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Hva vet vi egentlig om hva som fungerer?

Forskning om tiltak på arbeidsplassen for å redusere sykefraværet

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Konvensjonell visdom: Arbeid er bra for helsen

Men:
Pensjonering kan bedre subjektiv helse hvis arbeidsforholdene oppfattes som dårlige

Westerlund et al, The Lancet, 2009

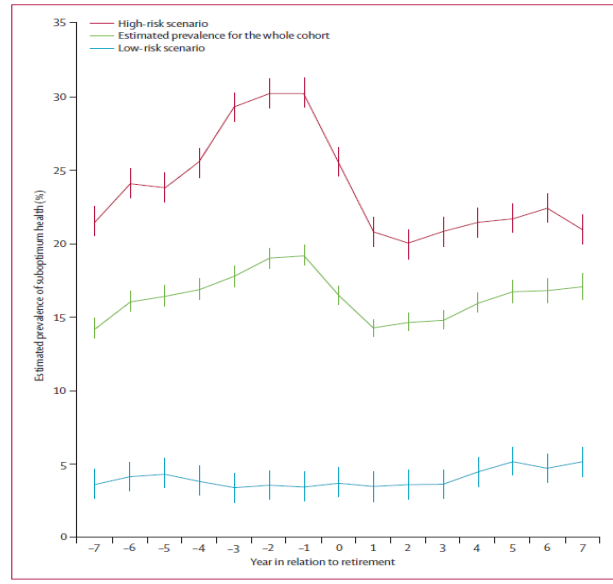


Figure 3: **Prevalence of suboptimum self-rated health in relation to year of retirement for a high-risk and low-risk scenario involving men who retired at the statutory age of 55 years and before the year 2000**
Low-risk profile=high occupational grade, low physical and psychological demands, and high job satisfaction. High-risk profile=low grade, high demands, and low satisfaction. Error bars indicate 95% CIs.

Samsvar Person – Arbeid 1

Arbeidsevne Kompetanse

Fysiologisk funksjon
Kognitiv funksjon
- Helse

Kompetanse =
- Utdannelse +
- Ferdigheter

Potensielle evner
- Kroppslig
- Psykisk
- Intelligens
- Kreativitet
- Sosiale
- etc

samsvar

Jobbens krav

Mekaniske krav
Kvantitative krav
- Tidspress
- Arbeidsmengde
- Arbeidstid

Kvalitative krav
- Kvalitet
- Kompleksitet
- Problemløsning
- Læringskrav

Rolleforventninger
Sosiale krav
etc

Samsvar Person – Arbeid 2

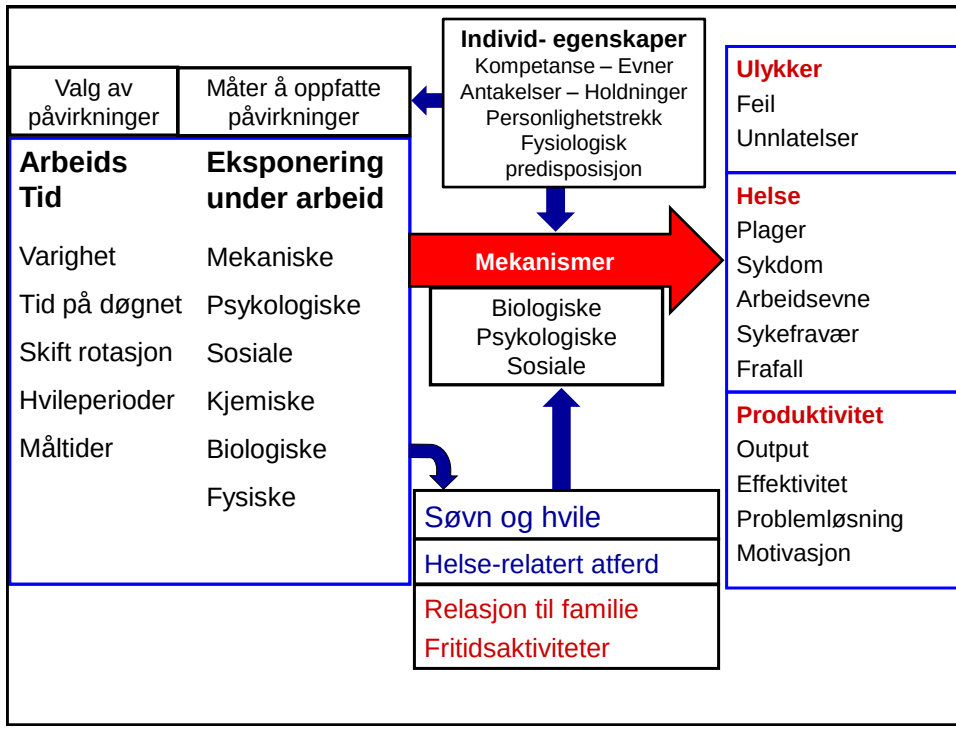
Ansattes ønsker motiver

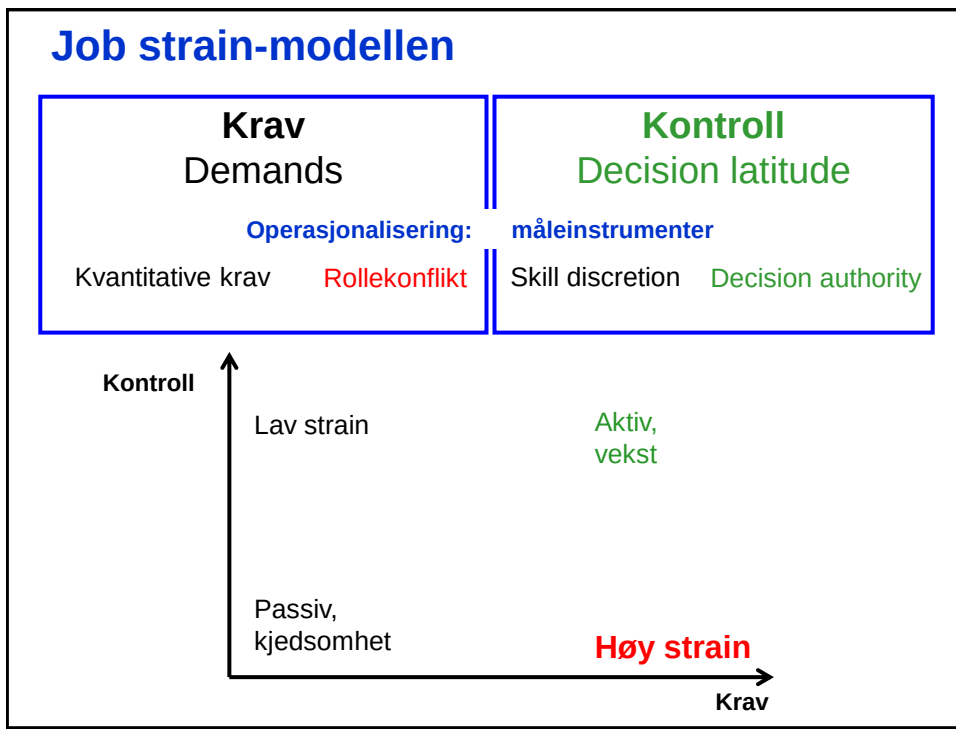
Behov
Mål
Verdier
Holdninger
Interesser
Preferanser
etc

samsvar

Jobbens tilbud

Penger
Positive utfordringer - moro
Mulighet for utvikling
Mulighet for sosiale forhold
Selvfølelse
Statuskontroll
Etc


Valg av påvirkninger
Måter å oppfatte påvirkninger
Arbeids Tid
Eksponering under arbeid
Varighet
Tid på døgnet
Skift rotasjon
Hvileperioder
Måltider
Mekaniske
Psykologiske
Sosiale
Kjemiske
Biologiske
Fysiske
Individ- egenskaper
Kompetanse – Evner
Antakelser – Holdninger
Personlighetstrekk
Fysiologisk predisposisjon
Mekanismer
Biologiske
Psykologiske
Sosiale
Søvn og hvile
Helse-relatert atferd
Relasjon til familie
Fritidsaktiviteter
Ulykker
Feil
Unnlatelser
Helse
Plager
Sykdom
Arbeidsevne
Sykefravær
Frafall
Produktivitet
Output
Effektivitet
Problemløsning
Motivasjon


Job strain-modellen
Krav
Demands
Kontroll
Decision latitude
Operasjonalisering:
måleinstrumenter
Kvantitative krav
Rollekonflikt
Skill discretion
Decision authority
Kontroll
Lav strain
Aktiv, vekst
Passiv, kjedsomhet
Høy strain
Krav

Sosiale samspill

SOSIAL STØTTE: Typer av støtte ***House 1982***

- Informasjon - råd
- Instrumentell - assistanse
- Evaluering - feedback
- Emosjonell - empati omsorg

Modeller: 1. Buffer
2. Direkte virkning på helse

IASP

PAIN® 151 (2010) 162–173

PAIN®

www.elsevier.com/locate/pain

Work and neck pain: A prospective study of psychological, social, and mechanical risk factors

Jan Olav Christensen [a,b,*,1], Stein Knardahl [a,1]

[a] The National Institute of Occupational Health, Norway
[b] Department of Psychology, University of Oslo, Norway

Øker risiko for nakkesmerter
- Rollekonflikter
- Arbeid hvor man må løfte armene til skuldernivå

Reduserer risiko for nakkesmerter:
- Kontroll over beslutninger
- Bemyndigende ledelse

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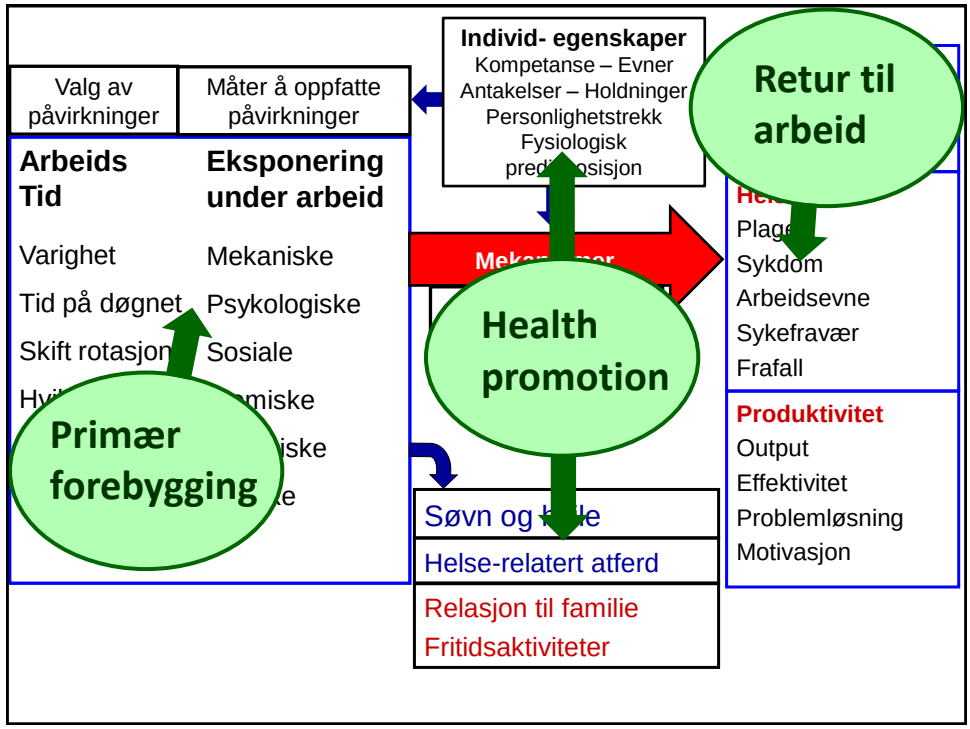
Keywords:
Neck pain
Occupational
Psychosocial
Prospective
Mechanical
Exposure

ABSTRA

To determine th
spective cohort
employees. The
low-up (n = 412
age exposure o
in exposure fro
follow-up ques
age, sex, neck p
consistent risk
to or above shou
empowering lea
0.36–1.00). Hence, psychological and social factors are important precursors of neck pain, along with mechanical factors. Although traditional factors such as quantitative demands and decision control play a part in the etiology of neck pain at work, in this study several new factors emerged as more important.

1. Introduction

Neck pain is a widespread health problem in the working population. The annual prevalence has been reported to be above 40% known, and several studies have reported very low levels of trapezius muscle activity during office work (e.g. [45]). During psychological challenge, active coping behavior includes a cardiovascular response pattern in which blood flow to muscles increases



Posten-prosjektet

Improving subjective health at the worksite: a randomized controlled trial of stress management training, physical exercise and an integrated health programme

H. R. Eriksen, C. Ihlebæk, A. Mikkelsen, H. Grønningsæter, G. M. Sandal, and H. Ursin

Occup. Med. Vol. 52 No. 7, pp. 383–391, 2002

Department of Biological and Medical Psychology, University of Bergen, Bergen; Rogaland Research, Stavanger; The Norwegian University of Sports and Physical Education, Oslo; and Department of Psychosocial Science, University of Bergen, Bergen, Norway

Effects of 12 weeks of:

- Stress management training (SMT): n= 162
- Physical exercise (PE): n= 189
- Integrated health programme (IHP): n= 165
- Control: n= 344.

No significant effects on subjective health complaints, sick leave or job stress.

The PE group showed improved general health, physical fitness and muscle pain.
The SMT group showed improved stress management.
The IHP group showed the strongest effects, affecting most goals set for treatment.

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Kilder til virkninger et tiltak

Tiltaket
Seleksjon av deltakere
Oppmerksomhet om forandringer
Placebo: Forventninger om virkning hos deltakere
Forventninger om effekt hos undersøker
Grunnleggende antagelser om årsaker
Ytre forhold: omorganiseringer, endringer

Active workplace interventions

Occupational Medicine 2013;63:7–16
Advance Access publication 5 December 2012 doi:10.1093/occmed/kqs198

Systematic review of active workplace interventions to reduce sickness absence

M. Odeen[1,2], L. H. Magnussen[1,3,6], S. Maeland[1,3], L. Larun[4], H. R. Eriksen[1,5] and T. H. Tveito[1,5]

"… limited evidence that active workplace interventions were not generally effective in reducing sickness absence, …"

Moderate evidence: **effect of graded actitivity**

Moderate evidence: **no effect of workplace education to prevent musculoskeletal disorders**

Moderate evidence: **no effect of workplace exercise programs**

Limited evidence: effect of Sheerbrooke model

Limited evidence: effect of cognitive behavioral therapy combined with problem solving therapy in employees with depression

No evidence: cognitive behavioral therapy

workplace physical activity.

Introduction

diagnostic categories with health outcome. Musculoskeletal and ment

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Ryggskoler Hjelpemidler

Cochrane corner

Manual material handling advice and assistive devices for preventing and treating back pain in workers: a Cochrane Systematic Review

J Verbeek, K P Martimo, J Karppinen, P P Kuijer, E P Takala, E Viikari-Juntura

Finnish Institute of Occupational Health, Cochrane Occupational Safety and Health Review Group, Kuopio, Finland

We concluded that there is moderate quality evidence that MMH advice and training with or without assistive devices does not prevent back pain or back pain-related disability when compared to no intervention or alternative interventions.

Accepted 13 June 2011
Published Online First
17 August 2011

In many occupations, it is difficult to avoid imposing heavy loads on the back (eg, lifting and moving patients in healthcare). Therefore, it is not

for RCTs and MINORS for the cohort studies. We combined the results of similar studies with a fixed-effect meta-analysis. We used the GRADE approach

niques and to provide them with assistive devices. Therefore, we wanted to determine the effectiveness of MMH advice and training and the provision of assistive devices in preventing and treating back pain. We have updated the previous version of the systematic review with a new search, new studies and improved methods.[1 2]

We searched CENTRAL (*The Cochrane Library* 2011, issue 1), MEDLINE, EMBASE, CINAHL, Nioshtic, CISdoc, Science Citation Index and PsychLIT to February 2011.

We included randomised controlled trials (RCT) and, because we thought it would be difficult to find RCTs, cohort studies with a concurrent control group that were aimed at changing human behaviour regarding MMH and measured back pain, back pain-related disability or sickness absence.

rather than participants were randomised.

Studies compared training to no intervention (four), professional education (two), a video (three), use of a back belt (three) or exercise (two). Other studies compared training plus lifting aids to no intervention (three) and to training only (one).

Studies were conducted among the following occupations with exposure to back load: healthcare workers exposed to lifting and moving patients (four RCTs and eight cohort studies), baggage handlers (two RCTs), construction workers (one RCT and one cohort study), postal workers handling mail (one RCT) and workers in a distribution centre (one RCT). The number of participants varied from 131 to 12 772 in RCTs, and from 41 to 345 in cohort studies.

The interventions varied from one session of

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Primær forebygging

AMERICAN JOURNAL OF INDUSTRIAL MEDICINE 57:56–68 (2014)

Prevention Program at Construction Worksites Aimed at Improving Health and Work Ability Is Cost-Saving to the Employer: Results From an RCT

K.M. Oude Hengel, PhD,[1,2*] J.E. Bosmans, PhD,[3] J.M. Van Dongen, MSc,[2,3,4] P.M. Bongers, PhD,[1,2,4] A.J. Van der Beek, PhD,[2,4] and B.M. Blatter, PhD[1,2]

Trening med fysioterapeut for å redusere fysisk arbeidsbelastning 30 min x 2.
Hvilepauseverktøy: (1) forventninger om tretthet (fatigue), (2) råd om minipauser, (3) valg av mulig årsaker til tretthet, (4) råd om å redusere tretthet på lang sikt.
Empowerment trainer: (1) ta ansvar for egen helse, (2) diskusjon om ansvar for egen atferd på jobben, (3) bedre kommunikasjon med sin overordnede.

- **Redusert sykefravær**
- **Økonomisk lønnsomt for arbeidsgiver: spart €6.4 for hver €1 investert**
- **Ingen målbar effekt på arbeidsevne, mental helse, muskelskjelettlidelser**

KEY WORDS: absenteeism; cost-effectiveness; health; return on investment; work ability

INTRODUCTION

As in many industries in Western countries, the working population in the Dutch construction industry is rapidly

decreasing and ageing [Beereboom et al., 2005; Eurostat, 2011]. These demographic changes have serious economic consequences as a shrinking labor force will have to pay for the national pensions of an increasing number of

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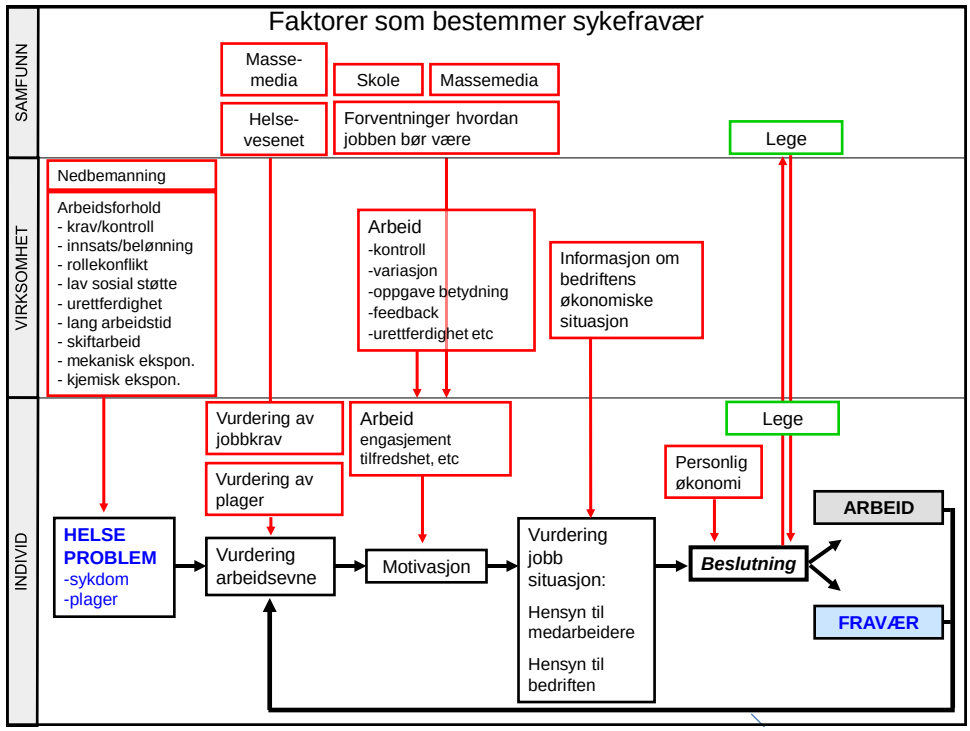
Faktorer som bestemmer sykefravær
SAMFUNN
VIRKSOMHET
INDIVID
Masse-media
Skole
Massemedia
Helse-vesenet
Forventninger hvordan jobben bør være
Lege
Nedbemanning
Arbeidsforhold
- krav/kontroll
- innsats/belønning
- rollekonflikt
- lav sosial støtte
- urettferdighet
- lang arbeidstid
- skiftarbeid
- mekanisk ekspon.
- kjemisk ekspon.
Arbeid
-kontroll
-variasjon
-oppgave betydning
-feedback
-urettferdighet etc
Informasjon om bedriftens økonomiske situasjon
Vurdering av jobbkrav
Arbeid
engasjement
tilfredshet, etc
Lege
Vurdering av plager
Personlig økonomi
ARBEID
HELSE PROBLEM
-sykdom
-plager
Vurdering arbeidsevne
Motivasjon
Vurdering jobb situasjon:
Hensyn til medarbeidere
Hensyn til bedriften
Beslutning
FRAVÆR