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Publication date
2024

Document Version
Final published version

UNIVERSITY OF AMSTERDAM

AIAS-HSI

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insights from interviews

Frank Tros, Maarten Keune and Wieteke Conen

University of Amsterdam, AIAS-HSI

Co-funded by the European Union

July, 2024

Contact: f.h.tros@uva.nl
General contact: aias-hsi@uva.nl
Bibliographical information:
Tros, F.H., Keune, M.J. and Conen, W.S. (2024). The Covid-19 crisis, mental health of healthcare workers and trade union actions: insights from interviews. University of Amsterdam: AIAS-HSI.

Deliverable 3.1 in Grant agreement Project 101052344 — COMET.
This report can be downloaded from the project's website http://hsi.uva.nl/ under the section:
https://aias-hsi.uva.nl/en/projects-a-z/comet/comet.html

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1. Introduction

COMET project

The Covid-19 crisis has had a severe impact on the already strained mental health of healthcare workers. Trade unions, workers and hospitals need a better understanding of what measures and initiatives can be effective to mitigate these effects, in order to avoid future pandemics putting hospitals and their workers under similar pressure, and to address the more structural mental health problems in the sector.

In this context, the *Amsterdam Institute for Advanced Labour Studies–Hugo Sinzheimer institute* (AIAS-HSI) is implementing a 2-year project COMET: "COvid-19 crisis, MEntal health of healthcare workers and Trade union actions" (Aug 2022 - July 2024). The *European Public Service Union* (EPSU) and the *European Psychiatric Association* (EPA) are providing support and in charge of disseminating the research findings. COMET is co-financed by the European Commission.

The interviews analysed in this draft report are a follow-up to the findings in the COMET survey (Conen et al., 2024).[1]

Methodology: COMET's qualitative contribution

The University of Amsterdam invited all respondents who indicated that they could be contacted in the COMET survey for an online interview. They were sent the main interview questions by email and were all offered the opportunity to respond in their own language other than English, if needed (in that case the University organised an interpreter, which we did for three interviews). From the total of sixteen survey participants who were willing to be contacted, seven responded positively to the invitation to do an interview, including trade unions from Belgium, Denmark, Finland, Germany, Romania, Serbia and Sweden. EPSU made some extra efforts to encourage participation in southern European countries (which were missing in our sample), but unfortunately this didn't generate higher response rates. We aimed for more respondents but this appeared to be difficult, firstly because of the limited number of survey respondents, secondly because not everybody was willing to be contacted and thirdly because the response to emails (with reminders) was limited. It would be going too far to analyse this non-response precisely but one reason might be that a lot of organisations and people wanted to forget this dark period.

All our interviewees were asked for further relevant contacts in their countries who could be interviewed, which finally led to five extra interviews: one in Belgium (psychologist), one in Denmark (stress councillor) and three in Germany (two works councillors and one former organiser and now union official). In total, we conducted twelve in-depth interviews in the period October 2023 – March 2024, all recorded by Teams or Zoom. Quotations in this draft report have been checked by the interviewees themselves for factual inaccuracies and we asked all of them for their agreement when using quotations.

It is important to say here that this research report is accompanied by a major disclaimer of not being representative for Europe because of the limited number of interviews. Since southern European countries are not represented it is difficult to make generalised statements about the European context. Another important remark here is that this report describes and analyses the perceptions of trade unions, meaning that we did not interview other stakeholders like employers and governments (only two professionals in psychological support in two hospitals). Nevertheless we

[1] Conen, W.S., Keune, M.J. and Tros, F.H. (2024). The Covid-19 crisis, mental health of healthcare workers and trade union actions: survey results. University of Amsterdam: AIAS-HSI.

aim with this report to provide a comprehensive picture of the views and experiences of twelve highly informed persons, to improve the understanding of the effects of the pandemic on mental health problems among healthcare workers and on trade union positions and actions. We also aim to contribute to policy learning concerning the prevention and reduction of mental health problems and concerning social dialogue in the hospital sector, to prevent the same problems from recurring in future crisis situations.

Main questions

The interviews and this draft report are structured along the following five main questions.

1. What were the experiences of the union about the main problems of healthcare workers during the Covid-19 pandemic? Thinking of aspects such as health and safety, stress, working hours, working conditions, etc.
2. Did the government do enough to protect and support hospital workers during the Covid-19 pandemic? And specifically in terms of mental health? Was it enough? What worked well, what did not work well?
3. Did the hospitals/employers do enough to protect and support hospital workers during the Covid-19 pandemic? And specifically in terms of mental health? Was it enough? What worked well and what did not work well?
4. What was the approach of the union in addressing mental health problems and work-related psycho-social risks of healthcare workers during the Covid-19 pandemic? Were there successes in the union's strategies, measures and practices ? What worked well and what did not work well?
5. What lessons were learned during Covid-19 for future pandemics or crises by the union, by hospital employers and by the government in your country relating to the mental health of healthcare workers ? Did the crisis-related measures appear to be sustainable? What are the post-pandemic issues and priorities regarding the mental health of healthcare workers?

2. Mental health problems of healthcare workers during the pandemic

Many respondents made the point that the hospital sector was already in a bad shape when the pandemic started. Many years of under-funding and under-staffing made hospitals vulnerable to sudden increases in patient numbers and unprepared to deal with a crisis like Covid-19. Just to cite a few: "*In Sweden we had structural under-staffing, there was already a crisis in the hospital sector before the pandemic started*" (int 1, SE) and "*hospitals in Romania were in a very difficult situation of low investments*" (int 4, RO). Also the four interviews with German respondents all stressed the point of the vulnerable position of hospitals to deal with a crisis. "*That we did not have enough nurses for intensive care in Berlin was because of lack of investments in the hospitals in the period before Covid and the hospital financing system based on Diagnosis Related Groups (DRGs) in general*" (int 3, DE). A works councillor in a hospital in Germany says that *"already before the pandemic started, a lot of staff members were sick for more than six weeks"* (int 8, DE). Also in Belgium "*Covid showed that hospitals were too lean to react flexibly to the pandemic… because hospitals were financed per bed, hospitals wanted them always full, so there was no extra capacity left*" (int 12, BE).

The overall picture that emerges from the interviews is that the start of the pandemic led to enormous chaos and stress everywhere, of course firstly among the healthcare workers at intensive care units that had to deal with Covid patients. They feared that they would get the corona virus themselves and/or that they would transmit it to their families. They also they felt highly isolated because of not having the right information on exactly what was going on or exactly what to do. This was further worsened by having to deal with large numbers of dying patients while not being able to communicate properly with colleagues and patients, due to the distancing rules. The works councillor in a German hospital talked about "*a surrealistic situation with many security staff around to protect the stock of vaccines in the hospital*." (int 8, DE). Several respondents mentioned the stressful circumstance of general uncertainty *"because we didn't know what was going to happen"* (int 8, DE). A psychologist who helped hospital personnel with mental health problems in a hospital in Brussels talked about problems of burnout, sleeping disorders, fear for getting the corona virus, and traumatic experiences in the intensive care units, especially among nurses (int 5, BE). In her hospital, workers had to continue to work if they got Covid, as long as they did not have symptoms, which indeed led to a lot more infections (int 12, BE).

Other important stress factors among all healthcare workers in all countries were related to the uncertainties and worries about the question of "how to organise it all with private and family life": transportation, childcare, the kids' schools and so on. Clearly, female workers - the large majority among healthcare workers - were in a more difficult situation because of their double responsibilities in work and family contexts. "*When a school would close a certain class because of some students having Covid, our nurses had to deal with this*" (int 12, BE). Many workers needed holidays during the pandemic, but most of the time hospitals would say ‘no, we need the personnel’. In Romania, for example, for the period 2020-2021 there was even a Government Ordinance issued in which the granting of vacations was prohibited for a period of one year (int 4, RO).

Remarkably, several respondents mentioned that healthcare workers were more than ever confronted with verbal and physical aggression by patients, and sometimes by family members of the patients as well: *"sometimes they did not want to believe the safety measures"* (int 8, DE). The respondent from Romania talked about the high levels of resistance and skepticism in the public sphere about the serious risks of the virus and the importance of vaccinations, which made it very difficult for healthcare workers to do their jobs (int 4, RO).

Nurses from other hospital departments who had been mobilised to Covid-related units also experienced many problems of stress. They felt high pressure to work in other units and to be trained for their new tasks (int 8, DE). An employee from the Occupational Health and Safety department of a hospital in Copenhagen said that the main problem of nurses who were coming to the Covid departments was *"the difficulty in taking care of patients where they actually didn't know what to do with them"* (int 10, DM). These employees had not previously worked with patients with respiratory problems and/or in intensive care units, so they lacked the required knowledge and experience. This led to extremely high anxiety and stress in the context where lots of Covid patients were at risk of dying. Hospital managers were also under great pressure: "*they sent long letters by mail to their employees to tell them about Covid, masks, what you have to do with the patients and how to handle respiration and stuff like that, but the problem was that the nurses didn't have the time to read the mails… it was a crazy situation*" (int 10, DM).

The interviews confirmed the COMET survey findings that a lack of protective equipment and safety measures for workers was a major problem in the first period (Conen et al., 2024). In Romania, there was a serious lack of good and clean protective equipment, such as face masks, face visors and safety jackets for healthcare workers in the country (int 4, RO). The lack of protective equipment was most acute in the first 3-5 months of the pandemic; later the problems were rather with the quality of the protective equipment, especially safety jackets that produced profuse sweating, according to our Romanian respondent from SANITAS (int 4, RO)**.** But in Finland as well, one of the biggest problems was the lack of protective equipment in the early phase of the pandemic: *"nurses told us that their employer gave them a raincoat that they had to use when they met corona patients"* (int 6, FI). The same situation arose in Germany, where employees had to reuse protective clothing and masks (int 8, DE). Another serious safety issue was that the healthcare workers quite often needed to wait for vaccinations because the elderly were being prioritised. For example, in Finland, "t*his caused anxiety among nurses and concerns about the health and safety of hospital staff… we tried to influence the government but only IC personnel were vaccinated early"* (FI, int 6). On top of these problems, the lack of information and communication was also creating stress- and anxiety-related problems in the first period.

In a later phase of the pandemic, healthcare workers and hospitals in all countries were confronted with extra problems, such as employees working systematically excessive working hours and more hospital personnel becoming sick or quitting their jobs. The picture here was one of "surviving" and "a war to win" in the hospitals. "*Under-staffing and sickness absence got worse during the pandemic and it just worked because we stuck together and helped each other out of this"* (int 8, DE). The same problematic picture of under-staffing and sickness absence applied to other countries, such as Romania (int 4, RO).

In several countries, governments had introduced "emergency regulations", regulating the exceptional situation of the pandemic. This led to the situation where hospitals were given extended options to order overtime, to limit the right to take breaks and cancel leave and holidays of their staff. Healthcare workers responded differently: some of them accepted the situation and could

handle it, but others were confronted with problems of fatigue or challenges in their private lives, such as taking care of young children or their parents. The respondent from Finland said: "*in retrospect, it turned out that this Emergency Act was used incorrectly by employers. Too many workers were ordered to work overtime. The employee did not have the opportunity to resign because the notice period was extended … .and workers' perceptions and experiences of injustice at work increased mental health challenges and anxiety in working life, both during normal and exceptional circumstances*" (int 6, FI). A work councillor in a private hospital in Germany said that after some time *"some individuals couldn't work wearing these FFP2-mask the whole day ….they couldn't breathe properly… and then they said that they would leave the hospital*" (int 9, DE). Remarkably, several respondents from different countries mentioned inter-generational tensions in work ethics. Older generations of nurses sometimes blamed younger generations of nurses for being less committed to work than they should be (int 5, BE; int 9, DE). In general, "*younger workers in the hospital experience more problems in work-life balance and have a different outlook on life*", according to the psychologist in a Brussels hospital (int 5, BE).

Besides the chaotic and extremely stressful effects of the pandemic at the level of individual healthcare workers and hospitals, governments were also under extreme pressure and trade unions were somewhat 'paralysed' in the new reality, where they were often forced to work at a distance from offices, hospitals and members. Such an environment of change and uncertainty increased the feelings of isolation, anxiety and stress among healthcare workers even more.

3. Governments' role during the pandemic

The interviews point to substantial differences in the positions of national governments in the healthcare sector and their positions and capacity to respond to the Covid-19 pandemic, both in general and through the regulation of hospitals and the working conditions of healthcare workers. In Romania, public hospitals were not only in a very difficult situation of excessively low investment in the past, but the government also communicated very poorly to the public about the usefulness of vaccinations and public safety measures. These conditions affected the hospitals and healthcare workers "*who had to deal with sceptical patients and it meant that the unions had to deal with sceptical members*" (int 4, RO). Also trade unionists from Northern and Western European countries talked critically about the role of the state and the contribution of government policies during the pandemic.

All interviews confirmed that unions were not key players in discussions with governments at the beginning of the pandemic. National governments prioritised public health policies such as vaccination strategies, lockdown measures, coordination of the availability of "Covid beds" across (specific) hospitals and the treatments of Covid patients. Sometimes they forgot that healthcare workers had to travel to work, such as in Belgium where the union demanded more trains but where train transport was still severely limited, so that nurses had to adjust their schedules to the new public transport timetables (int 12, BE). Several governments allowed suspension of Occupational H&S legislation and other labour regulations for the protection of healthcare workers, because of the emergency character of the pandemic. *Tehy,* the Union of Health and Social Care Professionals in Finland, tried to influence the Emergency Act of the Finnish government, but with not much success:

"*the Act reflected very much the governmental view alone" (*int 6, FI). Her Danish colleague from FOA was critical about the role of the government authority on health and safety in Denmark: "*they were not really helpful… they always set the patients at number one and far after that were coming issues like protection materials for healthcare workers…. the union was pressing every day, but it was difficult because they* (Occupational H&S authority) *were changing their views and recommendations every time*" (int 7, DE).

To summarise, unions in all the interviews thought that governments and public authorities did not do enough to protect the healthcare workers in terms of providing them with enough or good enough quality masks and other protective clothes, and taking into account the healthcare workers' position during the pandemic. And it is no consolation that workers in other care sectors - such as in homecare, nursing homes and homes for the elderly - were often in an even worse situation regarding the lack of protective equipment and access to vaccinations.[2]

A more positive view about the government during the Covid-19 pandemic comes from the respondent from the *Trade union of employees of health and social care of Serbia*, who appreciated the government's initiative in regulating a rota system for workers who had to work in the specialised Covid hospitals in Serbia in order to spread the burden among healthcare workers in the country (int 2, RS). The government arranged free transportation in this rota system and provided warm food and beverages for those on 12 hour shifts. The government was helped by the taxi drivers in Belgrade who were offering free rides for all healthcare workers.

Another positive experience about the government came from Denmark. Although FOA criticised the role of the specific Occupational H&S authority, on a more general political level the union appreciated social dialogue with the Ministries and municipalities: "*I think one of the good approaches in Denmark was that there was a willingness by the government to listen to the social partners (after the first more chaotic period), so we could say what we were experiencing and bring it back to the system….. The leader of my union had really easy access to the government, where people listened to what she said, and I also experienced that if she called a local mayor, the mayor would listen to her instantly*" (int 7, DM). It might be that Denmark's flat administrative structure helped in such a crisis situation: "*Denmark was really overwhelmed like everywhere else…. but Danish hospitals are organised in just five regions, which made it relatively easier and faster to talk together and then to try to pull in the same direction*" (int 7, DM). But longer traditions in cooperative social dialogue and industrial relations in the country seem to have paid off too. The effective lobbying activities by FOA concerned topics like protective equipment, sick leave payments, and the acknowledgement of Covid-19 as an occupational disease giving rights to benefits. Another agreement in Denmark was to be more flexible with young people in training to become nurses or social helpers, allowing them to work more hours in the context of the lack of staff during the pandemic.

Later in the pandemic, some unions negotiated extra, temporary compensation for workers from the state. An example is *Ver.di*, which agreed a €3,000 tax-free bonus from the German state for all workers in the public sector (i.e. including those working in public hospitals) (int 11, DE). Another example comes from Romania, where there was a collective agreement in the public sector during the pandemic, but where salaries and bonuses were not included in the negotiation of the agreement but were established by specific laws. In this context, SANITAS negotiated an amendment to the Bonus Law as a result of which a 75-85% (of regular salary) extra payment was made for those workers who worked with Covid-19 patients. This was maintained until the end of the pandemic (int

[2] See the report of 9 European countries in the care sector: On the Corona Frontline: The Experiences of care workers in nine European countries (fes.de)

4, RO). Also in Serbia, the government was more willing to listen to the unions and to make agreements with them about extra compensation for healthcare workers during the pandemic. But "*after the crisis, it appeared to be more difficult to negotiate*" (int 2, RS).

4. Hospitals' measures during the pandemic

For hospitals, the pandemic meant a crisis period with extreme high levels of uncertainty and managerial demands in adapting healthcare services and internal organisations to several 'waves' of Covid infections, while in the meantime they had to deal with many (constantly changing) rules from the government about the distribution of beds for Covid patients. Especially in the beginning, management had lots of work to organise resources like masks and other materials in chaotic circumstances. It was also a period when directors and boards of the hospitals used the new specific Emergency or Urgency legislation in the countries "*to stop consultations with workers, with unions, with representatives in health and safety and other issues, and to suspend collective agreements and all committees (so they could do what they wanted with working hours, protection, etc.)… And they used this law for 1.5 years in Belgium! There was individual contact with union reps, but no formal consultation*" (int 12, BE). Other interviewees also underlined the unilateral decision-making by management, in contrast to the period before the pandemic (int. 6, FI; int 8, DE: int 9, DE). Of course this can be understood if one thinks about the need for rapid responses in organisational adaptations, but it was at a time when employees already felt extremely overwhelmed in many domains of their profession and tasks; not giving workers any voice led to more feelings of losing a grip on the job and working conditions, and to further loneliness, fear and anger.

4.1 What worked well and what did not?

Regarding the healthcare workers, protection against transmission of the Covid virus was the first priority of the hospital measures that were taken. As noted earlier, this issue of protection was also one of the biggest H&S problems because of a lack of proper protective masks and other preventive equipment. Hospitals were not prepared, and mostly each hospital had to solve its own lack of materials, with no common strategies. "*And it was hard to obtain a mask on the market… the government said that the market would solve the problem, but this market stopped working*" (int 12, BE).

Another measure that was directly taken by hospitals was the introduction of new crisis-related working hours schedules for the healthcare workers in Intensive Care and other Covid-related departments. As mentioned before, this measure also caused many problems of excessively long working hours, working too much overtime, inconvenient shifts and the lack of enough breaks and resting time between the shifts. And it led to many other serious problems (see below) for those coming from other departments.

Hospitals adopted many other measures. In the context of the physical distancing rules and lack of live meetings among colleagues, some hospitals opened telephone helplines to give information and to provide a listening ear for questions from the healthcare workers about challenges at the workplace and in their profession during the pandemic. The union from Finland said about the practices in the Finnish hospitals: *"there was a possibility to seek telephone help and support from the hospitals' OH&S departments, including for mental health challenges. This was needed because*

of the new situation inside the hospital: many quarantine areas where you just cannot move and go and talk to someone. So, this was a quite good IT innovation for this difficult situation and nurses used this telephone line a lot." (int 6, FI).

Many interviewees mentioned the introduction of internal mobility programs of nurses across hospital departments, immediately after the pandemic started. Many hospital departments were closed for safety reasons. In this context, many hospitals organised that the nurses from the closed departments could work in intensive care units and other departments with Covid patients. As already mentioned by a respondent from a Danish hospital, this moving around in the hospital could lead to intense feelings of insecurity, fear and anxiety among nurses without the right experience and knowledge about respiratory and lung problems and high risks of death (section 1; int 10, DM). A trade unionist in a Brussels hospital had the same experience: "*those from other departments were not prepared at all.. they had to learn a lot about prevention of risks, protect themselves.. it was even worse and it was also a reason for many leaving the job"* (int 2, BE). Some hospitals organised digital training sessions for nursing staff on how to handle isolation measures professionally (int 9, DE).

Further, some hospitals organised individual psycho-social support for healthcare workers during the crisis, from psychologists and psychiatrists employed by the hospital. So, instead of treating patients with mental health problems, they organised a kind of "crisis counseling" for hospital colleagues in coping with extra stress, extra anxieties, and dealing with so many dying patients in Covid-related units (int 1, SE; int 5, BE; int 8, DE; int 9, DM). Psychiatrists from one of the German hospitals in this study had the advantage of experience in training people how to deal with post-traumatic stress disorders, now to be applied to their own colleagues (int 8, DE). It is also clear from several interviews that after the pandemic, hospitals stopped the extra support measures in this field, despite the needs among workers for such support and the structural psycho-social problems among healthcare workers (int 5, BE; int 9, DE).

In the sample of interviews we found two best cases in this domain.

The first case was from a hospital in Brussels. Because psychological assistance for hospital employees was already available before the pandemic and the hospital sent a lot of communication about this to the hospital workers during the pandemic, workers knew where to go with their requests for psychological help during the corona crisis. During the pandemic, the psychologist from the related HR department received help from the hospital's psychiatric department. These experts were available because they did not have to meet any outside patients during the pandemic. Healthcare workers were helped. According to the psychologist whom we interviewed: "*Individual psychological care and coaching works well because workers can put words to traumatic experiences… and in that way they can give these experiences and emotions a place"* (int 5, BE). The psychologists asked the workers if they were able to talk at home about what exactly happened at their work and what meaning they could give to that. The psychologists helped with the workers' problems and worries about "guilt" and what they could do with these thoughts and feelings. *"There was and still is a lot of guilt"*, according to the psychologist in the hospital (int 5, BE). A remarkable finding was that there were fewer requests for help during the crisis and that these requests mainly came after the crisis. "*Of course, it was all hands on deck during the crisis, while there is now a lot of deep and long-lasting fatigue"* (int 5, BE). After the pandemic, the psychologist was working alone again and her colleagues from the psychiatric department were back in their own department (see further section 5). Despite the fact that nowadays many healthcare workers in the hospital are asking for psycho-social help, the hospital is not recruiting a second psychologist.

The second case was from a hospital in Copenhagen. We interviewed the "stress councillor" who started her job on a temporary basis in the OH&S department of the hospital just before the pandemic started. At the beginning of the pandemic, she was sent home like most of the office workers, but she wanted to help her colleagues on the frontline of delivering Covid-related healthcare who had to continue working in extreme stressful circumstances. She went back to work and started working not individually with workers but in groups of around twelve nurses, to help them talk together about their anxieties and stress and especially about their feelings "of having contributed to" the death of Covid patients in their hospital, maybe because of a lack of knowledge and experience, as the nurses were mostly from other hospital departments. "*I talked to 350 people within six months with different groups, in different parts of the hospital …. their anxieties could be reduced by brainstorming together about the question of how to handle difficult situations in the Covid-related units …. they could talk to each other about what to do and so … so they didn't have to go home alone with these problems"* (int 10, DM). Similar to the experience of the psychologist in the Brussels hospital was her experience that, after the third wave in 2022, healthcare workers kept on talking about being exhausted. In that final period of the pandemic, there were more and more hospital workers who were ill from stress*. "When we started talking about their daily work, it became clear that it was not their actual daily work that was the problem… it was what they experienced during Covid: that was the problem … so it was like there was a heavy layer here and then you put something on top… Covid had set a baseline of exhaustion, so that the nurses were less able to solve the daily work afterwards … their resilience was lower"* (int 10, DM). The OH&S department of the hospital in Copenhagen evaluated the experiences of the internal mobility programs of the nurses and the related mental health problems. The temporary contract of the "stress councillor" has been converted into a permanent contract.

4.2 Workers' participation in hospitals

As we concluded in the earlier section regarding social dialogue with the government, the interviews showed that unions were not key players in taking measures during the pandemic through social dialogue with individual hospitals. Hospital management operated quite by itself in the context of "high emergency", "exceptional circumstances" and "crisis". During the pandemic, unions did not directly blame the hospitals for being understaffed. As the unionist from Sweden said: "*of course understaffing is also a responsibility of employers, but the unions understood that you cannot suddenly conjure up staff out of nowhere"* (int 1, SE). During the Covid-19 crisis, unions were more critical of the excessive working hours schedules, the lack of protective equipment and poor involvement of trade unions and workers' representatives by the employers in the hospital sector.

Also at the workplace level, workers were not much involved in management decisions. According to a works councillor in a hospital in Karlsburg: "*The employers and workers had quite diverging perspectives during the pandemic. So for the employers, it was important to see that everything was working, everything was functioning and that there were for example not many employees sick or ill, while the employees tried to cope with their challenging and isolated situation, and being close to patients not being sure whether these would infect them or not"* (int 9, DE).

The works council in one of the German hospitals had the feeling *"that they had to run after and discuss with everyone because they were left out of most of it"* (int 8, DE). The joint decision making of the sort they were used to wasn't there anymore and nor was the council involved in the new taskforces that made the decisions. Nevertheless, the works council succeeded in avoiding the twelve-hour shifts for the employees that had been planned by the management, because that was

seen as too dangerous regarding the risks of sickness. Further, the works council pushed the management to recruit additional employees in the Covid hospital to help and do tasks that were not too close to the patients. The council also made it possible for employees with chronic illness to get their full salary when they could not work on Covid (int 8, DE).

The works council in another hospital in Germany was less successful in influencing managerial decisions. "*The works council was rather invisible for the management… the management didn't care about the council and the council felt quite helpless because little was possible. The council was often ignored…. So, when there were meetings, the council was not informed that these were happening and had to fight to be there. And if works councillors did anything, the management side did not see any value and perceived them as annoying when they came up with their ideas, suggestions or whatever"* (int 9, DE). In contrast with the other hospital, this managerial attitude towards the council *"was like that before and is now again… there are always conflicts of interests: management tries to save money and the works council tries to get more money for social improvements… our management is quite old and patriarchal, so it's all quite hierarchical"* (int 9, DE).

Nordic countries and Belgium seem – at least theoretically - to have been in a relatively better position of trade union influence because of their single-channel system of workers' participation. Although the issue of working environment is actually the employers' responsibility, in Sweden you have workplace and OH&S representatives, elected by the members of the union, who cooperate with the employer in this field*. "At the beginning of the pandemic, the union representatives at the workplace level were focused on protection against the virus but as the crisis continued, there was a bigger focus on how to find the energy to keep on fighting when it felt like a never-ending situation"* (int 1, SE). These representatives had a lot of risk assessments to do and they felt a lot of stress. It appeared to be a success factor that *Kommunal's* representatives worked together with the doctors' union and the registered nurses' union at the local level during the pandemic. Together, these representatives supported each other in the negotiations for sufficient rest and holidays for the workers and in developing tools for risk assessments (int 1, SE). Whether the unions in Swedish hospitals cooperated or not was dependent on the culture in the hospital and if they had cooperation structures already in place before the corona crisis.

The picture from the hospital in Brussels is that the trade union at the local level was really needed to correct the employer in some crucial issues. Firstly, the union demanded the opening of a kindergarten in the hospital because normal childcare and schools in Belgium were closed for 2-3 months. Secondly, unions had to fight to make sure that healthcare workers would also have the right to temporary unemployment benefits if their kids' schools were closed because of Covid. Thirdly, the union blocked the hospital's measure that – in response to the lack of personnel - lower categories had to perform tasks for which they were not qualified if they were supervised by a qualified nurse… "*but our union was against: nurses are not supervisors of unqualified personnel"* (int 12, BE). The interviewee experienced a lot of mistakes by the employer: *'in case of a new Covid type pandemic, hospitals should work much more on explaining procedures and organisational choices to prepare the healthcare workers better without last-minute actions….. to help the workers to be relaxed, to be less authoritarian, and to show real appreciation, like an extra free week or something… something that the employees really see and like"* (int 12, BE).

5. Unions' approaches and practices in response to the pandemic

5.1 Adapting to new realities

When the pandemic started, trade union organisations were often sort of 'paralysed'. At that time, trade union workers, as with most of the working population, were not used to working from home and organising online meetings instead of having physical meetings. A works councillor from the hospital in Karlsburg said that she missed the trade union in that period: "*it felt like that the union was in shock and didn't do anything in the beginning… further, isolation and testing every time after physical meetings made union visits to hospitals difficult*" (int 9, DE). So, unions were confronted with new challenges for communicating with their rank and file and unions reps in the healthcare sectors. After the first chaotic period, trade unions tried to set up new digital ways to inform and support healthcare workers about the pandemic, the (new) health and safety rules, the importance of masks and other protective equipment, and their basic rights on working hours and benefits during sickness etc. All of the unions that we spoke to used their websites to provide information for their members and their representatives in hospitals. There was a variation in the way unions were able to have an influence at the hospital workplace. The most positive was our respondent from the *Trade union of employees of health and social care of Serbia:* "*one success factor here is that half of the healthcare staff are organised and that many unionists have crucial positions in the health organisation itself, also in the crucial zones in the Covid-19 hospitals…. this meant that public hospitals had to listen to unions*" (int 2, RS). In Finland, the union continued its communication with the shop stewards in the hospitals: *"we created links between shop stewards and the union, and the stewards told us a lot about how the staff were doing there … Tehy has around a thousand of such shop stewards in the hospitals in Finland*" (int 6, FI).

The Finnish single-channel system with union representation at the workplace seemed to have had beneficial effects in times of crisis. However, Sweden also has a single-channel system with local representation but *Kommunal* experienced more problems in its coordination between the centralised and decentralised levels. Further, "*the OH&S system in Sweden*[3] *works generally quite well in preventing illness and accidents, but there were challenges during the pandemic … the OH&S reps had too much to do and it was confusing and exhausting to do the (new) risk assessments in times of so many changes and situations that were completely new*" (int 1, SE). The central union struggled to support local union representatives: "*there was a great need to collaborate with unions, but during Covid-19 these unions had to coordinate with the government, a government that kept changing the guidelines without unions being included in the process, especially at the beginning of the pandemic*" (int 1, SE). Also the Danish unionist mentions a problem between the different levels during the pandemic: "s*tewards gave us an opportunity to gather some information there, but we had to be sure we didn't recommend something that the health authorities didn't recommend because then there would be a lot of discussions in the workplace*" (int 7, DM). Also, the unions in Belgium seem to have kept a distance from their representatives at the workplace level, as illustrated by a local unionist in a hospital in Brussels: "*we organised local meetings, but not with help of the national unions who were quite inactive, with the pretext of being responsible partners*" (int 12, BE).

[3] = the Swedish Work Environment Act and the Swedish Work Environment Authority's regulations that oblige the individual employer, in cooperation with workers and safety representatives, to provide healthy working conditions.

In the dual-channel system of worker participation in Germany, the unions offered an online meeting for works councils from different hospitals, where they could exchange their best practices across hospitals and could talk about new (national/regional) regulations that were coming in all the time (int 9, DE). There was variation among the works councils in Germany regarding their factual influence on management decisions (see section 3, under 'workers' participation'). *Ver.di* succeeded especially in Berlin in gathering a lot of healthcare workers and also politicians to their online meetings, directly at the start of the pandemic (see 5.3 Best case).

Union representatives within the hospitals suffered hard times during the pandemic. They were confronted with a lot of questions from colleagues in uncertain and fearsome working conditions while not having the answers in many cases (int 1, SE; int 8, DE; int 9, GE; int 12, BE). The interview with a union representative working in a hospital in Brussels gives the picture that he had to inform workers and calm them down and had to coordinate things that should have been done by the hospital management. The reps had to intervene regularly when the hospital unilaterally wanted to organise departments differently, such as when opening a new Covid-19 department. *"The hospital did not explain anything, did not prepare workers with explanations and training, and was very authoritarian, which all augmented the stress of the workers"* (int 4, RO; int 12, BE). Hospitals in Belgium – but also in other countries like Finland - wanted to continue the 'urgency period' with its suspension of workers' rights, because it gave management extra power, despite the union's demand to end it. One of the effects in Belgium was that the employer did not have to pay more for extra hours, that workers could not get paid for their overtime and that the hospital after the pandemic did not allow free time in lieu of overtime, but paid for it, meaning that workers got no rest and were very exhausted (int 12, BE). So, all in all, *"union representatives in our hospital worked more as psychologists and social workers than as unionists during the pandemic"* (int 12, BE).

And the hospital sector was not even the worst sector. In Sweden, but also in many other countries, the most serious problems that the unions faced, and the most lobbying that needed to be done during the pandemic, were in sectors of nursing homes, homes for elderly and homecare. Protective equipment was even less available and proper education and training were even more lacking in these care sectors. Also on other issues, the hospital sector showed relatively more competence, generally speaking: *"I think the reason behind this is probably the lower status that these other care sectors have"* (int 1, SE).

5.2 Collective bargaining

After some time, trade unions began to negotiate on the traditional collective bargaining topics of wages, special remunerations/bonuses and working hours. In every interview we heard examples.

In Romania, *SANITAS* agreed in November 2020 a 75-85% (of regular salary) bonus for all workers who had to treat Covid-19 patients (int 4, RO). In Serbia, the *Trade union of employees of health and social care* negotiated that all healthcare workers who contracted Covid kept 100% of their pay and they also managed to negotiate a 10% increase in pay for *all* healthcare workers (int 2, RS). Further, the Serbian union supervised the rota system of workers with a maximum of 45 days to be staffed in one of the three specialist Covid hospitals in the country. As agreed, the older workers were not sent to these hospitals, and the union did not get many complaints about this topic. Further, the union agreed a 30% increase in pay for those healthcare workers who were part of the Covid system. In general, our Serbian respondent is relatively positive about the trade unions' responses to the pandemic: *"the situation would have been definitely worse during Covid if there had not been unions and lots of measures would not have been taken"* (int 2, RS).

In Sweden, a 'collective crisis agreement' was negotiated to allow longer weekly working hours with some compensation. Because the crisis lasted so much longer than expected, the Swedish union *Kommunal* constantly renegotiated this agreement about working hours and time off during, for example, Christmas 2020 and the summer holidays in 2021. *"These are the core issues in collective bargaining, not mental health as such …. yeah, that's our role in this model: to negotiate about working hours and pay"* (int 1, SE). As the crisis continued, negotiations in Sweden became tougher and more conflicts emerged between unions and employers in the hospital and care sectors.

In Germany, *Ver.di* followed several paths in their strategy. From the beginning, it seemed that they were oriented to their rank and file *and* to the government. According to our respondent from Berlin *"the unions did lots of support work among the members about their rights concerning working hours, not being obliged to change working hours, as happened in so many other European countries… here, the unions did not want that….. unions also put pressure on long Covid being recognised as a professional disease with special treatment, that was happening already pretty early in time"* (int 3, DE). Also the works councillor in another German hospital was positive about the union: *"I really appreciated the union's support. The permanent video conferences that were offered always kept us up to date with the latest legal developments"* (int 8, DE). Her colleague in a North German hospital however was less positive about the unions' support, suggesting variations across the country (int 9, DE). In a later phase of the pandemic, unions in Germany raised wage demands to the hospital employers and lobbied the government, which allowed extra tax-free bonuses of € 3,000 for all public workers in the whole country; "*also good for hospital employers because this did not cost them more"* (int 11, DE).

6. A successful trade union case

Trade unions faced a lot of difficulties during the Covid crisis in effectively representing hospital workers, as described above. However, some unions managed to use the crisis as an occasion to address structural problems in the hospital sector. A successful case in this respect comes from Germany, where *Ver.di* used the pandemic as an 'opportunity' to address longer-term problems in the sector and to mobilise healthcare workers in public protest campaigns and long-lasting strikes. The case shows success in spreading awareness and in supporting empowerment of healthcare workers about the structurally bad working conditions in the hospital sector. The trade unions actions structurally increased membership levels of hospital workers in Germany and this led to better collective agreements on regulating staff-patient ratios in Germany. We will examine this in more depth below, from a longitudinal perspective.

Using the momentum of the pandemic in 2020 by 'organisers'

As in many countries, there were also many problems in Germany in the hospital sector, such as understaffing, high workloads, too much overtime and 'perverse financialisation' in governing the hospital sector. One of our interviewees is now working at the union *Ver.di*, but was working as an 'organiser' at the time the pandemic started. His first response was not like *"oh God everything is going down",* but it was more like *"this is our moment where we can bring up all the topics there have been in the hospital sector for many years while nobody listened"*. During the pandemic, everybody was watching the hospitals *"and we thought, OK, that's a problem, but it's also a big chance for the union movement"* (int 11, DE). One of the early success factors was that the organiser

and his colleagues were already experienced in online meetings. Where in general the union organisations felt paralysed, the organisers used the first weekend of the pandemic for designing a little campaign around the big topics of (i) safety and not having enough masks and (ii) inclusion of the unions in the crisis-related discussions among the doctors and managers in hospitals "*because we are the experts as well, not just the doctors, but also the nurses and the other hospital workers*" (int 11, DE). The organisers started to mobilise hospital workers with Zoom conferences and explaining how to use Zoom: *"it was really exciting, because suddenly we had like hundreds of hospital workers in Berlin all in one Zoom conference to talk about what's the situation in the hospitals"* (int 11, DE). A healthcare worker from a hospital in Berlin confirms that the "*digital meetings were a very good choice in the context of hospitals because of the many varieties in shifts and working hours… and the pandemic made physical meetings very complicated*" (int 3, DE). The campaign formulated nine demands to the federal government for the hospital workers, including pre-existing basic demands like better staffing together with new demands like the right for healthcare workers with chronic illnesses not having to work during the pandemic. *"It was really amazing, I think in two weeks over four or five thousand hospital workers in Berlin signed this petition with the demands, and I think around 30 Members of Parliament attended this video conference, including the Minister of Health from Berlin".* Although nothing really came out of the 9 demands, *"it was nevertheless a good moment of empowerment and having a voice for many of the workers who were really in a bad situation"* (int 11, DE). One year later, in 2021, it appeared that this protest campaign in Berlin was the starting point for mobilising larger groups of hospital workers in several parts of Germany for a much bigger campaign and strike movement by the trade union *Ver.di*.

Thirty days of strike in 2021 in Berlin and collective bargaining on staffing ratios

Ver.di's strike movement in 2021 had two demands: better contracts about staffing and better wages for the healthcare workers, including the same wages for outsourced hospital workers. The movement grew into a big strike at the end of 2021, 30 days in Berlin, which was the birth of the 'Berlin hospital movement', a big union community in the public hospitals of Berlin. Where hospital strikes had in the past been more symbolic, because of the continuing delivery of healthcare services, this strike became 'real' because parts of the hospital were closed. Emergency care continued, but operations and surgeries were cancelled during this strike. This hurt hospitals because of the financial system in Germany where the hospital gets paid for each surgery. *"So you can really put pressure on the hospital with a strike"* (int 11, DE). '*Every time a new patient came to the hospital, the hospital management called the strike leader and asked for an 'OK' after having explained the kind of patient involved*" (int 11, DE). If it was not seen an emergency by the strike leader, the patient was sent home or sent to another hospital.

One of the main activists, working herself in a Berlin hospital, reflects on this period as follows: *"Covid made it clearer that change has to come from our own hands and not from the government. The old way was just to keep on working, but that made people sick in the long run. Now we fought collectively to make the situation better, to come to collective solutions instead of individual solutions*" (int 3, DE). The strike led to public attention for the understaffing problems in hospitals. *"People agreed that good healthcare is a crucial thing, but people also had to realise that the system was not working: Covid and the strikes made this problem public"* (int 3, DE). In comparison to strikes in public transport, for example, public support in Germany for strikes in the healthcare sector was greater and, after the pandemic, "*there was more sympathy for hospital strikes than before*" (int 11, DE).

The main concrete outcome of the strike in Berlin was the improvement of collective agreements for 'Charité', the university hospitals in Berlin, about understaffing.[4] The choice to focus on collective bargaining by *Ver.di*, according to the earlier mentioned activist in the academic hospital of Berlin, has to be understood in the context that *"there was no legislation forthcoming on staffing ratios for hospitals, and that the hospital management had no incentives to reduce the workload; before the collective agreement on understaffing, management just paid extra money for those working on an understaffed shift but that did not help in solving the staffing problem"* (int 3, DE). From 2015, the university hospitals in Berlin had made internal guidelines on staffing ratios, but nothing had been regulated about the situation when these norms were not met, *"so there was no pressure for the management to meet these regulations"* (int 3, DE). Nevertheless, there was one example of a clever system in a small hospital in Southern Germany, in which people working in understaffed conditions were not paid money but compensated with leave. Having this example in mind, *Ver.di* negotiated better incentives for management at the public hospital in Berlin to respect the staff ratios through a 'points system' that was finally agreed in a collective agreement in 2021. For example, when the contract said the ward needed three nurses on a late shift and there are just two working, the two nurses would each get 'one point'. After collecting a certain number of points, the employee got one day off. These rules became better for the workers in recent years: *"in the first year of the agreement, you needed seven points for one day off; in 2023 6 points; and in 2024 just 5 points for one extra free day"*. The yearly maximum number of extra leave days in this system also rose from six to fifteen days. So, where in the past management just paid extra money to those working in understaffing situations, this system exerts strong pressure on the hospital because it leads to even worse understaffing; *"many people have two or three additional weeks of holidays because of this contract"* (int 3, DE).

According to our respondent from *Ver.di* , employers '*really hated'* this points system at the outset, but the academic hospital 'Charité' in Berlin was the first employer to change its mind as it became aware that it was better to make a collective agreement to stop the strike. They even reframed it as '*a great invention of the University Hospital'* and now all the public hospitals in Berlin are promoting big advertising campaigns to find new nurses with the workers' advantages from this collective agreement (int 3, DE). Nowadays, all university hospitals in all of Germany have this agreement, in response to a broader strike in the country (see later in this section).

Another, second, outcome of the Berlin strike and its ongoing protest campaign was a huge increase in union membership: *"If you compare the number of members in the public hospitals of Berlin at the beginning of the pandemic and now, we are at plus 40% membership*. *So, it was a massive boost in union membership in the Berlin hospitals"* (int 11, DE). There are in total 30,000 workers employed by 11 public hospitals in Berlin: eight hospitals from 'Vivantes' and three university hospitals from 'Charité'.[5]

A third outcome of Berlin's movement and strike can be formulated around the growth of healthcare workers' empowerment: *"these agreements are not only compromises in terms and conditions of*

[4] For understanding these collective agreements, it is important to know that they have nothing to do with the content and the structure of collective agreements on regular terms and conditions of employment, like wages, holidays and so on in Germany.

[5] But they are not all affected by the collective agreement because doctors, for instance, are not part of the collective agreement. It is estimated that around 13,000 workers are affected by collective bargaining in the hospitals in Berlin.

employment, but are an element of empowerment for workers. It is the demands of workers that are now in the collective agreements… mostly it used to be the union that said what had to be done, but now the workers were coming to the unions to say: this is what we want"' (int 3, DE). In other words, this case in Berlin is not only a best case of success in collective bargaining results, but also a best case of bottom-up democracy in trade union organisation and in workers' mobilisation. *"It is necessary to have a law for mandatory staff ratios, and Ver.di has been fighting for a law for years, but this will not come to happen without pressure from below"* (int 3, DE).

A final outcome of Berlin's experiences was the spread out of campaigns and strikes to other parts of the country (see below).

More strikes and collective contracts about staffing in hospitals

The campaign in 2020 and the strike in 2021 in Berlin influenced hospital workers across Germany to do the same *"so we had one year later in 2022 an even bigger movement, including the six university hospitals in the state of Nordrhein Westfalia"* (int 11, DE). Here, the hospital employees demanded the same as the Berlin workers, and also here the union agreed new staffing contracts after a very long strike of 77 days. *"The contracts were not as good as in Berlin, but still they are good contracts"* (int 11, DE). This had a boomerang effect on the smaller hospitals in Berlin that were not public. In 2024, a small Jewish hospital with around 700 workers became the best union organised hospital in Berlin and *Ver.di* negotiated here the first staffing contract in a small not for profit hospital in Germany. *"And now, in 2024, in another private hospital in Berlin, workers are getting organised and trying to get this contract as well*…. s*o I think the earlier movement of Berlin during the pandemic was really important and inspired many hospital workers across Germany" (*int 11, DE).

The fight is not over, however. The current contracts on staffing ratios are temporary, although by German law a collective contract continues until a new one is agreed. So the rules about staffing and the related points system still apply to those workers who were employed during the term of the collective agreement (int 11, DE). The four interviewees from Germany are still enthusiastic about the mechanism of collective bargaining, but the vulnerability of the temporary nature of collective agreements and the fact that new healthcare workers are not covered by the current contracts after their end-dates raises the relevant question whether legislation on staffing ratios across the whole hospital sector would not be a better option for Germany. But political will is needed for this option, while according to *Ver.di* it's a big, controversial, political topic whether the state is willing to pay that much money for the public hospitals to finance good working conditions (int 11, DE). The state is giving millions of euros to the public hospitals to finance the collective contracts between those public hospitals and the unions. "*So for example, the Berlin hospitals of Vivantes have 200 million euros of additional money just in this year from the state to finance its staff ratio system and other system costs"* (int 11, DE). This extra money for the public hospitals is also a big issue because of the private hospitals who say that this extra money is hindering fair markets for hospitals. Private insurers are also involved in that discussion, and do not want to be ruled over by an excessively mighty state.

7. Lessons learned, sustainability of measures and post-pandemic issues

7.1 Lessons learned?

A very worrying finding of the interviews was that, in general, unions think that very little or nothing is being learned from the pandemic and that hospitals are no better prepared for new public health crises in Europe, especially because of the negative spiral of understaffing and work-related psycho-social risks.

The respondent from *Kommunal* (Sweden) said that governments and employers are not paying any more attention to understaffing or structural workloads and stress among healthcare workers because of the experiences in the Covid-19 crisis, although *"we hoped for that"* (int 1, SE). *"It was like the crisis or the pandemic was over and nothing good came out of it … in the end, the health sector will be even worse off than it was before the pandemic"* (int 1, SE). The respondent from *FOA* outlines the same situation: *"in Denmark as well, people want to forget the past and want to talk about something else than the Covid-19 crisis, they want to move on"* (int 7, DM). According to the respondent from *They* (Finland): *"what we learned in this pandemic is that appreciation for caregivers must also be reflected in money. Nurses in Finland were forced by legislation to work overtime but not paid anything extra for this flexibility, which made them angry"* (int 6, FI). This lack of appreciation also influenced their mental health and prompted some to leave the sector. The same kind of frustration was observed in a hospital in Brussels: "*they promised more funds for wages, but this was only for the highest categories like managers, bosses… I understand that people leave, low pay, difficult schedules, many problems, stress…"* (int 12, BE). Gender inequality plays a role in this: *"women, including in childcare and elderly care, feel more and more that they are not equally paid… they were seen during that period as the heroes but they did not see that reflected in their wage"* (int 7, DM).

In Romania as well, many health professionals want to leave the system due to overload; migration is already under way to countries where the workload is lower (int 4, RO). Salaries in the Romanian health system have increased since 2018, but especially in the staff category of doctors, where they have doubled. Before 2018, a doctor in a Romanian hospital received between 1000 and 1500 euros net; after 2018 the income rose to 2000 - 3000 euros net, depending on the working conditions (for example in Intensive Care and the emergency room, the conditions of work are classified in the particularly dangerous category and a bonus between 55% and 85% is added to the basic salary). *"Unfortunately, the other categories of staff had increases in income of up to 75%. The smallest increase was for nurses who received approx. 30%: before 2018 350-500 euros, after 2018 600-900 euros"* (int 4, RO). On top of that, working night shifts has become more and more difficult in Romania. *"The night shifts that initially were 3-4 times per month are now 4-5 times, sometimes even 6 for nurses and healthcare assistants"* (int 4, RO).

The Nordic and German respondents all stressed the point that this lack of policy learning in the social domain is leading to an exodus from the sector. They all link this issue with the high numbers of workers leaving the sector, combined with the low willingness of new young workers to enter the sector (full time) and accept the inconvenient working hours and other psycho-social risks in the workplace. *"Danish hospitals are now better prepared, such as in personal protective equipment, but there are just not enough people who are willing to work nightshifts, to work longer hours or to have fulltime contracts. And if you see young people today, they do not want to have that stressful family*

and working life" (int 7, DM*).* The German unionist has the same story: *"when I talk to hospital workers, they say that the situation is even worse than before the pandemic and it's even getting worse that you can't find enough nurses who are willing to work in these kinds of conditions"* (int 11, DE). It cannot be taken for granted any more that (young) nurses will be prepared to work in bad conditions: *"nowadays, there are so many jobs out here, so you don't need to be exploited anymore… if you ask today the next hospital three kilometres away. You can start there tomorrow"* (int. 8, DE).

The experiences of the works councillor in a hospital in Northern Germany illustrates this persistent problem. According to her, hospital employers are just in the early stages of thinking about mental health problems among healthcare workers. *"Now, we have even more absences due to sickness than before or during Covid because of the high stress levels of nurses"* (int 9, DE). The employer has no incentive in the German system because he is paid for every nurse, regardless of whether the nurse is sick or not. *"So whether she's absent or not, whether she's sick or not, the management just thinks, yeah, I'll get the money anyway .. so why should I do anything about having a healthy nurse*?*"* Another thing is that management in the same hospital is still firing people with (long-term) illness as if they haven't understood the issue that it's difficult to get new personal and that you should rather prevent them from getting sick (int 9, DE). Further, the management here is not open (yet) to the idea that the works council is important to do work-related psycho-social risk assessments in the organisation to ensure that people stay healthy and to investigate what the problems are. A project group with the leaders of departments started on what would be needed for prevention: *"they collected suggestions, but the management doesn't want to listen to them.. so they don't care"* (int 9, DE). The works council discussed whether they should report to the state authorities or go to the Labour Court to fight for better OH&S in the hospital, but they are unsure whether this escalation with management would be good or counter-productive (int 9, DE). The situation in the Berlin university hospital seems not much better. A lot of nurses have looked for other jobs in recent years when they saw that nothing had changed regarding the level of work-related stress. In the academic hospital in Berlin, 80% of the nurses have reduced their working hours because of the workloads and not only older staff, but also younger nurses. *"If the level of work-related stress were OK, then people could have more working hours".*

On a slightly more positive note, some respondents observed a beginning of greater awareness of mental health problems among healthcare workers after the pandemic. A works councillor in a German hospital sees that there is now more attention to the importance of doing risk assessments in organisations, i.e. in the department of oncology where people are very sick and die: *"you don't have the time as a nurse to do justice to the patients by spending time with them. Nurses miss the meaningfulness of their work … the reason why they became nurses … namely their inner motivation to help people"* (int 8, DE). Despite this growing awareness, the risks of burnout and psychological disorders have not diminished since the pandemic.

7.2 Governments

Unions in several countries said that they were more disappointed by the government in the end phase of the Covid-19 crisis and after the pandemic than at the start of the pandemic. Where in the beginning, the strenuous efforts of healthcare workers were appreciated by public applause and by statements from governments and politicians, and by some temporary governmental measures, in the second half of the pandemic period, social dialogue quite often became more challenging. Several unions were worried about their position and influence in the new political contexts after the Covid-19 crisis. Some governments stopped consultation practices with unions altogether. The

interviewees gave several examples showing the challenges facing unions in the post-Covid period in campaigning against public cuts and having a voice and influence in national institutional reforms in healthcare regimes (int 2, RS; int 4, RO; int 6, FI; int 11, BE). Also in these areas of social dialogue, i.e. the lack of investment and persistent understaffing, the criticisms are that governments have not learned much from the crisis.

In Serbia, the government was willing to listen to the unions and to make several agreements about extra compensation during the Covid-19 pandemic. However, in their strategy to increase salaries for certain groups of healthcare workers in 2023, negotiations by the *Trade union of employees of health and social care of Serbia* proved to be much more difficult than during the pandemic. The combination of low pay and work-related stress among nurses even meant that they were leaving the sector or migrating away from Serbia. After the pandemic, the unions have also had to fight for the healthcare workers who were hired during the Covid pandemic and who have had to move into permanent employment. They were hired on temporary contracts and, by law in Serbia, temporary contracts can only last for 24 months. In this fight *"it is also a challenge for the union that new employees in the healthcare sector should become members: younger healthcare workers are less unionised than the older healthcare workers"* (int. 2, RS).

Also *SANITAS* in Romania is pushing the government for more public investment in healthcare. After the Covid-19 period, there were a number of public campaigns and strikes in the health and social care sectors of Romania to push for more investment in wages and working conditions in the sector. Romania still spends a small percentage of GDP on healthcare and *"prices and wages in the hospital sector are still calculated on the situation of two to five years ago, despite inflation"* (int 4, RO).

In Germany, *Ver.di* is in a big political conflict about the financial system of hospitals. *"It's crazy because four years ago we said we need more beds and more capacity in the hospitals, and now it's about closing many of the hospitals, especially the smaller ones in the rural areas"*. Problems of bad working conditions for healthcare workers, understaffing and lack of beds are still not solved (int 11, DE). The lack of structural budgets became even more severe because of inflation: the insurers and the government have not fixed this gap between real prices and the available money. Now, it is a big topic for unions how to deal with hospital closures in the next few years as well as reforming the financial system of the hospital sector. *"There are no union successes to mention in campaigning or lobbying at a national political level for a law for better staffing of nurses*. *Successes were at the local level like in Berlin or in single hospitals"* (int 11, DE). So, *Ver.di*'s bottom-up strategy of workers' actions and collective bargaining seems also to be related to the political context in Germany: when there is little to be achieved at the centralised level, unions look for other ways at decentralised levels.

In Finland, after the pandemic, *Tehy* succeeded in securing pay rises to some extent through collective bargaining (int. 6, FI). The last government also initiated a 'Mental health at work program' with small improvements in policies regarding mental health at work. With the recently installed right-wing government in Finland, she expects more difficulties in agreeing to better payments, also because this government do not want to cooperate with unions. *"The main problem in Finland is that everybody thinks that being a nurse is a good job, but no one wants to do it"* (int. 6, FI).

In Denmark, directly after the crisis, a 'National Commission' – including the Ministry of Health, general unions and nurses' associations - was set up to make recommendations on making the whole health system more robust. One of the union trials is to spread the burden of evening/night shifts across more healthcare workers, but it is difficult to get part-timers to work full time, including the inconvenience in working hours. A new 'Wage Commission' has agreed to give more wage

increases to employees who agree to work longer hours or to work on night/evening shifts. *"Before the pandemic, it was already clear that we in Denmark had a situation where it was really hard to recruit and maintain employees - during the pandemic the severe consequences of this became clear to all"* (int 7, DM).

Another issue that was addressed by the interviewees is the need for more inspections and control from the state on OH&S in hospitals. "*There are good laws, there are regulations, but they are not enforced enough*", according to a German works councillor (int 9, DE). Also FOA in Denmark mentioned the need for more and better Labour Inspectorates' advice on how to handle psycho-social risks for healthcare workers.

7.3 Mental health is about more than wages and (under)staffing

One of our interviewees, a psychological councillor in a Brussels hospital, points to the fact that especially *after* the pandemic, workers came to her more often talking about *"a real deep tiredness and exhaustion from long-lasting stress"* and that they *"do not have hope any more and are disappointed that there are not more colleagues as was promised"* (int 5, BE). Also traumas affecting healthcare workers came under the spotlight in the period after the pandemic. One of the main barriers that the psychologist experiences now is that she has no power over the organisation and management in the hospital units where mental health problems arise: "*there is a taboo on the issue of mental health problems at work, especially among management*" (int 5, BE). The extra efforts of the hospital in psycho-social support for their staff have gone 'back to normal' after the pandemic. The facility for psychological support is still there, but our respondent no longer has the support of those in the psychiatric department (int 5, BE). *"There should be at least two psychologists for the workers in a hospital of 3500 employees, but the hospital management is not ready for this"* (int 5, BE). The experiences during Covid-19 have not been evaluated: she herself is too busy with the coaching of individual healthcare workers and management is not ready to hear evaluations. *"Our management is exhausted and my own HR department is in crisis"* (int 5, BE). She sees the same situation in two other hospitals in Belgium: there as well, management is not ready to learn from the workers' mental health problems at policy and organisational levels.

The stress councillor at a hospital in Copenhagen who was interviewed also observes that there are still serious stress problems among the workers and too little attention from management for this issue. ".. *there is one important point that the hospital could have done better, even in a situation without crisis: that is that the emotions must be shared better among the employees, and that managers give time for this,… I think that we do that too little*" (int 5, BE).

There are more signs that hospital management has scaled down services in social-psychological support. A works councillor in a German hospital sees that the specialists in post-traumatic stress disorders are back to being the psychologists and priests for patients and *"that the employees themselves do not have the time and are too stressed in their work to ask them for help"* (int 8, DE). In the same hospital, the yearly traditional week for teambuilding succumbed during the pandemic and never came back because, as before, it required a week of the hospital being closed, which is now seen by the management and doctors as being no longer financially viable (int 8, DE).

Respondents have different views about the question whether trade unions should do more about supporting the mental health of healthcare workers beyond the issue of understaffing. On the one hand, some think that not just workers' representatives in hospitals should do more on issues like burnout, stress and work-related psycho-social risks, but also that trade unions should initiate or

support their local representatives more in this field (e.g. int 2, RS; int 9, DE). Unions might also strengthen their influence at a political level when trying to influence the law or demanding better enforcement in the field of Occupational Health & Safety (OH&S), including combating work-related psycho-social stress factors (int 8, DE). But more things can also be done in the context of collective bargaining, on issues such as workers' right to take courses about burnout or mental health issues, or measures related to healthcare workers who are faced with patient aggression. Since 2021, in the same way as for working in understaffed conditions, a healthcare worker who is assaulted gets a point in Berlin's points system for extra leave (int 11, DE). And of course, a union strategy focusing on reducing workloads and reduction in working hours rather than on money in collective bargaining is also an approach that centres around healthier working conditions (see section 6).

The Serbian respondent observed that her union now pays more attention to work-related stress of healthcare workers, including problematic relationships with supervisors and colleagues. The union wants workers to be able to complain to the unions but also for there to be specialist teams in hospitals to deal with such problems. This was an issue already raised before the crisis, but Covid-19 made the need for helping workers in these matters clearer. The *Trade union of employees of health and social care of Serbia* also sees this as part of the process to attract more (young) nurses.

On the other hand, there are unionists who say it is better for trade unions to keep focusing on the classical bargaining agendas of wages, working hours and understaffing. One might however question whether unions have really thought about the more qualitative and human aspects of mental health at work - such as fear, depression, burnout, dealing with trauma etc. - beyond the more structural issues like terms and conditions of employment and understaffing. At least it seems to be a controversial topic: *"as a healthcare worker you have to stay strong, that's true… my experience is that the younger workers are more open with these kinds of topics … maybe it's a more generational thing"* (int 11, DE).

Remarkably, not that many respondents mentioned the importance of trade union actions in OH&S policies. One reason might be the decentralised responsibilities for individual employers and workers' representatives at the workplace level. Sweden is a clear example of a system where *"the employees (through their union), OH&S representatives and employers work together mainly through the activities of examining the organisation, assessing the risks revealed by this examination, measures to reduce risks and checking that the measures have contributed to a better work environment"* (int 1, SE). *"We (Kommunal) do collective bargaining on wages and working hours and our OH&S representatives in hospitals are dealing with other working conditions and job quality in the context of occupational health and safety"* (int 1, SE). So, this (legal) system of OH&S responsibilities in Sweden is also part of the reason why unions at the more central level have a limited response to mental health issues in the workplace. However, the works councillor in one of the German hospitals points to the importance of empowering works councils and trade unions to investigate work-related psycho-social risks and related training about legal OH&S aspects in hospitals (int 8, DE). She also pleads for more involvement of the company doctor, OH&S specialist and works council representatives in management decisions that influence job quality and working conditions.

8. Conclusions

The hospital sector in Europe was structurally in a bad shape when the pandemic started, especially as regards understaffing and work-related psycho-social risks among healthcare workers. The pandemic led in all countries to severe mental health problems among healthcare workers, such as fear of corona infections, loneliness in isolated workplaces, frustration at the lack of protective equipment, feelings of 'guilt' at not being able to prevent deaths, exhaustion after long working hours and stress in combining work with family life in a pandemic that never seemed to stop. And sometimes anger at not being treated fairly or appreciated. After the third wave and after the pandemic, healthcare workers' severe exhaustion from long-term stress and sometimes trauma came under the spotlight.

All stakeholders were operating in new, very uncertain circumstances. The interviews showed that trade unions were not the key players in discussion with the governments. Neither were they much involved in social dialogue and collective bargaining with hospitals, although we see variations across the European countries. We critically discussed several measures initiated by hospitals during the pandemic: protection against transmission of the coronavirus, new crisis-related working hours schedules, telephone helplines, internal mobility programs for nurses, and individual psycho-social support for healthcare workers. Generally speaking, trade unions and other workers' representatives had very limited involvement in management decisions at hospitals. Many unions struggled to adapt to the new realities of difficult communication with their workers in uncertain circumstances and with the 'Emergency Legislation' that overruled labour law and traditional social dialogue. Nevertheless, some unions were successful in agreeing extra compensation for workers and/or income benefits for those who fell sick. We described a 'best case' from Germany where the union saw the pandemic as an opportunity to address structural problems in hospitals and was able to mobilise many healthcare workers and agree better staff-patient ratios in collective agreements with hospitals.

One important finding is that according to the twelve interviewees, very little or nothing has been learned from the Covid-19 crisis. Many measures, such as psychological help for healthcare workers, were scaled down after the crisis. Since the crisis, understaffing in the hospital sector has become an even bigger problem because many workers have left the sector and because many (new) young people find hospital jobs too unattractive and too stressful.

9. Reference to the interviews

Int 1 *Kommunal*, Sweden (SE)
Int 2 *Trade union of employees of health and social care of Serbia*, Serbia (RS)
Int 3 Healthcare worker in a hospital in Berlin / *Ver.di Berlin*, Germany (DE)
Int 4 *SANITAS Trade Union Federation*, Romania (RO)
Int 5 Hospital (psychologist/HR department), Belgium (BE)
Int 6 *Tehy*, Finland (FI)
Int 7 *FOA*, Denmark (DM)
Int 8 Hospital in Germany (works councilor/Ver.di), Germany (DE)
Int 9 *Klinikum Karlsburg* (works councilor/Ver.di), Germany 3 (DE)
Int 10 *Amager og Hvidovre Hospital* (stress councillor), Denmark (DM)
Int 11 *Ver.di Berlin,* Germany *(*DE)
Int 12 *CGSP-ALR*, Belgium (BE)