

# ETUI Policy Brief

European Economic, Employment and Social Policy

N°11/2020

Covid-19  
impact  
series

## Our failure to prevent known risks: Occupational safety and health in the healthcare sector during the COVID-19 pandemic

—  
Paula Franklin

Paula Franklin is a senior researcher at the European Trade Union Institute (ETUI) in Brussels.

### Policy implications

- Hazards from SARS-CoV-2, the virus that causes COVID-19, should be addressed in line with the EU Biological Agents Directive and by means of a strengthened centralised capacity of the European Union for the monitoring of and response to health emergencies.
- Mitigating and preventing the impact of the illness, COVID-19, should be done by classifying it as an occupational disease, ensuring the availability of personal protective equipment (PPE) and testing for health workers, and engaging workers in all aspects of 'work organisation'.
- The coronavirus crisis, which is the result of the impact of the nexus of austerity/virus/illness on society at large, should trigger a transformative change in the care economy, leading to the valuing of care work, pay transparency, full acknowledgement of psychosocial risks such as violence and harassment in the world of work, measures to promote occupational health equity, sustainable health workforce planning and the inclusion of the currently absent gender aspect in EU legislation on occupational safety and health.

### Introduction

The COVID-19 pandemic has brought numerous healthcare terms to the public's awareness. On a daily basis, we hear about respirators, N95 masks and personal protective equipment. Tributes to health workers have been echoing on the streets with people applauding their heroes for all their hard work. What is less audible is how austerity measures have contributed to the extremely demanding situation of health workers. Many policymakers voted to cut healthcare spending on staff, equipment and training in response to the fiscal pressures triggered by the 2008 economic crisis. These budget cuts affected women disproportionately, as they make up the majority of workers in the public sector and in the health sector in particular. It was predicted that the short-term savings would lead to negative unequal consequences for health outcomes and increased risks to staff safety in the long term (Thomson *et al.* 2014). The COVID-19 crisis has magnified these risks, as demonstrated by the lack of surge capacity, i.e. the ability of a community and healthcare systems to respond to a sharp increase in service demand. The occupational safety and health (OSH) situation of health workers is made worse because the OSH of women is far less likely to be considered, practised and accepted, and OSH legislation is essentially genderblind (EUOSHA 2014).

A fourfold argument is presented in this policy brief. First, the difficult working conditions of health workers at the front line of the pandemic response bring into focus the importance of eliminating gender inequalities in the world of work. Second, all health workers should have equal health and safety protection. Third, the 'hierarchy of controls' framework used in OSH should be completed from a 'work organisation' perspective to acknowledge the importance of the prevention of psychosocial risks. And fourth, in order for OSH measures in healthcare to be efficient, the principles of workplace democracy should be applied.

**etui.**

## The coronavirus crisis: exposing the consequences of austerity

The 2008 financial crisis led to reduced spending in public services, and health systems became a target for cuts. The salaries of health professionals were frozen, and some were even reduced. For nurses – the largest group of health workers – recruitment and retention rates were diminished and there was a reduction in nurses' posts across Europe (EPSU 2019). Large or sustained cuts to health-worker salaries where these were already low led to unintended consequences such as the out-migration or early retirement of skilled workers and an increased staff workload (Thomson *et al.* 2014). As early as 2012, the European Commission estimated the gap in supply of human resources in health by 2020 to be approximately 1 000 000 health professionals. Privatisation of services in the care economy routinely leads to lower wages, poorer working conditions and less secure employment (PSI 2019).<sup>1</sup>

The coronavirus crisis has highlighted severe shortcomings within healthcare in terms of workers' health and safety. First, inadequate staffing levels in Europe have worsened the effects of the coronavirus crisis. Despite the commitment of health professionals to maintain a quality service during the COVID-19 pandemic, their workplaces, which are often understaffed and under-resourced, are riddled with biological hazards and psychosocial risks. Second, with the onset of COVID-19, the demands for time efficiency have increased dramatically. Employees of home care services have to find time in already tight schedules for hand-hygiene and protective equipment routines (Pelling 2020). The lack of workers' participation in work organisation in situations such as this is apparent. Finally, but no less importantly, what can also be observed during the coronavirus crisis are inequalities in occupational health. These are avoidable differences in work-related morbidity and mortality that are closely linked to work arrangements, socio-demographic characteristics of the workforce (e.g. gender, age and ethnicity) and organisational factors. Occupational health inequalities can be found not only across industries, but also within an industry, as not all workers are exposed to the same level of health risks. Data in the UK, for example, show that social care workers have been twice as likely to die from COVID-19 as health workers. The deaths of doctors (GPs or hospital physicians) due to COVID-19 in France have tended to relate to professionals in their later years of service or those who have responded to a call to return to the health service. Meanwhile, the predominantly female long-term care (LTC) workers suffer disproportionately from health problems; 60% of the workers are exposed to physical risk factors, and 44% have mental health problems (OECD 2020). The challenges in the health and long-term care systems and the lack of integration between them is well documented across the Member States of the European Union (EU) (Spasova *et al.* 2018; European Commission 2019). While the systems are diverse in their structure

and funding, they share a fundamental common denominator: the feminisation of the workforce.

## Absence of gender in EU OSH legislation

While many hazards create a risk of harm in healthcare, prevention measures are often insufficient (Musu and Vogel 2018). Women are disproportionately represented in the health workforce, whose exposure to the SARS-CoV-2 virus that causes COVID-19 is high. The EU Labour Force Survey (2018) reports that, of all those employed in the human health activities sector in the EU27, 75% are women. Nursing is the largest occupational group in health services: in Europe, 90% of nurses are women. Moreover, a considerable percentage of health and care workers in the EU are migrants: for example, nearly one in five personal care workers are migrants. The growing demand for long-term care workers and significant differences in pay and working conditions between different countries has induced an influx of mainly women migrant workers. The EU has committed to implement the Sustainable Development Goals (SDG) in its internal policies, and one of the important targets related to gender equality is number 8.8 'Protect labour rights and promote safe and secure working environments of all workers, including migrant workers, particularly women migrants, and those in precarious employment'.

Health workers often end up compensating for the shortcomings of health systems through individual adjustments, sometimes to the detriment of their own health and lives (George 2008; Wenham *et al.* 2020). As noted by the World Health Organisation (WHO 2006), 'because their job is to care for the sick and injured, HCWs [healthcare workers] are often viewed as "immune" to injury or illness. Their patients come first. They are often expected to sacrifice their own well-being for the sake of their patients.' These shortcomings in OSH and working conditions in care services replicate gender inequalities in society more broadly. The importance of the 'care economy' lacks acknowledgement, and structural gender inequalities are replicated in the production of healthcare. For example, nursing suffers from an image of 'low-skilled work' that fails to match the reality of a professional life defined by high-level technical, emotional and cognitive skills (Clayton-Hathway *et al.* 2020). This is one of the reasons for the existence of a wage penalty for working in female-dominated occupations and industries (Müller 2018). Furthermore, over-qualification is a rather common phenomenon among skilled migrant women working in care (e.g. qualified medical nurses), who encounter difficulties in validating their qualifications and therefore tend to face a higher risk of being disadvantaged by unfair recruitment practices (Cangiano *et al.* 2009; EIGE 2020).

Health and safety at work is one of the areas for which the EU has developed a legal framework. The system of EU OSH legislation is based on Article 153 of the Treaty on the Functioning of the European Union, and it is Council Directive 1989/391/EEC that establishes the 'basic law' on occupational safety and health in the EU. This Directive covers the hierarchy of prevention and control measures (see Figure 1), including organisation of work, working conditions, social relationships and the working environment (Brück 2016). In December 2019, the Council of the European Union noted in its

<sup>1</sup> As an example, an inner-city district of Stockholm, Sweden, has more than 50 private elderly care workers, and, at the start of the pandemic in March, 40% of home care workers were employed on hourly contracts, from day to day and hour by hour. In the 1980s, an employee of the home care service would visit four people during a full-time shift; in 2015, that employee was expected to visit 12 people in the same time period. This is in spite of the fact that those who are granted home care service today are older and more vulnerable than the same group in the 1980s (Pelling 2020).

Conclusions the importance of occupational safety and health as well as decent working conditions as measures to guarantee wellbeing at work. Chapter II of the European Pillar of Social Rights (EPSR) specifies fair working conditions that include workers' rights to a healthy and safe work environment. What remains absent from EU OSH legislation is the gender dimension. Differences between female and male working lives – vertical and horizontal segregation – result in differences between the hazards and risks to which women and men are exposed. Women-dominated sectors such as health care are highly exposed to third-party violence, musculoskeletal disorder (MSD) risk factors and psychosocial risks (EUOSHA 2013; ILO 2018; Weber and Henke 2016). Although questions regarding the effects of occupational exposure to dangerous substances have been raised, they remain under-assessed in female-dominated industries and industries where women make up a large proportion of the workforce. The 2013 EUOSHA report on *New risks and trends in the safety and health of women at work* underscores that work-related risks to women's safety and health have been underestimated and neglected compared to men's, regarding both research and prevention. This situation is apparent in the risks that health workers are having to face during the COVID-19 pandemic.

## Poor work organisation can create hazards that endanger workers' safety and health

The concept of 'work organisation' is directly associated with the quality of work and employment. It refers to the choices made within organisations regarding issues such as how the tasks to be performed are structured and how they are allocated to workers. Poor work organisation can cause or contribute to injuries and illness. Exposure to physical hazards and psychosocial risks in healthcare arises, for example, from understaffing, excessive overtime, work overload, time pressure, a lack of training for the tasks being performed, an insufficient number of rest breaks and days away from work, low wages and job insecurity. A significant factor involved in work organisation is decision-making, in particular understanding whose knowledge is important in the planning of work. Workers' participation should form the basis of work organisation, and their involvement through information, consultation and participation in organisational decision-making is essential in order to ensure that OSH risk assessment and prevention plans remain relevant.

### Box 1 Why did medical staff in China spurn offers of psychological help over COVID?

'In Wuhan, the source of the COVID-19 outbreak, psychological support systems were implemented. These included building a psychological intervention team, online courses for medical staff to deal with psychological problems, and a psychological hotline team, which provided guidance to solve psychological problems and stress management. But medical and nursing staff did not use these services. When surveyed as to why they avoided them, people said they simply needed breaks that were uninterrupted, refreshments, enough equipment to keep them safe and the ability to communicate with families to reassure them. Their needs were more fundamental than psychological support.' (Marshall 2020)

'Decent work' in the healthcare sector respects human rights and the rights of workers in terms of conditions of work safety and remuneration, as well as workers' physical and mental integrity. **A democratic workplace protects all workers' rights and provides the possibility to execute those rights in practice.** In the context of the COVID-19 pandemic, this means, for example, allowing workers to exercise the right to remove themselves from a work situation that they have reasonable justification to believe presents an imminent and serious danger to their life or health, and not be required to return to a work situation where there is continuing or serious danger to life or health. Workers must be provided with a blame-free environment in which to report on incidents, and health workers who exercise their rights must be protected from any undue consequences (WHO 2020).

## Measures to protect health workers from COVID-19: 'hierarchy of controls' framework

Controlling exposure to occupational hazards is a fundamental way of protecting workers. The inverted pyramid known as the 'hierarchy of controls' (Figure 1, see below) is widely used in OSH planning, and it exemplifies the different levels of controls that should be applied in workplaces.

The most effective measures for controlling the spread of infectious diseases – elimination and substitution – are not options in healthcare settings. While the risk from SARS-CoV-2 can be eliminated from general healthcare settings by placing patients in centres for infectious diseases, this, for the most part, has not been done. Recommendations to prevent exposure to the virus in healthcare facilities thus focus on engineering and administrative controls, and on the use of personal protective equipment (PPE). As for psychosocial risks, the whole gamut of controls is required.

According to the hierarchy of controls pyramid, prevention of workers' exposure to the biological hazard that causes the COVID-19 disease can be achieved through a combination of measures at three levels: *engineering controls* that reduce exposure by placing a barrier between the hazard and the worker; *administrative controls* that concern work practices and policies; and the use of *PPE*, i.e. specialised disposable clothing or equipment used by health workers to protect themselves from exposure to infectious substances. The COVID-19 pandemic is a new and evolving situation, and continuous monitoring of OSH is therefore needed to ensure that the control measures reflect the most recent scientific knowledge. The following presents a non-exhaustive list of short-term engineering and administrative measures as recommended by a number of authoritative institutions<sup>2</sup> in the field of COVID-19 and occupational safety and health in healthcare settings.

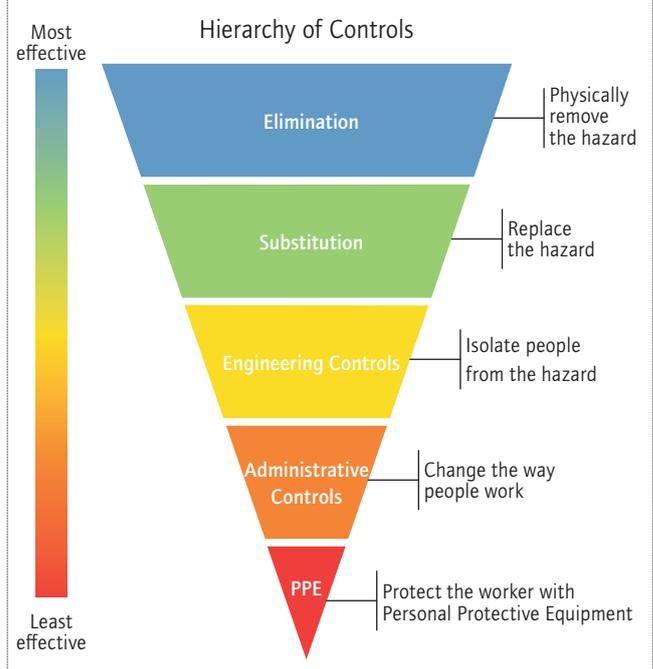
2 These measures are based on guidelines published by centres for disease prevention and control in the US, Canada, Australia, and Europe, and by European and international organisations, including the World Health Organization (WHO), the European Centre for Disease Prevention and Control (ECDC) and the EU Agency for Occupational Safety and Health (EUOSHA).

*Short-term engineering measures* involve the installation of physical barriers to provide protection from infection. The provision of separate patient pre-screening areas limits the number of patients going to hospitals or outpatient settings. A glass or plastic window or partition placed between an ill person and a health worker (e.g. receptionist) can prevent the virus from reaching staff. Installing an appropriate ventilation system in the premises and performing aerosol-generating procedures on patients with confirmed or suspected COVID-19 in an airborne infection isolation room (AIIR) can prevent aerosols from circulating freely in the air. Antechambers for staff donning and doffing of PPE limit the spread of the virus in the premises. Alcohol-based hand rub, soap dispensers and paper towels at points of care are an effective way of preventing the spread of pathogens and infections in healthcare settings. Skin moisturisation prevents hand hygiene-induced skin damage and severe hand irritation (chemical risks).

*Short-term administrative measures* include estimating needs in terms of patient beds, respiratory support, PPE, staff and diagnostics, as well as laboratory capacity and therapeutics. In addition, all control measures should be evaluated for their efficacy to prevent and mitigate the transmission of the virus. Conducting organisational and staff risk assessments is also essential. For example, medical examinations should be conducted to assess workers' fitness to work and to avoid any complications from pre-existing medical conditions; risks to pregnant workers should also be thoroughly assessed. Fit testing of PPE with health workers prior to receiving patients and comprehensive respirator training provided by employers to employees prior to use serve to prevent the risk of exposure to the virus. Management can use administrative measures to limit the number of staff that are exposed to the biological hazard, for example by allowing only dedicated health personnel to care for COVID-19 patients, including taking on the responsibility for food delivery to patients and the cleaning of their rooms. Organising the testing of health workers for COVID-19 is an important preventative measure in that it enables the identification of infected and ill workers who should self-isolate and thereby stop the spread of the virus. Support workers' role in preventing the biological hazard of the virus is crucial. One of the objectives of administrative measures is to establish a programme for the regular cleaning of healthcare facilities and to follow a policy of disposing of all waste as infectious clinical waste. The availability of PPE is vital, and PPE should also be used by any staff engaged in waste management. Administrative measures also include the use of telemedicine to screen and manage patients and to decide on the appropriate level of care. Owing to the increased workload resulting from a communicable disease outbreak, non-urgent patient appointments should be postponed and rescheduled so that staff can focus on treating COVID-19 patients.

The SARS-CoV-2 virus requires the implementation of specific occupational safety and health measures in the world of work and, more specifically, in the health sector. The engineering and administrative measures can prevent and mitigate the biological hazard of the virus to workers to certain extent. However, the hierarchy of controls pyramid originated in the 1950s as a standard to be used by industrial managers and is thus limited in scope. Applying the framework to analysis of the context of healthcare requires the inclusion of the 'work organisation' perspective. This is clear when looking into psycho-social risks that have intensified during the pandemic.

Figure 1 The hierarchy of controls developed by the US National Institute for Occupational Safety and Health (NIOSH)



## Preventing and mitigating psycho-social risks in healthcare settings

Psycho-social risks (PSRs) to health workers are well-documented and become exacerbated during disease outbreaks. During the COVID-19 pandemic, a shortage of staff and resources and increasing social tensions have resulted in an increased level of violence against health workers. Harassment, threats and aggression against health workers have been reported both inside and outside care facilities during the COVID-19 crisis.

The aspect of poor 'work organisation' is apparent in the COVID-19 pandemic. Health workers are required to work longer hours because of the increasing demand for health services. Owing to the shortage of health workers in many countries, junior staff are working in demanding new roles and retired personnel have been called back to duty. Long working hours, shift work and a high workload can lead to fatigue, occupational burnout, increased psychological distress or declining mental health – affecting not only the health of health workers but also the quality and safety of the care delivered.

Ergonomic risks increase as a result of having to move and lift a large number of patients and endure the physical strain of PPE use – dehydration, heat and exhaustion – leading to work-related stress and musculoskeletal disorders (MSDs). The constant state of awareness and vigilance required with regard to infection control procedures and the repetitive nature of procedures that must be followed can be draining.

Witnessing a large number of patients suffering and dying, communicating with and comforting their relatives, and worrying about one's own health and that of colleagues, not to mention needing to maintain physical distancing from family members

because of the risk of infecting them, can be extremely demanding emotionally.

Short-term OSH measures designed to prevent and mitigate PSR during the COVID-19 pandemic include<sup>3</sup> (the hierarchy of controls level from the most effective to the least effective is given in parentheses):

- Zero-tolerance of violence against health workers at the workplace and on the way to and from their workplace (elimination).
- Classification of COVID-19 as an occupational disease, thereby providing income maintenance to workers (elimination of financial stress).
- Prevention of the risk of violence and harassment through controlled access to care facilities, video surveillance and alarm systems (engineering).
- Prevention of the risk of violence and harassment through worker training, escorts to and from parking areas, liaison with police and efficient reporting procedures (administrative).
- Pre-deployment training for health workers to help them adjust to the challenging situations that they will face (administrative).
- Adequate staffing levels so that workers have appropriate working hours and enforced rest periods, and can take breaks, have time off between shifts and take their annual leave (administrative).
- Provision of access to mental health and psychosocial support (administrative): for example, the establishment of a dedicated mental health hotline or on-site counselling services for staff.
- Domestic support measures, such as on travel to work, childcare, care of ill or disabled family members (administrative).
- Effective crisis communication between hospital leaders and infectious disease experts, and within care institutions. As the information about SARS-CoV-2 changes, policies and practices may also change, and all health care workers need to be aware of these changes (administrative).
- Availability of all relevant equipment and materials to reduce the anxiety caused by the risk of infection (administrative).

A number of authoritative organisations have performed extensive mapping of hazards and levels of risk and provided guidance in relation to healthcare settings. The issues are known; however, does this knowledge take into account the lived reality of workers in ensuring their safety and healthy working conditions?

## Falling short in protecting health workers

Reports from the field and emerging academic studies on working conditions and the occupational safety and health of the feminised health workforce highlight vulnerabilities that the COVID-19 pandemic has exposed and aggravated within health systems. Juxtaposing the recommendations for preventative measures for the biological hazards and psychosocial risks that shape the lived reality of health workers tells a tale of multiple malfunctions across the various levels of control.

---

3 These measures were collated from recommendations made by the European Centre for Disease Prevention and Control (ECDC), the European Agency for Occupational Safety and Health (EU-OSHA), the World Health Organization (WHO), the International Labour Organization (ILO) and from scientific research.

## Working conditions

People working in the health sector are known to be especially vulnerable to gender-based violence and harassment, and yet workplace policies that promote zero-tolerance for all forms of violence and harassment, and mandatory risk and hazard assessments by employers are often lacking (EU-OSHA 2020). In addition to all the psychological strain to which health workers are exposed at work, their not being able to be close to their family because of the risk of infecting them (i.e. physical distancing at home or living in separate accommodation) highlights the importance of taking into account the social dimension of occupational risks and the work-life balance as part of PSR prevention.

Social protection of health workers is insufficient; in April 2020, only 13 Member States had adopted new measures facilitating access to paid sick leave in the current crisis (Eurofound 2020). This leaves many workers vulnerable to catastrophic loss of income. Moreover, there are only a handful of EU countries that recognise COVID-19 as an occupational disease, even in the health sector (e.g. Belgium, Denmark, Germany and Italy).

## Work organisation

The implementation of administrative measures relating to staffing practices has proved to be challenging during the COVID-19 crisis owing to staff shortages. In many countries, health workers have come out of retirement to work in acute hospital settings in order to help colleagues overwhelmed by the pandemic. Because of their advanced age, they are at a higher risk of infection, hospitalisation and death (Alberta Health Services 2020). There have also been alarming reports of pregnant nurses and healthcare assistants working in direct contact with COVID-19 patients. Working long hours increases the risk of work injuries and accidents, and COVID-19 infection rates increase in tandem with the number of hours worked per day (Ran et al. 2020). While seeking to limit the number of staff who are exposed to the virus, the administrative measure of requiring medical staff to take over responsibility for food delivery to COVID-19 patients and the cleaning of their rooms further increases health workers' workload. The postponement and rescheduling of non-urgent healthcare visits have created a backlog of care that will need to be delivered at some point in the near future. This places continued strain on the health system and its workers. While eHealth is recommended as a tool to eliminate the risk of infection in healthcare settings, health workers' training in telemedicine remains patchy, and the same applies to the eHealth literacy of patients.

## PPE, medical equipment and testing

There has been a lack of PPE for health workers both at hospitals and in the community across the different occupational groups, including for doctors, nurses, paramedics, cleaners, pharmacists, and long-term and elderly care workers. Furthermore, the PPE that is available for health workers is not necessarily suitable for women, as the design of most PPE is based on the sizes and characteristics of male populations (ILO 2013). Poor availability of medical equipment is widely reported, and the scarcity of ventilators, for example, means that bedside clinicians are forced to decide who receives care first, which causes moral distress and creates ethical dilemmas.

The capacity for testing health workers for COVID-19 continues to be insufficient, despite research showing that weekly screening can reduce their contribution to transmission by 25-33% on top of reductions achieved by self-isolation following symptoms (Grassly *et al.* 2020).

Accountability for occupational safety and health measures is mostly beyond the control of individual workers; at the institutional level, managers can have some influence, particularly on the prevention of psychosocial risks. Initiatives at the sector level between trade unions and employers' associations to improve general working conditions can help resolve many issues (Pinder 2016). However, opportunities to manage the hazards and risks associated with COVID-19 seem to have been very few and far between. A decade of austerity imposed by the EU institutions and the governments of the EU Member States is reflected in the inadequate capacity of European health systems to cope with an infectious disease outbreak (see, for example, Bramucci *et al.* 2020).

## From short-term 'fire-fighting' response to long-term transformative change

The COVID-19 pandemic has thrown into sharp relief persistent problems in occupational safety and health and working conditions in the healthcare sector, while also creating new ones. Since the impacts of the pandemic are multifaceted, so must be our responses to them. Measures to prevent infection and mitigate the impact of the COVID-19 pandemic on health workers range from those taken as an immediate 'fire-fighting' response to those requiring long-term transformative change. Occupational safety and health and working conditions must remain at the centre of any actions that are taken.

**Short-term OSH measures** must focus on the availability of PPE and health workforce testing. Prevention of violence and harassment is essential, and measures to mitigate psychosocial risks are crucial. It is likewise important not to introduce any new and unforeseen risks for workers' safety and health, including psychosocial risks related to work organisation, ergonomic and chemical risks (ILO 2020). Guidelines for safety and health in case of a pandemic and appropriate training of staff should be further developed. Treating COVID-19 as an occupational disease provides some level of a financial safety net for workers. The promotion of a gender-balanced representation of trade unions and health and social care organisations in governance and decision-making structures is imperative, because they are the ones who know what is needed. The inclusion of SARS-CoV-2 in the list of biological agents known to affect humans, set out in Commission Directive (EU) 2019/1833, with a short transposition period, supports the protection of workers' health. In the process, the trade unions called for an amendment of the Biological Agents Directive to include a clarification pointing to the need for adequate information and training for workers. The European Commission has also committed to workplace inspections and a review of the Directive with a view to preparing for future pandemics.

The implementation of **medium- to long-term measures** should run parallel with the short-term measures and focus on prevention rather than reaction. A second wave of COVID-19 could happen,

further testing the sustainability of health systems and continuity of care. The strain on the workforce is tremendous, and the consequences are grave; reported negative health outcomes in health workers during the COVID-19 pandemic include acute stress disorder, insomnia, anxiety, obsessive-compulsive symptoms and depression. The risk of developing post-traumatic stress disorder is therefore very real. Structural shortages of health workers intensify psychosocial risks, and so the recruitment of human resources must be planned and financed as part of a long-term vision. Importantly, any measures to reduce the public deficit should not lead to the underfunding of healthcare systems, the suffering of patients or hazards for workers; on the contrary, an effective alternative to austerity is public investment in social infrastructure and the care economy (ITUC 2016). Robust national preparedness plans for public health emergencies should be adopted and continually improved; to that end, on 20 May 2020, the European Commission outlined proposals for country-specific recommendations that require each Member State to strengthen the resilience of its national health system.

A review of 'work organisation' in the health sector is crucial; needless to say, it is essential to engage people who do the work in OSH planning and enable them to use their experience to influence strategic decision-making. Democratic workplaces where workers can exercise their rights and have their say should be the norm in the care economy, for such an environment supports the recruitment and retention of a strong workforce.

Viruses know no national borders, and this should be reflected in a major public health emergency response. In this connection, the EU has limited capacities, no leadership role and no budget (Greer 2020). However, efforts to ramp up the OSH measures related to 'engineering' and availability of PPE are ongoing (e.g. the EU's joint procurement of medical and protective equipment), and there already exists a robust scientific knowledge base on infection prevention and control that is continually being developed (e.g. through the European Research Area (ERA) platform launched by the European Commission to provide information on funding opportunities for coronavirus-related research and innovation).

In addition to policies related to medical equipment and clinical research, **transformative changes are required to address the root causes of the poor OSH and working conditions in the healthcare sector and in the care economy more broadly.** These changes support gender equality and decent work, calling for:

– **Recognition of the real value of the care economy.** An important step towards achieving this recognition is the EU Gender Pay Transparency Directive. Pay discrimination remains largely a hidden problem in the EU, partly because of a lack of information on pay, and so it is crucial to enforce the principle of 'equal pay for work of equal value'. The impact of unequal pay – on women, society and the economy – is stark. Redress is urgently needed, especially in the light of the pandemic, which puts women workers at the forefront of the fight against the virus, working as they do in one of the most underpaid sectors in the EU.

– **Inclusion of gender in EU OSH legislation.** It is essential to involve trade unions in the design, implementation and evaluation of the post2020 EUOSH strategy. Specifically, women's and gender equality committees have conducted ground-breaking work in bringing the gender perspective into, for example, working conditions, harassment and violence, and the work-life balance, an approach which should also be extended to the protection of workers' safety and health.

– **Prominence of OSH in employment policies within the care economy.** As an initial step, there should be an EU Directive on psychosocial risks in the world of work to take full account of all current and emerging risks. Member States should proceed to ratify and implement ILO Convention 190 and Recommendation 206 concerning the elimination of violence and harassment in the world of work, and to strengthen health workforce planning with the aim of eliminating occupational inequities from the care economy.

## Conclusion

Tens of thousands of health workers have been infected with COVID-19 globally, and hundreds have died, as there is no licensed vaccine or prophylaxis for the prevention or treatment of COVID-19. It is clear that the main focus should be on the prevention of exposure of all health workers to this biological agent. In addition, disease outbreaks are known to cause stress among health workers, making the prevention and mitigation of psychosocial risks essential.

This policy brief has mapped out the recommendations and the reality of OSH in the health sector during the COVID-19 pandemic, highlighting the shortcomings and the subsequent steps that need to be taken. Occupational health and safety measures must be developed according to worker's needs in order for them to be effective in real-life work situations. These needs may be as essential as sufficient provision of PPE and medical equipment. They may be structural needs that require protective engineering measures, or professional needs, such as continuous training delivered as part of administrative measures. Crucially, OSH needs arise from exposure to psychosocial risks and require a response that focuses on work organisation and working conditions.

A key characteristic of a well-functioning health systems is that it is staffed with enough workers with the right skills and motivation. And the motivation rises from being valued, having labour rights respected, working conditions that match the demands (salary, training, work organisation) and OSH that protects from the actual physical hazards and psycho-social risks.

Disinvestment in health and social care goes contrary to the reality of an ageing Europe with its ageing health workforce, shortage of health workers and challenges of recruiting staff with the right skills mix to respond to the needs of patients in critical care, and from paediatrics to geriatrics.

Investment in the care economy is long overdue. The value of the highly feminised care economy is immense in keeping our society up and running. It is well known that working conditions associated

with this economy are challenging, and that the workforce is too stretched to meet all the care needs both during and beyond the pandemic. There is no disputing that all workers have a right to a safe and healthy workplace. Summing up these facts leads to a clear conclusion: protecting the health and safety of all workers in the care economy is essential, and in order for this to become a reality, major changes are needed.

Health workers have been and continue to be on the front line of the pandemic. It is high time that the support shown by people for their heroes is matched by political support in ensuring their occupational safety and health and decent working conditions.

## References

Alberta Health Services (2020) COVID-19 Scientific Advisory Group rapid response report, 4 May 2020. <https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-hcw-risk-rapid-review.pdf>

Bramucci A., Prante F. and Truger A. (2020) Decades of tight fiscal policy have left the health care system in Italy ill-prepared to fight the COVID-19 outbreak, *Intereconomics*, 55 (3), 147–152.

Brück C. (2016) General principles of EU OSH legislation, OSH WIKI. [https://oshwiki.eu/wiki/General\\_principles\\_of\\_EU\\_OSH\\_legislation](https://oshwiki.eu/wiki/General_principles_of_EU_OSH_legislation)

Cangiano A., Shutes I., Spencer S. and Leeson G. (2009) Migrant care workers in ageing societies: research findings in the United Kingdom, Oxford, ESRC Centre on Migration, Policy and Society.

Clayton-Hathway K., Humbert A.L., Griffiths H., McIlroy R. and Schutz S. (2020) Gender and nursing as a profession. Valuing nurses and paying them their worth, London, Royal College of Nursing.

De Spiegelaere S., Hoffmann A., Jagodziński R., Lafuente Hernández S., Rasnača Z. and Vitols S. (2019) Democracy at work: better occupational health and safety protection, in ETUC and ETUI (2019) Benchmarking working Europe, Brussels, ETUI, 67-89.

ECDC (2020) Surveillance of COVID-19 at long-term care facilities in the EU/EEA. 19 May 2020. <https://www.ecdc.europa.eu/sites/default/files/documents/covid-19-long-term-care-facilities-surveillance-guidance.pdf>

ECDC (2020) Cloth masks and mask sterilisation as options in case of shortage of surgical masks and respirators, 26 March 2020. <https://www.ecdc.europa.eu/sites/default/files/documents/Cloth-face-masks-in-case-shortage-surgical-masks-respirators2020-03-26.pdf>

EIGE (2020) Gender equality and long-term care at home, Luxembourg, Publications Office of the European Union.

EPSU (2019) Europe's public health systems: death by a thousand cuts, 18 December 2019. <https://www.epsu.org/article/europe-s-public-health-systems-death-thousand-cuts>

EU-OSHA (2020) ESENER 2019. What does it tell us about safety and health in Europe's workplaces? Policy Brief, Luxembourg, Publications Office of the European Union, 2020.

EU-OSHA (2014) Mainstreaming gender into occupational safety and health practice, Luxembourg, Publications Office of the European Union.

EU-OSHA (2013) New risks and trends in the safety and health of women at work. European Risk Observatory Literature review, Luxembourg, Publications Office of the European Union.

Eurofound (2020) COVID-19: Policy responses across Europe, Luxembourg, Publications Office of the European Union.

European Commission (2019) Joint report on health care and long-term care systems & fiscal sustainability. Country Documents 2019 Update, European Economy Institutional Paper 105, Luxembourg, Publications Office of the European Union.

Fazzani F. and Mazza J. (2020) A vulnerable workforce: migrant workers in the COVID-19 pandemic, JRC Technical report, Luxembourg, Publications Office of the European Union.

Fité-Serra A.M., Gea-Sánchez M., Alconada-Romero Á., Tomás Mateos J., Blanco-Blanco J., Barallat-Gimeno E., Roca-Llobet J. and Muntaner C. (2019) Occupational precariousness of nursing staff in Catalonia's public and private nursing homes, *International Journal of Environmental Research and Public Health*, 16, 4921. <https://doi.org/10.3390/ijerph16244921>

George A. (2008) Nurses, community health workers, and home carers: gendered human resources compensating for skewed health systems, *Global Public Health*, 3(Supp. 1), 75-89.

Grassly N. et al. (2020) Report 16: Role of testing in COVID-19 [sic] control, 23 April 2020, London, Imperial College COVID-19 response team. <https://www.imperial.ac.uk/media/imperial-college/medicine/mrc-gida/2020-04-23-COVID-19-Report-16.pdf>

Greer L. (2020) Another European rescue of the Member States? EU public health policy for COVID-19, Opinion Paper 22, Brussels, European Social Observatory.

ILO (2020) A safe and healthy return to work during the COVID-19 pandemic. Policy Brief, May 2020. [https://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---safework/documents/briefingnote/wcms\\_745549.pdf](https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---safework/documents/briefingnote/wcms_745549.pdf)

ILO (2018) Ending violence and harassment against women and men in the world of work. Report V (1), International Labour Conference 107th Session 2018, Geneva, ILO.

ILO (2016) Decent work and the care economy. <https://www.ilo.org/global/topics/care-economy/dw-and-care-economy/lang-en/index.htm>

ILO (2013) 10 keys for gender sensitive OSH practice – Guidelines for gender mainstreaming in occupational safety and health, Working paper, Geneva, ILO.

ITUC (2016) Investing in the care economy: A gender analysis of employment stimulus in seven OECD countries, March 2016, Brussels, ITUC.

Marshall J. J. (2020) Why medical staff in China spurned offers of psychological help over Covid? *The Scotsman*, 14 April 2020. <https://www.scotsman.com/news/uk-news/why-medical-staff-china-spurned-offers-psychological-help-over-covid-dr-john-j-marshall-2537283>

Messing K. (ed.) (1999) Integrating gender in ergonomic analysis, Brussels, European Trade Union Technical Bureau for Health and Safety.

Müller T. (2018) She works hard for the money. Tackling low pay in sectors dominated by women: evidence from health and social care, Brussels, European Federation of Public Service Union.

Musu T. and Vogel L. (eds.) (2018) Cancer and work: understanding occupational cancers and taking action to eliminate them, Brussels, ETUI.

NIOSH (2020) Hierarchy of controls. <https://www.cdc.gov/niosh/topics/hierarchy/default.html>

OECD (2020) OECD Policy Responses to Coronavirus (COVID-19) Women at the core of the fight against COVID-19 crisis, 1 April 2020. <https://www.oecd.org/coronavirus/policy-responses/women-at-the-core-of-the-fight-against-covid-19-crisis-553a8269/#section-d1e63>

Pelling L. (2020) Sweden, the pandemic and precarious working conditions, *Social Europe Journal*, 10 June 2020. <https://www.socialeurope.eu/sweden-the-pandemic-and-precarious-working-conditions>

Pinder A. (2016) Managing psychosocial risks in the cleaning sector, OSH WIKI, 1 March 2016. [https://oshwiki.eu/wiki/Managing\\_psychosocial\\_risks\\_in\\_the\\_cleaning\\_sector](https://oshwiki.eu/wiki/Managing_psychosocial_risks_in_the_cleaning_sector)

PSI (2019) Privatisation and women's human rights. Factsheet for CSW63 advocacy, March 2019. [https://world-psi.org/uncsw/wordpress/wp-content/uploads/2019/03/FactSheetCSW63\\_Privatisation.pdf](https://world-psi.org/uncsw/wordpress/wp-content/uploads/2019/03/FactSheetCSW63_Privatisation.pdf)

Ran L., Chen X., Wang Y., Wu W., Zhang L. and Tan X. (2020) Risk factors of healthcare workers with corona virus disease 2019: a retrospective cohort study in a designated hospital of Wuhan in China, *Clinical Infectious Diseases*, ciaa287. <https://doi.org/10.1093/cid/ciaa287>.

Spasova S., Baeten R., Coster S., Ghailani D., Peña-Casas R. and Vanhercke B. (2018) Challenges in long-term care in Europe. A study of national policies, Brussels, European Commission.

Thomson S., Figueras J., Evetovits T., Jowett M., Mladovsky P., Maresso A., Cylus J., Karanikolos M. and Kluge H. (2014) Economic crisis, health systems and health in Europe: impact and implications for policy, Policy Summary, Copenhagen, WHO Regional Office for Europe.

Watterson A. (2020) COVID-19 in the UK and occupational health and safety: predictable not inevitable failures by government, and trade union and nongovernmental organization responses, *New Solutions*, 30 (2), 86-94.

Weber C. and Henke N. (2016) Employment trends and their impact on women's OSH, OSH WIKI, 1 March 2016. [https://oshwiki.eu/wiki/Employment\\_trends\\_and\\_their\\_impact\\_on\\_women%E2%80%99s\\_OSH](https://oshwiki.eu/wiki/Employment_trends_and_their_impact_on_women%E2%80%99s_OSH)

Wenham C., Smith J. and Morgan R. (2020) COVID-19: the gendered impacts of the outbreak. *The Lancet*, 6 March 2020. <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2930526-2>

WHO (2020) Coronavirus disease (COVID-19) outbreak: rights, roles and responsibilities of health workers, including key considerations for occupational safety and health, Interim guidance, 19 March 2020. [https://www.who.int/docs/default-source/coronaviruse/who-rights-roles-respon-hw-covid-19.pdf?sfvrsn=bcabd401\\_0](https://www.who.int/docs/default-source/coronaviruse/who-rights-roles-respon-hw-covid-19.pdf?sfvrsn=bcabd401_0)

WHO (2006) Occupational health. Health workers. [https://www.who.int/occupational\\_health/topics/hcworkers/en/](https://www.who.int/occupational_health/topics/hcworkers/en/)

All links were checked on 13 July 2020.

ETUI publications are published to elicit comment and to encourage debate. The views expressed are those of the author(s) alone and do not necessarily represent the views of the ETUI nor those of the members of its general assembly.

The *ETUI Policy Brief* series is edited jointly by Jan Drahoukoupil, Philippe Pochet, Aída Ponce Del Castillo, Kurt Vandaele and Sigurt Vitols.

The editor responsible for this issue is Kurt Vandaele, [kvandaele@etui.org](mailto:kvandaele@etui.org)

This electronic publication, as well as previous issues of the *ETUI Policy Briefs*, is available at [www.etui.org/publications](http://www.etui.org/publications). You may find further information on the ETUI at [www.etui.org](http://www.etui.org).

© ETUI aisbl, Brussels, August 2020

All rights reserved. ISSN 2031-8782



The ETUI is financially supported by the European Union.

The European Union is not responsible for any use made of the information contained in this publication.