HUMAN RESOURCES FOR HEALTH DURING COVID-19: SUPPORTING AND PROTECTING HEALTH WORKERS

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Summary: Health workers have worked long hours in highly stressful environments during the COVID-19 pandemic, which has had enormous implications for their physical and mental health. European Union Member States have put in place a wide range of measures during this uniquely challenging period to protect and support health workers and to help guide professionals facing difficult ethical decision-making in patient care. In the future, the recovery of health systems will be dependent on ensuring continued support for health workers to reduce absenteeism, turnover and early retirement. This will require continued mental health support, along with wider reforms to improve working conditions and working lives.

Keywords: Health Workforce, Mental Health, Ethics, COVID-19

Introduction

Health workers often work long hours in demanding and stressful work environments, but these pressures have increased drastically during the COVID-19 pandemic. Many health workers have had to care for very sick and dying patients, while adhering to strict hygiene measures and other COVID-19 restrictions. Some have taken up new roles and sometimes unfamiliar tasks, while others have had to adapt quickly to a shift to remote working. Moreover, health workers have had to deal with practical barriers to working as a result of measures implemented to reduce the transmission of COVID-19, such as closure of childcare facilities and schools or reduced public transport. These factors together have taken a dramatic toll on the health and wellbeing of health workers across the European Union (EU); rates of anxiety, fear and emotional distress have substantially increased, linked to feelings of helplessness, lack of support and essential personal protective equipment (PPE), the trauma of COVID-related deaths and fear of transmitting the virus to friends and family.

The high demands placed on health workers have seen EU Member States take action to create safe working environments, as well as to support mental
In this article, we provide an overview of the strategies that have been adopted to support health workers, both in clinical settings and outside; an overview of these strategies is provided in Table 1. This work provides an update to a previous study that reviewed strategies to protect and support health workers during the first wave. Here, we cover a longer-time frame, with data extracted from the COVID-19 Health System and Response Monitor from April 2020 to July 2021. We conclude by considering some reforms to improve working conditions and working lives that may be needed in the future to help support health workers further and help reduce the potentially high number of staff that may choose to leave their profession.

<table>
<thead>
<tr>
<th>Support strategy</th>
<th>Implementation examples</th>
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| Protecting physical health | • Putting in place hygiene measures in health and long-term care facilities  
• Ensuring sufficient and appropriate personal protective equipment  
• Providing regular testing for health and social care professionals  
• Putting in place isolation procedures  
• Moving vulnerable staff to remote roles  
• Shifting towards remote consultations where appropriate |
| Mental health and wellbeing support | • Providing helplines, websites or apps offering counselling or referrals for additional support  
• Provide guidance and support on the ethical aspects of working during a health crisis  
• Offering remote counselling sessions  
• Organising wellbeing sessions in health facilities  
• Teaching self-care  
• Relaxing rules to access mental health support |
| Financial compensation | • Awarding bonuses to health and social care workers working with COVID-19 patients or in long-term care  
• Offering vouchers or financial compensation of childcare for health workers  
• Defining COVID-19 infection as an occupational disease, entitling health workers and their families to sick leave or compensation |
| Other practical support | • Keeping schools open for children of essential workers  
• Providing free parking, free transport to health workers  
• Free accommodation if shielding family from potential transmission  
• Campaigns to reduce discrimination against health workers  
• Continuing medical education credits |

Source: 5

Table 1: Strategies to protect and support health workers in EU Member States during the COVID-19 pandemic

Measures to protect physical health within clinical settings mainly focuses on mitigating against the risk of infection

Being at the forefront of treating COVID-19 patients has placed health workers at high risk of infection. To reduce this risk, health facilities in all Member States have had to put in place preventative measures such as hand and respiratory hygiene/cough etiquette, alongside ensuring provision of sufficient PPE, regular testing and enforcement of isolation procedures. In the early stages of the pandemic, however, logistical issues combined with the global shortage of sufficient PPE and difficulties in scaling-up testing facilities in many countries made the provision of PPE and routine testing immensely challenging. It should also be noted that working in full PPE for long hours has placed an extreme physical toll on many health workers, adding further to stress and exhaustion levels.

More recently, it has become paramount for countries to ensure health workers have access to vaccinations. Given limited availability early on, almost all Member States identified health care workers as a priority group to receive COVID-19 vaccines. Some countries (e.g. France, Greece, Italy) have since mandated compulsory vaccinations for some or all health workers to promote uptake and help protect health workers and patients.

To further protect health workers, some countries have moved older health workers or those with chronic conditions that make them vulnerable to COVID-19 away from face-to-face interactions with patients. The huge shift towards remote consultations in care areas such as primary care has played a key role in keeping staff safe (see the article in this issue by Williams et al. on digital health). Some health providers or regional/national governments have also provided free accommodation for health
Implementing measures to protect the physical health of health workers has required coordinated governance actions across the health system. For example, national or regional policies have been needed that define infection control policies and minimum standards of PPE use in different health and long-term care facilities and for different types of health worker. Systems for monitoring PPE supply and distribution and the development of regular testing and isolation procedures have also been required. Managers and employers meanwhile have played an important role in protecting the health of their workforce by creating and ensuring a safe working environment, training staff on infection control measures and use of PPE, monitoring and reporting PPE supply and demand, and monitoring staff absences.

**Measures to support mental health and wellbeing are becoming more accessible**

The stress and intensive workloads during the sustained period of COVID-19 has increased the risk of mental health problems and burnout for frontline workers, with some groups of the health and care workforce facing more risk factors than others. Research shows that as many as 43% of frontline workers are experiencing significant levels of anxiety, with a prevalence of 27% in nurses and 17% in medical doctors, higher levels than before the pandemic. A further study reported that as many as 40% of clinical staff working in intensive care met the clinical threshold for post-traumatic stress disorder.

In light of increasing levels of stress and psychological disorders, the majority of Member States have put in place measures during the pandemic to protect the mental health and wellbeing of health workers. In most countries, this support took the form of governments, professional associations and/or health providers establishing helplines, apps or online resources where health workers could seek support and, if needed, referrals for further help. Free remote counselling sessions have also been made available in some countries (e.g. Denmark, Finland, Italy, Lithuania, Malta, Poland). Other types of support have included training on self-care provided online or by health providers, the establishment of a “buddy-system” whereby health professionals can talk to a matched peer and health providers offering mindfulness and wellbeing sessions.

Alongside the implementation of targeted mental health support, initiatives to manage the work environment, such as through implementation of breaks, ensuring the availability of staff break rooms and beds and sufficient staffing levels, were also important for protecting mental health, and will be so beyond the crisis period. The World Health Organization (WHO) Regional Office for Europe has supported countries in developing mental health support for health and social care workers (see Box 1).

Putting in place mental health and wellbeing initiatives has had important governance implications. Changes in regulation have been required in some countries, for instance to relax requirements on seeking help during working hours, to make counselling available for free, or to remove limitations on seeking help directly and not via an employer. The development and provision of guidelines by professional associations or government actors on protecting mental health and wellbeing aimed at employers and health workers have also been important in shaping mental health initiatives. Managers and employers also had to play a critical role in creating a supportive work environment to ensure health workers feel able to seek help when required. New, targeted funding has also been needed in many instances; for example, in Sweden the government provided SEK 150 million (about €14.6 million) in crisis support for staff who have undertaken COVID-19 related work with older people in long-term care.

The mental health burden for health workers has been exacerbated by feelings of moral injury, which arise when health
Box 2: Measures in France to support health professionals with ethical issues that emerged during the COVID-19 pandemic

In March 2020, the French National Consultative Ethics Committee (CCNE) issued an opinion at the government’s request on Ethical issues in the face of a pandemic. This opinion proposed that “health care teams need ethical support, which could be provided by an ethical support unit”.

The 15 Regional Ethical Reflection Centres (ERER) have all taken up the CCNE’s proposal and have created ethical support units (CSE) throughout France. The ERERs, with the constant support of the Ministry of Solidarity and Health, anticipated the need for providing assistance to professionals dealing with ethical questions as a result of caring for COVID-19 patients and public health measures taken to address the pandemic. Actions were developed to respond to this need by consulting with professionals to establish their concerns on ethical dimensions, helping them with ethical dilemmas, and guiding them with the help of ethical reflection tools (i.e. an ethical reflection grid, asking questions and then applying major ethical principles, etc.). These issues were analysed at local level, and where justified, at the national level.

Upon reflection, it was found that health professionals indeed needed this reassurance due to their concern about whether their practice may deviate from ethical principles. The main concerns related to the decision to provide care; maintaining links (especially between patients/residents and their families); support at the end of life; mortality/funeral; home confinement; governance and organisation of care; consent for testing; support for ethical reflection; health democracy; the suffering of carers; and research ethics. From March to September 2020, the CSEs dealt with 245 referrals (including 21 self-referrals), primarily from health care professionals and managers of hospitals, care homes and other institutions.

By taking account of the perspectives and ethical questions of health professionals as well as patients, governments can endeavour to move towards more inclusive and participatory health policymaking (including in times of health crisis), which is a challenge for health democracy (see the article by Rajan et al. in this issue).

workers have to act against their beliefs or values; for example, by being unable to provide appropriate care due to resource constraints or watching patients die without friends or family present. In recognition of these challenges, the Minister of Solidarity and Health in France asked the National Consultative Ethics Committee to consider the potential ethical issues facing health workers during the pandemic and potential options for providing support (see Box 2).

Strategies to provide financial support have compensated for lost income or offered bonuses

Most countries have also provided financial support to health workers. In many cases this has been to compensate for income lost during the pandemic (see the article by Webb et al., for more details), but in other circumstances it has been to reward health workers for their work during COVID-19. This was usually provided through bonus payments (e.g. Estonia, France, Greece, Germany, Hungary, Italy, Romania) or occasionally monthly salary increases for the duration of the crisis (e.g. Latvia, Lithuania). In France, financial bonuses have been awarded to all staff working in public hospitals, staff working in private hospitals that care for COVID-19 patients, and those working in nursing homes. The bonuses paid depended on how severe the COVID-19 outbreak was in the region: ranging from €500–1,500 for health workers and from €1,000–1,500 for nursing home staff. Allied health students that participated in handling the second wave of the pandemic also received financial compensation of €550 per month.

In addition to bonuses and salary increases, some countries have recognised COVID-19 as a work-related injury for health care staff, enabling them to access associated benefits (e.g. Denmark, France, Lithuania, Spain). In Lithuania, Romania and Spain, health workers’ families are also entitled to receive a lump sum payment if a health care worker working with COVID-19 patients dies due to COVID-19 infection. In Spain, Social Security will consider COVID-19 as the cause of death if the fatality occurs within five years after the onset of the infection. Furthermore, to support prevention efforts, doctors in Poland received 100% of their salary if they were required to quarantine or isolate.

Additional support measures included providing childcare, continuing educational credits and efforts to reduce discrimination

In the early months of COVID-19, health workers were often viewed as “heroes” and received a wave of support and goodwill from the public. But as the pandemic progressed, health workers in many countries have faced increasing hostility, anger and sometimes violence. There are a variety of reasons for this occurrence which may emanate from members of the public viewing health workers as an infection risk, or those who felt the threat from COVID-19 was overstated and were protesting COVID-19 prevention measures and vaccinations. In some cases, professional associations, health providers and occasionally governments have publicly called for this abuse to stop. In Poland, for example, the University Hospital in Zielona Góra together with the Polish Radio West promoted a ‘support the medic campaign’ (#wspierajmedyka) to reduce discrimination and harassment against health workers. Overall, however, actions and legislation to address this issue have been lacking.

Interventions that countries have taken to control the spread of COVID-19, such as closing schools and childcare facilities and reducing public transport, have
created practical barriers to working for some health workers. To help overcome these challenges, special provisions were implemented in some countries to keep schools and childcare facilities open for key workers, including health care staff (e.g. in Austria, Belgium, Czech Republic, Denmark, France, Germany, Vilnius Municipality in Lithuania, Netherlands, Portugal). Free transport and accommodation were also provided in some countries in initiatives either from national or local government or individual health providers (e.g. Hungary, Malta, Poland, Romania). Health workers in Helsinki, Finland meanwhile were granted free parking near health facilities.

Another example of support for health workers in some countries has been to reward them with continued education credits for their work during the pandemic. In Italy, for instance, doctors, dentists, nurses and pharmacists who continued working during the COVID-19 pandemic have been awarded 50 Continuing Medical Education (CME) credits for the year 2020.

Conclusion: Improved mental health support and working conditions are needed to support health workers during the pandemic and in the future

The COVID-19 pandemic has placed health workers under high and sustained pressure. Even when the pandemic eventually subsides, many of these pressures are likely to remain as health systems grapple with addressing care backlogs that have emerged as a result of postponed care and which may have been worsened by staff leaving the profession due to exhaustion and burnout during the pandemic (see the article by van Ginneken et al. in this issue on addressing backlogs and managing waiting lists). Health workers will be key towards the recovery of health systems after the pandemic, but can only do so effectively if they are supported and allowed to recover themselves.

This article has shown that a number of physical, mental health, ethical, family, and financial support options were available to help support health workers during the COVID-19 crisis. While these were often adopted temporarily during the specific circumstances of the pandemic, many will remain relevant in the future as strategies to help to improve working conditions and working lives. For example, long-term solutions for the provision of appropriate mental health and wellbeing support for the workforce will be an important element going forward as will the development of systematic procedures to capture and respond to ethical questions of health professionals. The increase in harassment and violence against health workers, in some countries, is also a concerning development that needs highlighting and may require legislation to address.

A long-standing challenge for some Member States will be to improve salaries and other financial compensation to increase retention and reduce migration to countries that offer better renumeration. It will be equally imperative for Member States to take action to improve work-life-balance and working conditions, such as by enforcing limits on working hours and rest requirements and providing, for instance, break rooms and staff beds. Guaranteeing appropriate training and career pathways to support progression will also prove vital to attract and retain health workers. However, efforts to improve working conditions, work environments and work-life-balance will be more successful if they are part of wider actions to improve the number and skill-set of the health workforce across Europe.

References

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