Policy brief 2: trade unions' experiences and actions concerning the mental health of healthcare workers during the COVID-19 crisis

Insights from interviews

Tros, F.H.

Publication date
2024

Document Version
Final published version

Policy brief 2 COMET (interviews), July 2024

Trade unions' experiences and actions concerning the mental health of healthcare workers during the COVID-19 crisis

- insights from interviews -

COMET-project

The *Amsterdam Institute for Advanced labour Studies–Hugo Sinzheimer Institute* (AIAS-HSI) at the University of Amsterdam implemented a 2-year project COMET: 'COvid-19 crisis, MEntal health of healthcare workers and Trade unions actions' (Aug 2022 - July 2024). In cooperation with European Public Service Union (EPSU) and European Psychiatric Association (EPA). COMET is co-financed by the European Commission.

We conducted in total 12 in-depth interviews with 10 trade union officials from healthcare unions and 2 respondents from hospitals. We covered Eastern European countries (Romania, Serbia), Nordic countries (Denmark, Finland, Sweden), and Western European countries (Belgium, Germany). Unfortunately we could not arrange interviews in Southern Europe. The aim of this qualitative part of the COMET study is not to be representative but to further our understanding of the position, experiences and actions of trade unions during the COVID-19 crisis.

Main questions

The interviews with trade unions were a follow-up to a literature review and the findings of the COMET survey. They were structured along the following five main questions:

1. What were the main problems of healthcare workers during the COVID-19 pandemic?
2. Did the government do enough to protect and support hospital workers during the COVID-19 pandemic?
3. What kind of measures did hospitals take during the COVID-19 pandemic in terms of (mental) health of its workers? What worked well? What did not work well?
4. What was the approach of the union in addressing mental health problems and work-related psychosocial risks of healthcare workers during the COVID-19 pandemic? Were there successes and what did not work well?
5. What lessons were learned from the pandemic? Were crisis-related measures sustainable? What are the post-pandemic issues regarding the mental health of healthcare workers?

Work-related mental health problems

A first important finding of the interviews is that the hospital sector in Europe was structurally in a bad shape when the pandemic started, especially in regard to understaffing and work-related psychosocial risks among healthcare workers. Hospitals were too lean too to react flexibly to the pandemic. The pandemic led to severe mental health problems among the healthcare workers in all countries, such as fear for corona infections, loneliness in isolated workplaces, frustration at the lack of protective materials, 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 end. Nurses from other hospital departments were mobilised towards COVID-related units but *'the stressful difficulty was that they didn't know what to do with it'.* Hospital workers were confronted more than ever before with verbal and physical aggressive behaviours of patients and their family members: '*sometimes they did not want to believe the safety measures*'. Healthcare workers sometimes felt anger at not being treated fairly or appreciated after doing extremely long working hours and not having had holidays. After the third wave and after the pandemic, healthcare workers' severe exhaustion from long-term stress and sometimes trauma came into the spotlight.

Governments' role during the pandemic

All interviews confirmed that unions were not key players in discussions with governments, at least not at the beginning of the pandemic. All unions that we spoke to thought that public authorities did not do enough to protect the healthcare workers and failed to provide them with sufficient and good quality masks and other protective equipment. In several countries, governments introduced 'emergency regulations' in the context of the exceptional situation of the pandemic. '*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, augmented*'. However, we found substantial differences in the unions' perception of the governments. In Denmark for example, the union FOA was relatively effective in lobbying activities for protective equipment, sick leave payments, the acknowledgement of COVID-19 as an occupational disease and young workers' help in hospital work. Later in the pandemic, unions in Romania, Serbia and Germany for example negotiated extra financial compensations for healthcare workers who had to work with COVID patients.

Hospitals' measures during the pandemic

Regarding the healthcare workers, protection against transmission of the COVID virus was the first priority of the hospital measures that were taken. The issue of protection was also one of the biggest health and safety 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. A second measure that was taken directly by hospitals was the introduction of new crisis-related working hours schedules for the healthcare workers in Intensive Care and other COVID-related departments. This measure caused many problems of

excessively long working hours, working too much overtime, inconvenient shifts and the lack of enough breaks and resting time between shifts.

Many interviewees mentioned the introduction of internal mobility programmes for nurses across hospital departments immediately after the pandemic started. Many hospital departments were closed for safety reasons. In this context, many hospitals organised for the nurses from the closed departments to work in intensive care units and other departments with COVID patients. This measure could lead to intense feelings of insecurity, fear and anxiety among nurses without the proper experience and knowledge about breathing and lung problems and high risks of death. Some hospitals organised digital training sessions for nursing staff on how to handle isolation measures professionally. 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.

Some hospitals organised individual psychosocial support for healthcare workers during the crisis by psychologists and psychiatrists who were employed by the hospital. So, instead of treating patients, they organised 'crisis counselling' for hospital colleagues to help them cope with extra stress, extra anxieties, and dealing with so many dying patients in COVID units. '*Individual psychological care and coaching works well because workers can place words on traumatic experiences… and in that way they can give these experiences and emotions a place…. there was and still is a lot of guilt*' (psychologist, Belgian hospital). Another hospital worked more in groups: '*I talked to 350 people within six months with different groups. Their anxieties could be reduced by brainstorming together about the question how to handle difficult situations in the COVID related units …. … so they didn't have to go home alone with these problems*' (stress counsellor, Danish hospital).

The picture we got from the interviews is that trade union representatives and works counsellors at the workplace level were not much involved in management decision in hospitals. The quality and frequency of co-determination and consultation practices were far less than workers' representatives were used to before the pandemic. Nevertheless, in some hospitals they succeeded in avoiding too extreme and too inconvenient working hours, pushing for additional employees, providing childcare, negotiating enough rest and holidays, and developing tools for risk assessments in the field of Occupational Health and Safety (Belgium, Germany, Sweden).

Unions' approaches and practices in response to the pandemic

When the pandemic started, trade unions were slightly paralysed and confronted with new challenges in communicating with their members and shop stewards in the healthcare sectors. After some time, they began to negotiate about issues such as bonuses for healthcare workers who were working with COVID patients (Romania, Serbia), compensation for longer working hours (Sweden), and recognition of COVID as an occupational disease for sickness benefits and exceptions for healthcare workers with chronic diseases who would not to have to work with COVID patients (several countries). In Serbia, the union played an important role in supervising a rota system for hospital workers and exceptions for those who had children of pre-school age. See the Box for an example of effective trade union actions. The lesson learned here, is that long-term protests and strikes led to more empowerment among healthcare workers and more public awareness about understaffing and unhealthy working conditions in the German hospitals. In the end it also resulted in better regulations regarding staffing norms in hospital departments and incentives for hospital managers to solve staffing problem other than with paid overtime.

BOX

Effective union actions: using the momentum for strikes and bargaining on staffing ratios

At the time when the pandemic started, an organiser working for the trade union Ver.di responded '*not like 'oh God everything goes down', but this is our moment where we can bring up all the topics that were important in the hospital sector for many years while nobody listened*'. In 2020, organisers in Berlin started with big online conferences among healthcare workers, leading to a petition with five thousand signatures. This movement grew towards a strike of 30 days in Berlin at the end of 2021, demanding better contracts for staffing in hospitals and better wages for healthcare workers. '*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'*. The strike led to public attention for the understaffing problems and *Ver.di* negotiated better incentives for management to respect the necessary staff-ratios for the public hospitals in Berlin. For example, *when a hospital department prescribes three nurses in a late shift and there are just two working, then the two nurses would each get 'one point'. After having collected a certain number of points, the employee gets one day off. These rules became better for the workers in the last years .. many people have like two or three additional weeks of holidays because of this contract.* Management has now a concrete incentive to solve the problem of understaffing. Another outcome was a huge sustainable increase of 40% in union memberships at the public hospitals of Berlin. The whole protest movement with positive outcomes has boosted the empowerment of the hospital workers: *"these agreements are not only compromises in terms and conditions of 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"*. 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.

The campaign in 2020 and the strike in 2021 in Berlin influenced hospital workers across Germany to do the same. For six *university hospitals in Northrine Westfalia*, the union agreed new staffing contracts after a very long strike of 77 days. The fight is not over. *"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"*. However, it is a big, controversial political topic whether the state is willing to pay that much money to finance good working conditions.

Lessons learned, sustainability of measures and post-pandemic issues

A very worrying finding of the interviews was that in general, unions thought that very little or nothing had been learned from the pandemic and that hospitals are not now better prepared for new public health crises in Europe. Especially because of the negative spiral of understaffing and work-related psychosocial risks. In all European countries, there are not enough nurses who are willing to work in unattractive conditions of high workloads, stress and inconvenient working hours. '*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'*. Many measures, such as psychological help for healthcare workers, have been scaled down after the pandemic and 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.

Unions in the hospital sector are nowadays again (and more than before the COVID-19 crisis) confronted with challenging political environments that push for greater cost containment and, in labour market contexts, a scarcity of personnel (especially in the public sector). They ask for more public investments to combat understaffing, better wages and more compensation for inconvenient working hours. Nevertheless, there are more work-related psychosocial stress factors, and mental health requires more than compensation. It is also about psychosocial help in preventing burnout, (re-) building resilience after difficult experiences at work, better balancing of work and private life, healthy relationships with supervisors, colleagues and patients, and social safety in addressing emotions and compassion for each other. Therefore unions also demand better enforcement in the field of Occupational Health and Safety legislation and – in cooperation with shop stewards and works councils - more attention for work-related mental risks to healthcare workers in hospitals.

PROJECT IDENTITY	
Project management and research team	Prof. Dr. Maarten Keune Dr. Wieteke Conen Dr. Frank Tros
EPSU	Dr. Adam Rogalewski
Duration	1 August 2022 – 31 July 2024 (24 months)
Funding	Call: SOCPL-2021-IND-REL | Acronym: COMET | number: 101052344
Website	https://aias-hsi.uva.nl/en/projects-a-z/comet/comet.html
Further reading	• 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. • 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. • Tros, F.H., Conen, W.S. and Keune, M.J. (2023). The COVID-19 crisis, mental health of healthcare workers and trade union actions: a literature review. University of Amsterdam: AIAS-HSI.
For more information	Project: Maarten Keune, M.J.Keune@uva.nl Policy brief 2 (interviews): Frank Tros, F.H.Tros@uva.nl EPSU policy officer: Adam Rogalewski, arogalewski@epsu.org