balanced relationship with work. The consequences of burnout are potentially very serious for the staff, the patients and the larger institutions in which they interact.

The purpose of this study was to examine the economic aspects and consequences of burnout for health professionals. For its implementation were solved the following tasks: analysis and assessment of the environment in which they live and work, analysis and evaluation of burnout rate; possible approaches to solving problems.

Participants and data collection: 1500 doctors and 1500 nurses (154 midwives included), volunteers, from the six regions in Bulgaria have completed an anonymous questionnaire on burnout rate.

Disparities in geographic regions, in types of healthcare facilities, in physicians and nurses per 10 000 of the population create conditions for further stress in the work of medical professionals.

The distribution of respondents by gender and age groups is as follows: 25,8% of physicians respondents are in young labour active age, among nurses they are 44,9%.

Especially alarming is the fact that more than 50% of our respondents physicians and nurses show moderate to high and very high degree of burnout. The analysis of the degree of burnout by age groups shows some differences between doctors and nurses.

Sources of stress have increased despite the development of new information technologies and communication and reduction of working time. The future is bright for those who had the courage to recognize the damage of stress, to help their employees to overcome it and have managed to organize the activity of environment-friendly human factor.

Prevention of the burnout syndrome should be developed and implemented in programs at individual and team level. With their help at the first signs specialists and the managerial team of the health institution will be able to take adequate measures for treatment and rehabilitation.

M.1. Workshop: Understanding the causes of chronic diseases burden in Europe-how can recent advances, new concepts and future perspectives in relation to migrant/ethnic health help?

Chairs: Charles Agyemang, The Netherlands and Iveta Nagyova, Slovakia

Organiser: EUPHA section on Migrant and Ethnic Minority Health & EUPHA section on Chronic and Non-communicable Diseases

Chronic diseases such as cardiovascular diseases (CVD) and diabetes are major public health burdens in most ethnic minority and migrant populations living in Europe. The causes are incompletely understood, but they are likely to be multifaceted. Traditionally, ethnicity and health research has mostly concentrated on comparing the health of ethnic minority groups with the majority populations of the countries

in which they live. This is an important area of research which illuminates ethnic inequalities in health. However, in recent times, the need to search for other models in explaining ethnic inequalities in health is increasing. International comparative studies including the European Commission's (EC) funded MEHO project, recently showed that a lot can be learned from comparing similar ethnic groups living in different European countries. Equally, comparing migrant populations to similar populations in their countries of origin may generate new knowledge about factors that predispose them to poor health outcomes.

The aim of this joint workshop between the two EUPHA sections (i.e. Migrant and ethnic minority health & Chronic diseases) is to discuss the recent advances in ethnicity and health research on chronic diseases in Europe. In particular, the lessons from the MEHO project and their implication for future research will be discussed. Furthermore, the potential impact of comparing migrant populations with similar populations in their countries of origin will be discussed using the recent EC funded RODAM project as a case study (<http://www.rod-am.eu/>). Additionally, the recent project on role of severe chronic diseases on remigration of migrants to their country of origin will be discussed.

Three key papers will be presented by researchers from the leading institutes on ethnicity and health in Europe (University of Edinburgh; University of Amsterdam and University of Copenhagen).

From epidemiological surveillance to epidemiological explanations in ethnicity and health research: the example of cardiovascular diseases

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By the early 1960s clear epidemiological evidence was showing major, and often very unexpected, variations in the incidence and/or mortality from cardiovascular diseases. For example, one of the earliest such studies showed that the largely vegetarian, non-smoking South Asian (mainly Indian) population in South Africa had higher rates than the South African population. In the subsequent decades, a number of countries have consolidated this evidence base with national analyses of mortality rates, in particular, and to a lesser extent morbidity rates. Amongst the European nations leading in this endeavour we can include the UK and The Netherlands. The MEHO project recently demonstrated that, across Europe, few countries are well placed to describe cardiovascular diseases by ethnic group/migrant status. Nonetheless, MEHO also showed that there are very many interesting and important variations that warrant both further research and policy and service action. Variations of the size demonstrated also require to be explained. Explaining them requires information within datasets on both ethnic group and on potential confounding, mediating, interacting and causal factors. While basic surveillance data are scarce, explanatory information of this kind is largely non-existent with relatively few exceptions in limited ethnic groups in regional or citywide studies (mostly starting as cross-sectional). Two very recent advances will be discussed, firstly, the experience of data linkage in this field, with particular reference to the Scottish Ethnicity and Health Linkage Study, and secondly, the development of three large-scale cohort studies that are poised to fill the gap i.e. the West of London cohort study (LOLIPOP), HELIUS (Netherlands), and UK Biobank. The need for research across the lifespan will be emphasised, with particular reference to birth cohort studies. Finally, I will consider the potential benefits of more sophisticated designs where comparisons are made between migrant/ethnic groups within the country, across different European countries, and simultaneously, in the countries of origin.

Type 2 diabetes and obesity among sub-Saharan African native and migrant populations: dissection of environment and endogenous predisposition

Charles Agyemang

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Sub-Saharan Africa (SSA) origin populations in Europe have increased substantially for the last few decades. Evidence suggests that the risk of Type II diabetes (T2D) and obesity is higher in these populations than in European host populations. By the same token, the prevalence of T2D and obesity are on the rise in many SSA countries. The reasons for these observations are not well understood, given the absence of data on the relative importance of environmental and genetic factors. With the increasing prevalence of T2D and obesity and their adverse complications in these populations, there is an urgent need to unravel the underlying factors to guide prevention and treatment efforts. The RODAM (acronym for Research of Obesity & Diabetes among African Migrants) is a recent European Commission (FP-7) funded project, which addresses these fundamental health issues among a homogeneous, and one of the largest SSA migrant groups in Europe (i.e. Ghanaians) (<http://www.rod-am.eu/>). RODAM thus aims to: study the complex interplay between environment (e.g. lifestyle) and (epi)genetics in T2D and obesity; identify specific relevant risk factors to guide intervention; provide basis for improving diagnosis and treatment. In a multi-centre study, 6250 Ghanaians aged ≥ 25 years will be recruited in rural and urban Ghana, Germany, The Netherlands, and the UK. The differences in prevalence rates within Ghana on the one hand, and three European countries on the other, will allow us to unravel environmental as well as (epi)genetic factors in relation to T2D and obesity. This unique study will generate relevant results that will ultimately guide intervention programmes and will provide a basis for improving diagnosis and treatment among SSA migrants in Europe as well as in their counterparts in Africa and beyond.

Is there an association between severe disease and remigration among migrants?

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European studies show lower all-cause mortality among migrants versus host populations. Results are explained by 'the healthy migrant effect', but also by 'the Salmon bias' entailing the remigration of severely ill individuals. We set out to investigate the latter hypothesis. Our study aim was to assess whether severely ill migrants were more likely to re-migrate to their home country than those not severely ill. The study cohort was obtained through the Danish Immigration Service. Migrants were included if they had obtained residence permission as refugees or through family reunification in Denmark between 1.1.1993 and 31.12.2010. We identified 116,073 migrants. \bar{x} 31.8 years. The study cohort's civil registration numbers were cross-linked to the Danish National Patient Registry (LPR), which contains discharge diagnoses (ICD-10). From the Danish Civil Registration System we obtained data on date of registered emigration events. In regression, the independent variable was disease occurrence and the dependent variable remigration status. We adjusted for age, sex and income and stratified for county of origin. We expect to find that the prevalence of disease will affect the likelihood to re-migrate, but that the size and even the direction of this association strongly differs according to discharge diagnosis, country of origin, and types of outmigration (remigration vs. migration towards another host country). Such findings would imply that salmon bias has a large potential in affecting observed mortality rates, but mostly that its actual effect strongly depends on specific conditions.