GOVERNING HEALTH WORKFORCE RESPONSES DURING COVID-19

By: James Buchan, Gemma A. Williams and Tomas Zapata

Summary: Countries in Europe have rapidly scaled-up, redeployed, repurposed, retrained and retained their workforce during COVID-19 to create surge capacity, protect the health and well-being of the workforce, and ensure effective implementation of vaccination programmes. Doing so has had enormous governance implications, including the need for intra-governmental and cross-organisational governance actions, increased transparency for planning, and delegated leadership to health employers and health workers. It is important that stakeholders continue to learn and share their experiences on the effectiveness of different workforce governance responses to allow the health workforce to recover, rebuild and repurpose.

Keywords: Human Resources, Health Workforce, Surge Capacity, Governance, COVID-19

Introduction

The health workforce has been a critical determinant of the effectiveness of policy responses to COVID-19. Health care is always labour intensive, but in the specific conditions of the pandemic, the ability of a health system to rapidly scale up, redeploy, repurpose, retrain and retain its workforce has been crucial to success. It is important to note that “insufficient staff availability” was the most common reason for service disruption reported by Member States in the European Region in the second WHO “pulse” survey on health services during the pandemic (January – March 2021). A review of the sparse literature on health workforce governance shows no agreement on conceptualisation or definition. The wider governance literature nevertheless emphasises that governance is largely about how decisions are made and implemented, including the ability to take and effectively implement evidence-based decisions and create alignment between different stakeholders. There is also broad agreement on key elements of good governance, such as the need for transparency, accountability, and participation in decision making. Applying these dimensions to governing the health workforce during a pandemic, with the pressure for rapid responses, raises several critical questions. Do countries have the necessary data and systems to plan for health workforce up-scaling, redeployment, etc? How are those responsible for decision-making...
COVID-19 and governance – key dimensions

In this article, we consider some of the effective governance tools that have been utilised to mobilise, redeploy and repurpose the health workforce during the COVID-19 pandemic. We also consider key messages that are emerging on health workforce governance, which can be drawn on to help support the development of a more resilient health workforce in the future.

For the purposes of this paper, within the context of responses to COVID-19, we focus on four dimensions of health workforce governance:

- national/regional government policies (e.g. policies on health care, education, employment);
- legislation (e.g. legislation covering working hours, prescribing);
- regulation (e.g. professional councils defining roles and standards); and
- the role and remit of employers and management (e.g. determining pay levels, working patterns).

These are all important factors in determining how the workforce is employed, deployed and contributes. Different stakeholders may be involved in different countries, but will usually include government departments/ministries, professional councils and employee associations, universities, politicians/legislators. The interplay and balance of effect across the four dimensions will vary in different contexts and countries, but we keep all four in mind as we examine the workforce implications of the response to the pandemic.

We explore the workforce governance implications of responding directly to the pandemic challenges in three key areas:

- creating “surge” capacity to meet new and rapidly growing demand, notably in hospital care;
- protecting workforce health and well-being; and
- rolling out the vaccination programme.

These key elements are presented linearly but the variable timing, phasing and number of pandemic waves in different countries and regions has created different circumstances, timelines, and policy challenges. They have also had to be aligned with the need to maintain essential (non-COVID-19) services. Our focus is to highlight the key aspects of health workforce governance from early 2020 to May 2021 by reporting on specific case studies from across Europe.

Governance implications for creating workforce surge capacity

In Europe, the need for a surge response first became apparent in early 2020, but it has also been a factor in previous pandemics. Whilst “surge” is often characterised as a short-term phase about rapidly increasing numbers, the reality is that redeployment, reskilling and new ways of working are also required, and will be needed in the longer term, to support recovery and re-mobilisation of other essential services. Countries in Europe entered the pandemic with a marked variation in health workforce profile and availability, with many health systems experiencing staff shortages and/or a sub-optimal workforce skill profile and deployment. The initial impact of the pandemic increased demand for services but also increased infections of unprotected health workers, and has exposed these workforce gaps and weaknesses, adding to the governance challenge.

Analysis of the immediate health workforce surge responses by the European Observatory highlighted that there were a core group of interventions to “scale up” the workforce, all of which had governance challenges. These interventions included: increasing the capacity of the existing workforce, bringing student health professionals into the workforce, bringing retired and inactive health professionals into the workforce, “fast tracking” the deployment of foreign health workers, encouraging volunteers, and included other measures such as deploying the military.

Implementing these changes often required adoption of emergency legislation to facilitate exceptional hiring procedures, or suspension of existing legislation such as on working time limits or minimum staffing requirements (e.g. Germany), and changing (re-)registration requirements (see Table 1). Surge was, however, not just about “more” staff; it was also about redeployment, additional training and development of new competencies, and the accelerated use of technology, such as for remote consultations or use of electronic health records. This had significant workforce governance implications in terms of training, development of new skills, and learning new ways of working.

One essential component of an informed approach to workforce governance is the ability to plan and project in order to understand staffing requirements during a surge. This enables policy-makers to identify the necessary governance levers—be it a legislative change, new regulations, or incentives—to understand how many and where more or different types of health workers may be needed or to attract
Table 1: Examples of governance mechanisms utilised to create surge capacity, support the health and well-being of health workers, and enhance vaccination programmes

<table>
<thead>
<tr>
<th>Governance areas</th>
<th>Examples for surge capacity</th>
<th>Examples for health and well-being</th>
<th>Examples for vaccination programmes</th>
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<tbody>
<tr>
<td><strong>National/regional government policies</strong></td>
<td>Authorisation for new staff to be hired National or regional recruitment campaigns to attract new or returning workers Agreements to temporarily employ private sector workers in the public sector Allocation of additional/new funding to provide support and remuneration and hiring of new workers Coordination between health facilities and regional or national government to assess rapidly and report workforce demand and supply Supporting implementation/adaption of IT systems to monitor supply and demand/project “surge” requirement for staff Authorisation for certain professions to take on new tasks</td>
<td>Ensuring sufficient supply and distribution of PPE Developing clinical guidelines, protocols and training programmes for using PPE Supporting implementation/adaption of IT systems to monitor supply of PPE through funding and policies Establishing strategies for mental health support and occupational health and safety Ensuring health and care workers have access to free mental health treatment and care Providing alternative accommodation for health workers to prevent infections of people living in the same household</td>
<td>Defining and authorising health and non-health workers permitted to vaccinate Developing clinical guidelines, protocols and training programmes and minimum standards for training for administering vaccines</td>
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<tr>
<td><strong>Legislation</strong></td>
<td>Emergency legislation to restrict or cancel leaves of absences Suspend legislation on working hours, change shift working or relax minimum staffing requirements Emergency legislation for public sector organisations to take over private sector hospitals and staff Emergency legislation to launch exceptional recruitment procedures Legislation to clarify or extend medical indemnification to health workers taking on new tasks</td>
<td>Suspending legislation restricting access to mental health services Updating legislation to direct effective use of PPE Calls for all countries to classify COVID-19 as an occupational disease, which can then trigger health worker compensation for, e.g. illness or death</td>
<td>Temporary legislation allowing additional/different types of workers to administer vaccines Legislative amendments to enable retired and foreign-trained staff to administer vaccines Legislation to clarify or extend medical indemnification to health workers newly vaccinating</td>
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<tr>
<td><strong>Regulation</strong></td>
<td>Building competencies through training and education Changing registration requirements to fast track new or “returner” workers Establishing registers of inactive workers Medical and nursing schools approve early graduation Reduce language requirements and waive fees for conversion exams for foreign-trained workers Suspending requirements for re-registration Relevant professional associations or health authorities to develop and offer temporary recruitment contracts Agreement from professional associations that certain professions could take on new tasks</td>
<td>Defining PPE requirements for different roles Establishing helplines/online services for mental health support</td>
<td>Defining professional competencies to administer vaccines</td>
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COVID-19 and governance – key dimensions

Box 1 below highlights the application of surge planning tools at the national level in Kyrgyzstan.

Governance for protecting workforce health and well-being

Another critical aspect of workforce governance during the pandemic has been the need to protect the health and well-being of the workforce. This first became evident as a policy priority early in the pandemic with the large shortage of sufficient Personal Protective Equipment (PPE) and the need to put in place other preventative measures such as hand and respiratory hygiene/cough etiquette to prevent infection. This has had a range of governance implications at all levels, including defining infection control policies and minimum standards of PPE use, monitoring PPE supply and distribution, and the development of regular testing procedures among others (see Table 1). Managers and employers also had an important role in protecting the health of their workforce by providing training to staff, monitoring PPE supply and demand, and ensuring a safe working environment.

There was also a need to protect the mental health of health workers due to stress, intensive workload, and increased volunteers. Box 1 below highlights the application of surge planning tools at the national level in Kyrgyzstan.

Box 1: Applying and adapting health workforce tools to support COVID-19 “Surge” Response in Kyrgyzstan

The Ministry of Health in Kyrgyzstan used health workforce planning tools to rapidly assess workforce requirements to respond effectively to the “surge” of infections during the COVID-19 pandemic. These projections helped inform operational planning and management of the deployment of the workforce, and optimise the aggregation and analysis of relevant data.

The WHO Adapt and Health Workforce Estimator planning tools were used, which had been developed rapidly by the WHO Regional Office for Europe in response to the pandemic. The Ministry of Health and e-Health team in Kyrgyzstan used the tools, with support from WHO experts, using data on the available health workforce, collected both nationally and in the Bishkek (capital) region, and the number of patients hospitalised over time. Treatment times per patient per day, by type of health worker and level of disease severity were determined.

The outputs from the tools were checked to confirm that the estimated workforce times for treating patients was realistic. This enabled an assessment of the potential impact on the workforce if there were to be subsequent surges. The application of the planning tool highlighted which workforce groups would have shortages, and how soon this would occur, and therefore played a major role in supporting effective planning and management of the workforce. Recommendations were made for data collection to highlight any regions and workforce groups in deficit or surplus and indicate which staff may need to be moved or shared to balance resources in order to best respond to the workforce deployment challenges of the pandemic.


* The WHO Adapt and Health Workforce Estimator is available at: https://www.euro.who.int/en/health-topics/Health-systems/pages/strengthening-the-health-system-response-to-covid-19/surge-planning-tools
Box 2: Ireland has implemented an adaptive response to protect the health and well-being of health workers

In Ireland, it has been recognised that the mental health and well-being of health care workers have been severely affected by COVID-19. An analysis by the Health Service Executive (HSE) Workplace Health and Wellbeing Unit showed absence rates in 2020 (6.1%) were 1.4 percentage points higher than in 2019 (4.7%). Since the pandemic began, the HSE Workplace Health and Wellbeing Unit has mobilised and adapted pre-existing structures to safeguard the mental health and well-being of health care workers during the COVID-19 pandemic and worked on strengthening and improving its infrastructure for providing mental health and well-being services to HSE workers. Key aspects of the adaptive response have included:

- HSE Employee Assistance Programme—a free-of-charge, needs based, individualised, confidential and independent counselling service for all HSE workers. The issues identified may be personal or work-related, affecting job performance or home life.
- National Health and Security Function and the HSE Work Positive Framework—provides resources that enable managers and staff to discharge their legal and moral duties with regard to occupational safety and health management.
- Organisational Health Service and WHO healthy workplace framework—supports the implementation of evidence-based best practice to support sustainable health and well-being. It provides direct support to managers and their teams in preventing and managing complex psychosocial risks in the workplace and working environment.
- Occupational health services—provide support to proactively reduce health care worker exposure to work-related stressors; and also in building working environments in which health care workers feel mentally safe. Work and organisational psychology interventions will continue in support of and in response to complex psychosocial workplace risks.

The Workplace Health and Wellbeing Unit is planning for a future of mixed delivery of online and face-to-face services to improve the accessibility of the provided services.

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Source: 12

skill mix changes to expand the workforce staff profile of authorised vaccinators

These long-term solutions to address health and well-being support for the workforce are needed not only to secure a sustainable supply of workers by mitigating against people leaving the workforce, but also to reduce the long-term impacts of decreased quality of life after the pandemic. 11

A critical aspect of effective workforce governance during the pandemic should be the ability to rapidly assess the changing rates of absenteeism amongst the workforce. This can help highlight concerns about health and well-being and support making more informed decisions about where to focus attention on staffing concerns, but this has not been feasible in all countries because of lack of data and monitoring. Ideally this should take account of trends and patterns of variation by area and by occupation. It can also signal where issues of workforce health and well-being are most prominent. An example of good practice in this area can be seen in the National Health Service (NHS) in Scotland, which used nationwide, rapidly updated data to monitor workforce absence (see Box 3).

Governance implications for expanding the workforce to support vaccination campaigns

A population wide delivery system for vaccinations must have workforce at its core. While health workers that normally perform vaccinations, in particular physicians and nurses, have been tasked with administering COVID-19 vaccinations in most countries, some countries have also implemented skill mix changes to expand the workforce staff profile of authorised vaccinators. 14 For example, authority to perform vaccinations has been granted to dentists (Ireland), doctors’ assistants (Germany, Netherlands), medical students (Austria, Israel, Ukraine, UK), paramedics (Austria, Israel, Ukraine, UK), pharmacists (Portugal, Switzerland), physiotherapists (UK) and speech therapists (UK). Some countries have also involved military personnel,
The NHS in Scotland used an absence monitoring and reporting system which provided almost ‘real time’ reporting, updated every week. Absence rates were reported in standard format, by regional health authority (Health Board), by main occupation (nurse, doctor, etc.), and by type of absence (non-COVID related absence was identified separately; and eight types of COVID-related absence were reported) (see Figure below). This rapid, standardised, unified whole system reporting of absence rates and types of absence supported more effective governance of the system, in terms of responsive policies and informed management.

**Figure 1:** NHS Scotland: COVID-19 related types of staff absence over time, March 2020 to April 2021

This unified system covered about 170,000 staff in total, working in the NHS in Scotland. The ability to tap into existing data reporting systems using standard definitions and data templates helped the rapid response, national analysis and reporting. The ability to connect directly with 170,000 employees was also used to conduct research, led by Public Health Scotland, on other aspects of COVID impacts on the population.

Training has been accompanied by the publication of clinical guidance and protocols in some countries (e.g. Ireland, UK), that have been updated as evidence evolves and new vaccines are authorised. Adjustments to payment mechanisms have also been required to support health workers to carry out vaccination, which has often required legislative changes to be made (e.g. Romania), negotiations with professional bodies (e.g. UK) and/or government approval for additional funding (e.g. Ireland).

or utilised members of the public and trained volunteers (“peer” and “non health care”) to administer vaccines (Belgium, Ireland, UK).

There are obvious governance implications to using “new” types of workers to vaccinate, most notably where there is legislation and/or regulation that in normal times limits which professions can be involved (see Table 1). Introducing skill mix changes has necessitated the implementation or suspension of such existing legislation, while in some cases (e.g. Italy) legislation has needed to clarify or extend medical indemnification to health workers newly tasked with administering vaccines. Rules in most countries also still require those vaccinating to be supervised by a registered nurse or physician.

In order to administer vaccines, health workers in most countries have been required to undertake online or in-person training, which was often adapted for different vaccines (e.g. Estonia) or skills of the person undertaking it (e.g. Belgium). Training of volunteers (both with and without medical experience) to assist in all other operations of the vaccination process, including check-ins, taking vitals, helping vaccinators complete paperwork, and staying with people in the recovery area following their jab has also been required. While training in these support aspects of vaccination delivery usually do no necessitate legislative changes, it does have implications for management governance.

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**Box 3:** NHS Scotland closely monitors and manages staff absence

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* See for example Shah ASV, Wood R, Gribben C, et al. Risk of hospital admission with coronavirus disease 2019 in healthcare workers and their households: nationwide linkage cohort study. BMJ 2020;371. doi: [https://doi.org/10.1136/bmj.m3582](https://doi.org/10.1136/bmj.m3582)

**Workforce governance is at the core of the recovery**

Rapidly scaling-up and repurposing the health workforce during COVID-19 has had enormous implications for health workforce governance structures at the national, sub-national and local levels and for coordination and cooperation across all stakeholders. At the time of writing, there has been little comprehensive evaluation of the impact of these governance measures for health workforce planning, recruitment, deployment, management and training; there are thus more lessons to learn and share about how effective the different workforce governance responses have been, in order to be better prepared for the future.
While the pandemic has proved challenging for the health workforce and those involved in its governance, it may provide opportunities for building a more resilient workforce in the future. In many countries, some of the pandemic responses have broken up sclerotic governance structures which have hampered past health workforce development and reform. For example, changes to scope-of-practice that have previously been resisted (e.g. allowing pharmacists to vaccinate) have been implemented with unprecedented speed, while new competencies and training programmes have been rapidly developed, often making use of online delivery. Meanwhile, leadership roles have been delegated to health professionals that did not have them in the past. Monitoring systems that provide more rapid data on staffing levels have been put into place, facilitating greater coordination between health facilities and between health organisations and policy-makers at different levels. Learning from these governance changes will be important to help inform future pandemic responses, and can also provide insights into how governance of the health workforce can be strengthened.

The WHO European Programme of Work 2020–25 has recognised that Member States will face post-COVID-19 recovery related health workforce challenges. The 2021 World Health Assembly further reinforced that Member States should prioritise investments in a sustainable health and care workforce that is responsive to population needs, universal health coverage and future preparedness and response capacities, aligning with the Year of the Health and Care Worker theme: Protect. Invest. Together.

Health system recovery and future preparedness will be dependent on the workforce and the continuing ability to flexibly mobilise, train and deploy sufficient health and care workers with the necessary skills, whilst also making effective use of technology. In turn, the workforce itself must be “protected”: supported and enabled to recover, rebuild and repurpose. Notably, the pandemic has left its mark on workforce health and well-being, with increasing concern about workforce absence, burnout and the potential of higher levels of turnover and early retirement. If the workforce is to be both effective, and effectively protected, then system responses will have to be channelled through the four strands of workforce governance which have been identified in this paper, with appropriate coordination by the different responsible authorities.

References


Box 4: The Israeli vaccination workforce has been led and managed by the nursing profession

Managing the COVID-19 vaccination campaign in Israel was a complex and significant challenge that involved aspects of policy, legislative, and management governance.

To meet the campaign objectives defined by the Israeli government, the Ministry of Health (MOH) published a professional outline defining the groups within the health workforce which were authorised to vaccinate, the training and professional competences required, and the legal authorisations enabling them to do so. According to the outline, the workforce authorised to vaccinate included doctors, nurses, and certain advanced medical students and paramedics.

The Nursing Division at the MOH formulated a national training programme for all vaccination teams, and conducted webinars with thousands of physicians and nurses. Videos, information sheets, and posters were also produced and distributed to all clinics, forming the professional basis of clinical knowledge required to deliver the vaccination programme.

The chief nurses at the health plans and hospitals have led and managed the vaccination campaign workforce. They deployed personnel to vaccination clinics, trained them according to the required programme, supervised and monitored their quality and safety of practice with structured tools and procedures.

One significant resource, which reinforced the nurses, were civilian paramedics who had been certified in the past as military paramedics, and had since maintained ongoing professional qualification. This was the first collaboration of its kind between the MOH and the Israeli Defense Forces (IDF). More than 700 paramedics were recruited and trained by the health plans for four months, and worked under the direct supervision of the nurses. Within this framework, paramedics received access to patients’ digital files for assessing and documenting and were required to meet the standards of safety and quality.

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Use of digital health tools in Europe: before, during and after COVID-19

By: N Fahy, GA Williams, COVID-19 Health System Response Monitor Network

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Digital health tools hold the potential to improve the efficiency, accessibility and quality of care, but widespread adoption in Europe had been slow prior to the COVID-19 crisis. Many digital health tools nevertheless moved from being viewed as a potential opportunity to becoming an immediate necessity during the pandemic, and their use increased substantially. This forthcoming policy brief takes stock of how digital health tools have been used in Europe during the COVID-19 pandemic, in order to review what has happened, assess how uptake and use of these tools has been facilitated, identify issues that are emerging, and learn lessons for the longer term to support the sustained use of digital health tools in the future.

The authors show that digital health tools have been used to support four main areas during the pandemic: communication and information, including tackling misinformation; surveillance and monitoring; the continuing provision of health care such as through remote consultations; and the rollout and monitoring of vaccination programmes. Policy changes to regulation and reimbursement, investment in technical infrastructure, and training for health professionals has been needed to facilitate utilization. The authors conclude by arguing that greater strategic investment is needed longer term to support developments in digital health, targeting both the development of infrastructure within the health setting and outside (e.g. internet provision), and research and development to ensure that technologies continue to evolve.