► ILO Sectoral Brief

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COVID-19 and the health sector

The outbreak of novel coronavirus disease (COVID-19) puts a spotlight on the resilience of health systems and countries' emergency preparedness and response. The rapid expansion of COVID-19 emphasizes the urgent need for a strong health workforce as an integral part of every resilient health system.[1]

Health workers[2] are the backbone of the health system. Due to the nature of their profession, millions of them risk their own health doing their daily work. So, who is protecting health workers, who are so critical to the fight to stem the COVID-19 pandemic? Respect for labour rights and decent conditions of work are crucial to give these frontline workers the protection they need for waging the long battle ahead to save lives.

This brief is intended to provide information on the impact of the COVID-19 pandemic on health workers and health systems, as well as information on early response measures taken. As the situation is changing so rapidly, the brief provides a preliminary overview, which will be updated and complemented in the coming weeks.

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Tamil Nadu, India: collecting data on the status of citizens' health during coronavirus lockdown

► 1. The impact of COVID-19 on health workers

By 10 April 2020, more than 1.4 million confirmed cases of COVID-19 and over 87,000 deaths had been reported by the World Health Organization (WHO), affecting more than 200 countries, areas and territories.[3]

22,073 cases of COVID-19 in health workers from 52 countries have been reported to WHO by 8 April 2020. WHO states,

however, that this number probably under-represents infections in health workers globally due to lack of systematic reporting.[4] Infection among health workers has been common since the emergence of the disease. By February 2020, a study from China had observed 3,019 cases of COVID-19 among health workers, of which 1,716 were confirmed cases (3.8 per cent of all confirmed cases, 63 per cent of them in Wuhan). Of the cases among health workers, 14.8 per cent were classified as severe or critical, and

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1 Li L et al.: "COVID-19: the need for continuous medical education and training", in The Lancet (2020), [accessed 9 April 2020].

2 In this piece, the term "health workers" refers to: (a) personnel trained in health occupations delivering clinical work in health facilities; (b) all staff employed in the health sector, public and private, regardless of their occupation; and (c) all those whose work supports the delivery of health services, even if they are employed by other sectors or industries, such as outsourced service providers: cleaning, catering, security or agency staff. See ILO: Improving Employment and Working Conditions in Health Services: Report for discussion at the Tripartite Meeting on Improving Employment and Working Conditions in Health Services (Geneva, 2017).

3 Coronavirus (Covid-19), WHO [accessed 10 April 2020].

4 WHO Coronavirus disease 2019 (COVID-19) Situation Report – 82 (Geneva, 11 April 2020).

five deaths were reported.[5] In Italy, at 9 April 2020 there had been 14,066 confirmed cases of COVID-19 in health workers, representing an infection rate of over 10 per cent.[6] Ireland has reported that 1 in 5 of its COVID-19 cases is a health worker.[7] Five infected health workers have been reported in Togo, representing an infection rate of 8.6 per cent.[8]

Robust data on the number of infected health workers are not, however, being collected systematically, as many countries do not have adequate reporting mechanisms in place. Furthermore, many reports do not distinguish health worker infection by general and occupational exposure, but rather include all sources of infection.

Occupational safety and health aspects

Every infected health worker means a further gap in the fight against the pandemic. Ensuring the safety and health of health workers is therefore a matter of high priority. The health-care workplace is particularly vulnerable to the risk of exposure to COVID-19. According to current knowledge, the two main routes of transmission are direct interaction with patients and contact with respiratory droplets in the space closely surrounding an infected person. To date, the survival time of the virus on surfaces remains unknown.[9] This further extends the risk of contact transmission to support personnel, such as laundry staff, cleaners and workers dealing with clinical disposal.

The protection of health workers focusses on the prevention of contracting and spreading COVID-19. The transparent and timely dissemination of information on the transmission of the disease is key in this regard. The availability of personal protective equipment (PPE), as well as training and education in its correct usage, is also critical. Specific infection control measures, such as visual alerts, respiratory hygiene and cough etiquette, masking and separation of persons with respiratory symptoms, and droplet precautions, can help to prevent occupational respiratory

infection among health workers and patients in health-care settings.[10]

In a recently published survey by National Nurses United in the United States, only 30 per cent of respondents reported that their employer had sufficient PPE stock to protect staff in the event of a rapid surge in potential COVID-19 patients. Only 65 per cent reported having been trained in safely donning and doffing PPE in the previous year.[11] Moreover, observations from the United States show that guidance on when and where to use masks is not well developed. While in some places health workers wearing protective masks have faced disciplinary consequences for causing anxiety among patients,[12] in others, health workers have received threats of dismissal when speaking out about the lack of PPE and their working conditions during the pandemic.[13]

The International Council of Nurses and the Italian Nurses Association issued a warning about the severe consequences of shortage of PPE for health workers. Lack of availability of PPE, or supply of inadequate PPE, leaves health workers dealing with COVID-19 patients at high risk of infection.[14] High rates of infected health workers result in more constraints to the health system and an intensified workload for colleagues covering those who have to be quarantined for at least 14 days.

The use of PPE, such as masks and eye protection, for an entire shift may cause discomfort due to heat, skin irritation and breathing difficulties. Preliminary data from Wuhan, China during the COVID-19 outbreak suggest a high prevalence (up to 97 per cent)[15] of cutaneous irritation and skin damage in association with the use of PPE, which increased with the duration of PPE use.[16]

A study conducted in Zhongnan Hospital of Wuhan University suggests that long duty hours and suboptimal hand hygiene also increase the risk of contracting COVID-19 among health workers.[17]

This highlights the need for a sustainable approach to safety and health at work as an integral part of the overall management of the health sector. Several ILO tools set out detailed guidance on

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5 Z. Wu and J.M. McGoogan: Characteristics of and important lessons from the Coronavirus disease 2019 (COVID-19) outbreak in China - Summary of a report of 72 314 cases from the Chinese Center for Disease Control and Prevention, JAMA Network (2020) [accessed 9 April 2020].

6 Epicentro. Daily infographic [accessed 10 April 2020]. Based on occupational group, not place of exposure.

7 Statement from the National Public Health Emergency Team - Wednesday 18 March, Government of Ireland. [accessed 9 April 2020].

8 Presentation by the Director of Occupational Health, Ministry of Health, Togo, at the WHO EPIWIN webinar on National occupational health programmes for health workers, 7 April 2020.

9 COVID-19 transmission questions, WHO [accessed 9 April 2020].

10 ILO and WHO: Occupational safety and health in public health emergencies: A manual for protecting health workers and responders (Geneva, 2018) [accessed 9 April 2020].

11 Survey of Nation's Frontline Registered Nurses Shows Hospitals Unprepared For COVID-19, National Nurses United, [accessed 9 April 2020].

12 Why Would Hospitals Forbid Physicians and Nurses from Wearing Masks?, Scientific American [accessed 9 April 2020].

13 Hospitals Tell Doctors They'll Be Fired If They Speak Out About Lack of Gear, Bloomberg [accessed 9 April 2020].

14 High proportion of healthcare workers with COVID-19 in Italy is a stark warning to the world: protecting nurses and their colleagues must be the number one priority, International Council of Nurses [accessed 9 April 2020].

15 J. Lan et al.: "Skin damage among healthcare workers managing coronavirus disease - 2019", Journal of the American Academy of Dermatology (2020), [accessed 9 April 2020].

16 J. Kantor: "Pre-proof behavioral considerations and impact on personal protective equipment (PPE) use: Early lessons from the coronavirus (COVID-19) outbreak", Journal of the American Academy of Dermatology. 2020 [accessed 9 April 2020].

17 R. Li et al.: "Risk Factors of Healthcare Workers with Corona Virus Disease 2019: A Retrospective Cohort Study in a Designated Hospital of Wuhan in China", Infectious Diseases Society of America, (2020), [accessed 9 April 2020].

protecting health workers (see Section 3).

Timely access to information and transparent dialogue between health workers and employers are also crucial. Health workers and employers should share the most recent information on clinical protocols, guidelines, measures and decisions to ensure effective implementation, as well as on workplace situations that expose health workers to risks.

Mental health and psychosocial support

The COVID-19 pandemic is placing health workers in exceptionally demanding situations. In addition to a heavy workload, they are coping with the fear of contracting the disease and of spreading it to their family and friends. Furthermore, the overall atmosphere of anxiety among the general population is impacting health workers and their mental health.

A mental health survey of 230 medical staff in a tertiary infectious disease hospital for COVID-19 in China revealed a 23 per cent incidence rate for anxiety and 27 per cent for stress disorder among health workers responding to the COVID-19 outbreak. The incidence rate of anxiety among nurses was higher than for doctors.[18]

Management and health workers in highly burdened hospitals are calling for psychological support to help staff cope with excessive hours, high intensity of work and experiences with unprecedented death rates.[19]

With many countries shutting down schools and public life, health workers, many of whom are women, are confronted with high professional demands, while also having to organize their home life and look after their dependants, particularly if they have children or ill or disabled family members.

In addition, health workers in areas that report high numbers of COVID-19 cases face tension between public health priorities and the wishes of patients and their families regarding treatment.[20] The consequences of dealing with difficult decisions can range from anxiety to post traumatic stress disorders.[21]

Lessons from other outbreaks, such as the Ebola virus disease epidemic in West Africa 2014, have shown that health workers may experience violence, discrimination and stigma in society and in their communities, due to fear of contracting the disease.[22]

In some countries, health workers and other public services workers are considering alternate accommodation during the outbreak, such as low-cost hotel rooms, to protect their families from exposure to COVID-19.[23]

Providing support in health-care teams and among families, and friends, information and guidance for health workers on how to deal with stress, and post-traumatic stress counselling must be an integral part of the COVID-19 response. The ILO Guidelines on decent work in public emergency services outline measures to prevent and address stressors and their consequences.

Working hours

In response to the COVID-19 outbreak, many health workers are facing heavy additional workloads, long working hours and a lack of rest periods. In many countries, struggling with an increasing number of cases requiring hospitalization[24] is resulting in extensive use of overtime. In some countries, holiday restrictions have been imposed on health workers to ensure sufficient staff are present at all times to respond to the COVID-19 outbreak.

Decent working time arrangements help balance health workers' well-being with health service requirements. In emergency situations, however, health workers are required to work under irregular and sometimes atypical conditions. The ILO Guidelines on decent work in public emergency services (2018) set out the principles for defining working time arrangements during the emergency.

The ILO Nursing Personnel Convention, 1977 (No. 149) and its accompanying Recommendation (No. 157) establish standards for decent working time arrangements specifically for nursing personnel.[25] The Convention calls for nursing personnel to enjoy conditions at least equivalent to those of other workers in the country concerned. Conditions particularly pertinent to the pandemic include: hours of work, including regulation and compensation of overtime, inconvenient hours and shift work; weekly rest; maternity leave; sick leave; and social security. The Recommendation provides that temporary exceptions to the provisions on normal working hours should be authorized only in case of special emergency. In addition, the Annex to the Recommendation provides that "overtime should be worked on a voluntary basis, except where it is essential for patient care and sufficient volunteers are not available".

18 J. Z. Huang et al.: Mental health survey of 230 medical staff in a tertiary infectious disease hospital for COVID-19, (2020) [accessed 9 April 2020].

19 Corona-Pandemie: Wie lange muss sich die Schweiz abschotten?, in SRF, 23 Mar. 2020 [accessed 9 April 2020].

20 J. Cabrita: "COVID-19 intensifies emotional demands on healthcare workers" (2020) [accessed 9 April 2020].

21 PTSD: National Center for PTSD, U.S Department of Veterans Affairs, 2020 [accessed 9 April 2020].

22 Mental health and psychosocial considerations during the COVID-19 outbreak, WHO, 2020 [accessed 9 April 2020].

23 Zielinski S.: Essential services workers consider alternate accommodations to protect their families, in Red Deer Advocate, 31 Mar. 2020 [accessed 9 April 2020].

24 Public Services International: "French health workers face rapid escalation of cases" (2020) [accessed 9 April 2020].

25 ILO: Policy Brief Health Services Decent Working Time for Nursing Personnel: Critical for Worker Well-being and Quality Care (2018) , Geneva, 2018.

Protecting volunteers and short-term recruits

To secure the availability of sufficient health workers to respond to the COVID-19 outbreak, several countries have sought professional assistance from volunteers, other sectors such as the military, retired doctors or medical and nursing students. The Health Service Executive in Ireland, for example, has issued a call for all health-care professionals from all disciplines who are not currently working in the public health sector to register and to be on call for Ireland.[26] Following this example, Kenyan health workers used social media to share "On call for Kenya", a call to join forces against COVID-19.[27] In Germany, there is a call to fast-track work permits for foreign health workers who are already in Germany and awaiting their registration certificate.[28] Medical schools in the United Kingdom have been urged to fast-track medical and nursing students who are in their final year, and to waive requirements for clinical examinations to ensure that doctors are registered as soon as possible.[29] [30] The United Kingdom is also calling retired doctors back into its National Health Service workforce.[31] Many other countries, including Kenya[32] and South Africa,[33] are following this path by launching recruitment campaigns for additional health workers.

With growing unemployment in many countries and the unequal distribution of health workers, the idea of training local residents to become community health workers to help respond to the pandemic is becoming attractive.[34] Training community-based health workers to ensure delivery of care has long been practiced in countries with health workforce shortages. During recent outbreaks, such as the Ebola virus disease epidemic in the Democratic Republic of the Congo and West Africa, affected countries trained thousands of community health workers as part of interdisciplinary teams to help prevent, detect and respond to the outbreak in Ebola-affected and at-risk communities.[35] This community-based strategy to implement prevention and control measures is becoming a way for countries to strengthen their COVID-19 response.

While these measures appear encouraging to secure the care needed, they require careful implementation to ensure that these workers are afforded the same protection as other workers. Sustainable health systems depend on forward-looking health workforce planning. Ad hoc recruitment should take into account logistical, ethical and financial issues.

As well as occupational safety and health, other terms and conditions of employment need to be addressed, including social protection, remuneration, rest periods and working time arrangements. Governments should consult with social partners to monitor and regulate such ad hoc recruitments during the crisis, as appropriate. Inexperienced recruits and older workers coming out of retirement are especially vulnerable to infection; adequate protection is therefore essential.

Governments must also ensure proper supervision and management for health workers and new recruits, to ensure that they all are trained and up to date with the skills required to respond to the pandemic.

The country example in box 1 shows a comprehensive approach to ad hoc recruitment with decent work aspects.

26 Be on call for Ireland, Government of Ireland, 2020 [accessed 9 April 2020].

27 COVID-19 respone [accessed 9 April 2020].

28 Ausländische Pflegekräfte schnell zulassen, Federal Government of Germany, 18 Mar. 2020 [accessed 9 April 2020].

29 G. Iacobucci: "Covid-19: medical schools are urged to fast-track final year students", BMJ (2020) [accessed 9 April 2020].

30 E. Mahase "Covid-19 medical students to be employed by NHS as part of epidemic response", BMJ (2020) [accessed 9 April 2020].

31 C. Dyer: "Covid-19: 15 000 deregistered doctors are told "your NHS needs you", BMJ (2020) [accessed 9 April 2020].

32 E. Kivuva: "Covid-19: Kenya begins hiring of 6,000 more health workers", in Business Daily, 2 Apr. 2020 [accessed 9 April 2020].

33 Citizen reporter:"Health department embarks on massive recruitment drive", in the Citizen COVID-19, 28 Mar. 2020 [accessed 9 April 2020].

34 R. Panjabi: "The job description for a COVID-19 community health worker - and how this could fight US unemployment," in WEF, 31 Mar. 2020 [accessed 9 April 2020].

35 S. O. Wiah et al.: Prevent, Detect, Respond: Rapidly expanding healthcare teams through community health workers in the fight against COVID-19. BMJ Opinion (2020) [accessed 9 April 2020].

women's contribution to health care accounts for nearly 5 per cent of global GDP, almost half of their contribution is, in fact, unpaid and unrecognized. Women in the health and social work sectors tend to be engaged in lower-skilled jobs, with less pay and at the lower end of professional hierarchies, contributing to a gender pay gap of on average 26 per cent in high-income and 29 per cent in upper-middle-income countries.[38]

During this pandemic, women in particular are being confronted with the challenges of balancing an increased workload, the anxiety of spreading the virus to loved ones and the management of their care responsibilities at home. Some health facilities are providing free childcare for health workers to reduce that burden. Governments should ensure that measures are taken to support health workers, in particular those with additional care responsibilities at home.

Previous outbreaks have shown the importance of integrating a gender analysis into public health emergency preparedness and response since women play a predominant role as informal carers and frontline health workers.[39] The pressing demand on health workers with family responsibilities, most of whom are women, highlights the strong need for flexible working time arrangements that are predictable and gender responsive, and that allow and encourage men and women to better balance their work and family responsibilities. The Annex to the Nursing Personnel Recommendation, 1977 (No. 157) provides guidance in this context, stating that: "In the organization of hours of work, every effort should be made, subject to the requirements of the service, to allocate shift work, overtime and work at inconvenient hours equitably between nursing personnel, and in particular between permanent and temporary and between full-time and part-time personnel, and to take account as far as possible of individual preferences and of special considerations regarding such matters as climate, transportation and family responsibilities".

Travel restrictions and anxiety about infection pose additional obstacles to providing home care for the elderly and sick people. This type of care is predominantly provided by women, who comprise 88 per cent of all personal care workers.[40] In Germany, for example, there is a heavy reliance on migrant care workers for the provision of home care. The current COVID-19 outbreak is significantly reducing the number of care workers from eastern European countries traveling to Germany to provide care. The German association for home care and nursing expects that from mid-April onwards, 100,000–200,000 people will no longer be cared for at home. The association is calling for incentives to encourage home care personnel to stay in Germany, following the example of Austria where a premium of € 500 per month has been offered to retain migrant care workers. [41] [42]

Box1. Ad hoc recruitment to address short-term health workforce needs: "Be on call for Ireland"[1]

In preparing the health system for the response to COVID-19 Ireland's Health Service Executive (HSE) has issued a call for all health-care professionals from all disciplines not currently working in the public health sector to register and be on call for Ireland in case the health system requires additional help. This also includes volunteers or others who have skills that could be needed during the pandemic.

The HSE has published an online "Frequently Asked Questions" page, which provides transparent information on the process, roles and responsibilities, and conditions of employment under the call. The topics covered are:

. About the sign-in process
. Filling in the online form
. The roles
. When and how the person will be contacted
. Hours of work
. Holidays & annual Leave
. Salary
. Retired workers
. Agency worker
. Qualified Professionals not registered with relevant Irish authority
. Working as an undergraduate
. Working outside a discipline
. Employment contract type
. Volunteering
. About HSE jobs
. The Selection Process
. Childcare/ care arrangements
. Social welfare payments
. About COVID-19

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1 Be on call for Ireland, Government of Ireland, 2020 [accessed 9 April 2020].

Gender aspects

Women are facing particular challenges during this pandemic. Globally, they make up more than 70 per cent of the health workforce.[36] They also carry the burden of unpaid care work, such as taking care of children or elderly family members.[37] It is estimated that while

36 ILO: ILO Monitor, 2nd edition: COVID and the world of work. Geneva: ILO, 7 April 2020 [accessed 9 April 2020].

37 ILO: A quantum leap for gender equality: for a better future of work for all, Geneva, 2019.

38 ILO: Improving Employment and Working Conditions in Health Services: Report for discussion at the Tripartite Meeting on Improving Employment and Working Conditions in Health Services (Geneva, 2017).

39 C. Wenham, J. Smith and R. Morgan: "COVID-19: the gendered impacts of the outbreak", The Lancet, (14 March 2020, Vol. 395) [accessed 9 April 2020].

40 ILOSTAT: "These occupations are dominated by women", (2020) [accessed 9 April 2020].

41 Versorgungsnotstand wegen Corona, 2020 [accessed 9 April 2020]

42 Pressemitteilung, Berlin, 2020 [accessed9 April 2020].

Social dialogue in times of crisis

The Employment and Decent Work for Peace and Resilience Recommendation, 2017 (No. 205) emphasises the importance of social dialogue and the vital role of employers' and workers' organizations in crisis response.

Voice and participation are critical for enabling health workers, employers and other stakeholders in the health system to play an active role in responding to the COVID-19 outbreak. The freedom to express concerns, for example around the topics of occupational safety and health or refusing work that health workers believe will endanger themselves or others, as well as their right to organize and participate freely in dialogue, are important principles that must be upheld, even in emergency situations such as the COVID-19 pandemic.

Around the world, many unions are engaging actively in the response to COVID-19 by providing guidance and regular updates to their members, engaging in dialogue with employers' organizations and governments, and mobilizing members to actively help during the outbreak.

Public Services International (PSI) has issued a briefing note on union action during the COVID-19 outbreak, providing guidance on key aspects relevant to workers.[43] Furthermore, PSI has launched the "Public Health Once and for All" campaign, which draws attention to critical measures for responding to the COVID-19 outbreak, while at the same time advocating for changes in health systems to put people first, and underscoring the importance of public health systems that are sufficiently well funded, staffed and equipped to respond to future public health challenges.[44]

The Michigan Nurses Association filed a complaint against a health service facility for not allowing nurses to use their own protective masks. This shows the important role that unions and associations can play in addressing health workers' concerns.[45]

In Argentina, an agreement between the federation of health workers' associations and the Government provides a guarantee that all health-care workers will continue to earn full salaries while in quarantine, and will be eligible for free transport during the pandemic, subsidized by the Government.[46]

In Italy, the Government and social partners have concluded a new collective agreement on occupational safety and health for health workers.[47]

Social dialogue is important not only to ensure emergency preparedness, but also to improve response and coordination during emergency situations. It is vital for timely exchanges of information and for addressing issues such as occupational safety and health, increased workload and responsibility.[48]

Box 2. Republic of Korea: Tripartite health-care sector committee agreement on COVID-19 countermeasures[1]

In the Republic of Korea, tripartite members of the health-care sector committee, under the Economic, Social and Labour Council, have reached an agreement on overcoming the crisis caused by the spread of COVID-19 and protecting health-care workers in the field. Key points of the agreement include:

i. creating a labour environment that can ensure the safety of health-care service;
ii. improving job security and treatment for health-care workers;
iii. coping with the shortage of medical supplies and building a sustainable health-care system; and
iv. enhancing public health-care capabilities and collaboration with the private health-care sector.

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1 Economic, Social and Labour Council: Healthcare Sector Committee Agreed on COVID-19 Countermeasures, ESLC Newsletter, 26 Mar. 2020.

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43 Public Services International: "Coronavirus: Guidance Briefing for Union Action – Update", (2020) [accessed 9 April 2020].

44 Public Services International: "Public Health, Once and for All! - concept note" (2020) [accessed 9 April 2020].

45 C. Rainey: "Michigan Nurses Association files complaint against Mercy Health Partners Hackley campus", in Newschannel 3, 23 Mar. 2020 [accessed 9 April 2020].

46 Argentina battles Covid-19 with trade union support, Uni Global Union, 2020 [accessed 9 April 2020].

47 Protocollo per la prevenzione e la sicurezza dei lavoratori della Sanità, dei Servizi Socio Sanitari e Socio Assistenziali in ordine all'emergenza sanitaria da «Covid-19» [accessed 9 April 2020].

48 ILO: Guidelines on decent work in public emergency services, Geneva, 2018.

▶ 2. Impact on the health system

The capacity of health systems for rapid reorganization to respond to the crisis by mobilizing heath workers, while at the same time ensuring the ongoing provision of essential services along the continuum of care, is equally critical and challenging. Key strategies include ensuring occupational safety and health, decent working conditions, psychosocial support for health workers, and providing training and education mechanisms to rapidly repurpose health workers and new recruits according to health system requirements. Emergency preparedness also includes optimizing service delivery platforms, such as through tele-medicine.[49]

Technological advances, such as online and mobile health applications, 3D-printing and artificial intelligence can enhance health service delivery and ways of working during and beyond the pandemic.[50] Some countries have introduced the use of mobile phone location data to track COVID-19 spread at the national level.[51] In the Netherlands, medical students are being employed in a call centre, which patients experiencing severe symptoms can use to be directed towards the care they need. Introducing and scaling-up digital technologies to inform, train and guide health workers, especially in poor and remote locations, can improve transparency, service delivery and management during the pandemic.

Health employment and workforce shortages

The health sector is a major source of employment; in most regions, employment growth rates for health have been higher than for other sectors. Health and social work together accounted for more than 105 million jobs worldwide in 2013, 130 million jobs in 2018 and for an estimated 136 million jobs in 2020.[52] Moreover, health systems have the potential to generate more decent jobs by stimulating growth in other sectors, such as equipment and technological production.[53] In the United States, for example, the health sector contributed to overcoming the 2007–2008 financial crisis; between 2006 and 2016 employment growth in health care settings was 20 per cent, compared with 3 per cent in the rest of the economy.[54] This employment growth trend is projected to continue; 18 out of the 30 fastest growing occupations are in healthcare and related occupations, adding projected 3.4 million jobs by 2028.[55]

The United Nations High-Level Commission on Health Employment and Economic Growth recognized the health sector as a key economic sector and that investments in the health workforce are needed to make progress towards meeting the Sustainable Development Goals.[56] Data show, however, that almost all health systems are facing challenges in recruiting, deploying and retaining sufficient well-trained, supported and motivated health workers. Overall, it is estimated that there will be a global shortfall of 18 million health workers by 2030, which will primarily affect low- and lower middle-income countries. The unequal distribution of health workers both between and within countries constitutes a barrier to health equity; gaps in the health workforce primarily affect the poorest populations, particularly in rural areas. In 2014, the proportion of the population without access to health services due to health workforce shortages was estimated at 84 per cent in low- income countries, and 55 per cent and 23 per cent in lower-middle-income and upper-middle-income countries, respectively. In some African and Asian countries, over 90 per cent of the population had no access to health care due to extreme health workforce shortages (less than three health workers per 10,000 people).[57][58]

The recently published State of the world's nursing report, 2020, highlights the need to create at least 6 million new nursing jobs by 2030 to address the projected shortages of nurses primarily in

49 WHO Regional Office for Europe: Strengthening the Health Systems Response to COVID-19 Technical guidance #1, (Copenhagen, 2020) [accessed 9 April 2020].

50 ILO: The future of work in the health sector. Working Paper No. 325 Geneva, 2019.

51 A. Hutchinson: "More Nations Are Looking to Use Cell Phone Data to Track the COVID-19 Outbreak, Raising Privacy Concerns", in Social Media Today, 24 Mar. 2020 [accessed 10 April 2020].

52 Sources: ILO WESO data base 2015; ILO calculations 2018 based on labour force and household survey microdata; ILOSTAT calculations 2020 (Geneva, forthcoming).

53 ILO: Improving Employment and Working Conditions in Health Services: Report for discussion at the Tripartite Meeting on Improving Employment and Working Conditions in Health Services (Geneva, 2017).

54 E. Salsberg and R. Martiniano: "Health Care Jobs Projected To Continue To Grow Far Faster Than Jobs In The General Economy", in Health Affairs, 9 May 2018.

55 U.S. Bureau of Labour Statistics. Employment projections 2018-2028. Economic news release, 9 September 2019 [accessed 9 April 2020].

56 WHO: Working for health and growth: Investing in the health workforce, Report of the High-Level Commission on Health Employment and Economic Growth (Geneva, 2016).

57 ILO: Improving Employment and Working Conditions in Health Services: Report for discussion at the Tripartite Meeting on Improving Employment and Working Conditions in Health Services (Geneva, 2017).

58 ILOSTAT: COVID-19: Are there enough health workers? [accessed 9 April 2020].

low- and middle-income countries, and to work towards a more equal distribution of nurses around the world. [59]

Balancing public and private health sector

While in many countries, the private sector is playing an increasing role in providing health services, the leading role of the public health sector in ensuring equal access to health care as a human right is particularly prominent in times of crisis. Over the years, the increasing commercialization of health services has raised concerns among some stakeholders. The conclusions of the 1998 joint meeting on terms of employment and working conditions in health sector reforms provide that: "… health care for all must be in the public interest. This does not necessarily mean that health care must be organized and implemented by public services but that it can also be provided on a private basis. Health care is a not a commodity and thus not a tradable good."[60]

In light of the ongoing COVID-19 outbreak, some countries, including Ireland and Spain, are now enhancing the role of private hospitals by integrating them temporarily in the public health system for the duration of the outbreak. According to Irish State officials, this will ensure a coordinated health system, with around 2,000 additional beds, as well as testing and treatment resources, which will give a substantial and greatly needed boost to the public health system's capacity to respond to the crisis.[61][62]

The private sector can also play a role in contributing to the fight of the Covid-19 pandemic beyond the health sector. In some countries, individual enterprises have taken initiatives to temporarily change business models during the crisis, helping to ensure production of medical supplies, such as PPE or ethanol for sanitizer products.[63] To further explore effective options for private sector contributions to health emergencies, the International Organization of Employers has initiated discussions with multilateral organizations and the business community on challenges and opportunities in public–private collaboration.[64]

Addressing income losses among health system actors

While the main focus of attention is on protecting and supporting frontline health workers, the battle against COVID-19 impacts all health actors, including the self-employed and health enterprises.[65]

Many health and care workers who are now at the front line of the response and at high risk of being infected are in those categories. Lack of universal coverage of sickness benefits has therefore been identified as a major challenge to the success of virus containment strategies; in several countries, specific steps have already been taken to remedy to this situation.[66] The COVID-19 crisis is revealing significant coverage gaps, not only in access to health care but also in terms of sickness benefit, leaving health workers and carers who are in non-standard forms of employment, or are self-employed, unprotected. The lack of income security when ill or caring for sick family members creates an incentive to go to work while unwell and increases risks of contagion. It also increases the risk of impoverishment for those affected by the disease and their families.[67]

Health workers should also be provided with access to health care and financial compensation in the event of becoming infected with COVID-19 during employment, either under specific employment injury insurance or, where no such insurance schemes exist, through direct compensation from employers, in line with the ILO Employment Injury Benefits Convention, 1964 (No.121).

Some governments, such as those of Germany, Switzerland, Italy and Spain, have called on health systems to minimize patient contacts to essential services and to reschedule preventive and routine patient follow-up visits where possible. While these measures aim to reduce the risk of transmission and to make resources available within the health system, they are expected to have a challenging impact on the income of medical and dental practices as the number of patient visits has decreased significantly, while recurrent operational costs, such as rent and power for medical devices continue. In Switzerland for example, the Swiss medical association is clarifying the possibility of short-time work compensation for affected doctors and aims to inform its members about options for compensation as soon as possible.[68] In addition to income losses, these doctors are preparing for an increasing amount of work once social distancing measures are revoked and health systems return to normal.

Where hospitals have been asked, as part of national preparedness strategies, to free capacity by discharging patients and delaying planned routine surgeries, hospitals are facing considerable income losses. The German Hospital Federation has

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59 WHO: State of the world's nursing 2020 (Geneva, 2020) [accessed 9 April 2020].

60 ILO: Note on the proceedings, Joint Meeting on Terms of Employment and Working Conditions in Health Sector Reforms (Geneva, 1999), Conclusions, para. 2.

61 "Private hospitals will be made public for duration of coronavirus pandemic", the journal ie, 24 Mar. 2020 [accessed 9 April 2020].

62 A. Payne: "Spain has nationalized all of its private hospitals as the country goes into coronavirus lockdown", in Business Insider, 16 Mar. 2020 [accessed 9 April 2020].

63 according to various media reports in journals, television and radio.

64 IOE: "Private sector contributions in health emergencies" (2020) [accessed 9 April 2020].

65 ILO: "Social protection responses to the Covid-19 crisis - Country responses and policy considerations", Social protection spotlight, ILO Social Protection Department (Geneva, forthcoming).

66 ILO: "COVID 19 health crisis: the need for sickness benefit during sick leave and quarantine", Social protection spotlight, ILO Social Protection Department (Geneva, forthcoming).

67 Ibid.

68 Das Virus macht auch Ärzte arbeitslos – warum ausgerechnet in Corona-Zeiten manche Mediziner wenig zu tun haben [accessed 9 April 2020].

estimated that the related financial losses amount to € 3.7 billion and has expressed concern about the financial viability of several of hospitals. The Federation has called on the Federal Ministry of Health to consider covering the additional costs arising from the emergency measures, including for current and additional health personnel.[69]

International collaboration

The global shortage and unequal distribution of qualified health workers constitutes a major constraint in responding to the outbreak of unexpected and easily transmitted diseases, such as COVID-19.

As the disease continues to spread, even well-resourced health systems are at a breaking point while responding to the outbreak. The rapid escalation in the number of cases around the world highlights the urgent need to strengthen less resourced health systems to respond to the COVID-19 outbreak. This includes addressing health workforce challenges, and scaling up laboratory diagnosis facilities, disease surveillance mechanisms and risk communication strategies.[70] Many countries will not be able to increase their capacity immediately. Global actions are therefore needed to support those countries in disease outbreak response and beyond.

In Europe, several countries are facing tremendous challenges with regard to providing care and treatment to the unprecedented number of patients being hospitalized. This has given rise to considerable international solidarity with countries including China, Cuba and the Russian Federation, which have sent doctors and equipment to severely affected countries, such as Italy, to support the response on the ground.[71] Moreover, cross-border collaboration between countries is intensifying. In the border regions between France and Germany, for examples, patients are being transferred from overwhelmed French hospitals to German facilities with capacity, and Switzerland and Germany are taking intensive care patients from Italy.

This highlights the crucial need for adequate government spending to create strong, resilient and robust health systems that are, above all, able to provide equitable access to quality health care in general, and that have sufficient resources to respond to unexpected disease outbreaks, such as the COVID-19 pandemic.

Social health protection and health-care financing [72]

In addition to ensuring adequate social protection for health workers, guaranteeing access to affordable health care for the whole population is equally critical during the Covid-19 crisis. Social protection plays key role in ameliorating and averting the health crisis itself.[73] This includes, first and foremost, preventing the impoverishment of individuals and households as a direct result of seeking care, and also encouraging preventive behaviours.

Social health protection provides a rights-based approach to attaining universal health coverage, which ensures financial protection and effective access to health-care services.[74] Collectively financed social health protection mechanisms, funded by social security contributions, taxes, or a combination of both, generate positive redistributive effects, and do not transfer the financial and labour market risks onto individuals. This way, the economic dimension of seeking care when needed is not a consideration that would encourage delaying or forgoing care. In the context of a health crisis related to a communicable disease, this is particularly relevant.

In response to the COVID-19 crisis, many governments have taken measures to channel additional fiscal resources into their health system. The Government of the United Kingdom, for example, has assigned US$ 6.1 billion, as part of its biggest fiscal stimulus in 30 years, to support its National Health Service.[75] Spain has allocated one billion Euros to the Ministry of Health; Italy provided 3.5 billion Euros to resource the fight against the pandemic; and Germany decided a number of financial measures to guarantee the funding of hospitals, outpatient care and long-term care to compensate for COVID-19 related costs.[76] In some countries such as Spain, in cases where health care is privately provided and where those providers are therefore not usually integrated into the network of social health protection schemes, measures have been taken to integrate them in the response.[77] This illustrates the importance of a coordinated health system where public provision plays the central role, which can be complemented by private service providers under public regulation. In countries where the financial burden of accessing health care falls on households or is met through voluntary

69 DKG zur Behauptung des Ministers die Kliniken erhielten 7,8 Milliarden Euro zusätzlich 7,8 Milliarden Euro angebliche Zusatzfinanzierung der Kliniken hält einem Fakten-check nicht stand, in DKG Press, 21 Mar. 2020 [accessed 9 April 2020].

70 J. Hopmann et al.: Managing COVID-19 in Low- and Middle-Income Countries, JAMA Network (2020) [accessed 9 April 2020].

71 Gemeinsam für Italien, in tagesschau.de, 23 Mar. 2020 [accessed 9 April 2020].

72 This section is a contribution from the ILO Social Protection Department. More information can be found at:
ILO: "Towards Universal Health Coverage: Social Health Protection Principles", Social protection spotlight, ILO Social Protection Department (Geneva, 2020); and ILO: "Social protection responses to the Covid-19 crisis - Country responses and policy considerations", Social protection spotlight, ILO Social Protection Department (Geneva, forthcoming).

73 ILO: "Social Protection Monitor: Social protection responses to the COVID-19 crisis around the world" Social protection spotlight, ILO Social Protection Department (Geneva, forthcoming).

74 ILO: "Towards Universal Health Coverage: Social Health Protection Principles", Social protection spotlight, ILO Social Protection Department (Geneva,2020).

75 P. Russell: Budget: Extra £5 Billion for the NHS to Combat COVID-19 (2020) [accessed 9 April 2020].

76 COVID-19 Response monitor [accessed 6 April 2020].

77 ILO: "Social protection responses to the Covid-19 crisis - Country responses and policy considerations", Social protection spotlight, ILO Social Protection Department. (Geneva, forthcoming).

private insurance, governments have had to take broader public health measures to avoid hardship.

A strong and well-designed financing structure is required to provide incentives for health service providers to meet the criteria of universal availability, accessibility, acceptability and quality health care, in line with human rights instruments and international social security standards,[78] and to reinforce the overall health system of a country. This requires close and effective coordination between stakeholders in the financing, purchasing and provision of health services.

Box 3. Progressively building shock responsiveness: China's crisis response

China's ability to respond to this unprecedented health crisis is rooted in decades of investment in its health system and specific efforts to extend social health protection coverage over recent decades, including in response to health and economic crises.
In the face of COVID-19, the Chinese Government took specific social protection measures to contend with the crisis. These included reducing or waiving social health insurance contribution obligations for up to five months to ease pressure on employers to pay contributions.[1] The Government also pursed a sensible administrative approach that supported physical distancing, for example, by enabling medial consultations for chronic and common diseases to be conducted online, and facilitating electronic submission of medical reimbursement claims.[2]

What lessons can be learned?

An evaluation of the effectiveness of any social protection system response in the midst or immediate aftermath of a crisis risks being premature. What is clear however, is that China's progressive extension of social health protection allowed for significant investment in the health-care system and its infrastructures over time and supported increased utilization of services. China's strategic approach of progressive extension offers an important lesson and leaves some scope for replication, albeit on a smaller scale, even in lower-income countries with resource constraints.

A coordinated response by the health and social protection systems contributed to China's success in "flattening" the infection "curve".

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1 This would translate into a reduction in contribution collection of US$ 71 billion. See: link [accessed 9 April 2020].

2 National Medical Insurance Bureau: Online consultation for patients with common or chronic diseases during the epidemic can be reimbursed, the People's Republic of China (PRC) [accessed 9 April 2020].

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78 According to Recommendation No. 202, nationally defined social protection floors should comprise "access to a nationally defined set of goods and services, constituting essential health care, including maternity care, that meets the criteria of availability, accessibility, acceptability and quality;" (para. 4 (a)).

▶ 3. ILO tools and responses

While other public health emergencies, such as the outbreaks of Ebola virus disease and severe acute respiratory syndrome have demonstrated the effectiveness of short-term emergency planning, the COVID-19 pandemic is underscoring the need for coordinated and sustainable investment in the health sector. It is challenging traditional views on health systems as a resource-draining burden for national economies by highlighting health systems' significance for economic growth and societal well-being.

The COVID-19 crisis is drawing attention to the already overburdened public health systems in many countries, and to the challenges faced in recruiting, deploying, retaining and protecting sufficient well-trained, supported and motivated health workers. It highlights the strong need for sustainable investment in health systems, including in the health workforce, and for decent working conditions and equipment.

In follow-up to the UN High-level Commission on Health Employment and Economic Growth, in 2017, ILO joined forces with WHO and OECD in establishing the Working for Health Programme and Multi-Partner Trust Fund. This programme provides assistance to countries and constituents for the development of strategies for scaling up investments in their health workforces based on improved health labour market data, multi-stakeholder involvement, and social dialogue.

Social dialogue is essential to building resilient health systems, and therefore has a critical role both in crisis response and emergency preparedness.

The Employment and Decent Work for Peace and Resilience Recommendation, 2017 (No. 205) addresses disaster situations similar to those that countries are facing with COVID-19. The Recommendation provides detailed guidance to constituents on actions that should be taken in the field of employment and decent work, both to prevent and recover from crisis situations, as well as to build resilience. It emphasises the importance of social dialogue and the vital role of employers' and workers' organizations in crisis response.[79]

The notion of the participation of workers' and employers' organizations in health policymaking has already been set out in the Nursing Personnel Convention, 1977 (No. 149), which stipulates that: " [...] a policy concerning nursing services and nursing personnel designed, within the framework of a general health programme, [... ,] shall be formulated in consultation with the employers' and workers' organizations concerned [...] " and specifies that "participation of nursing personnel in the planning of nursing services and consultation with such personnel on decisions concerning them" should be promoted and "the determination of conditions of employment and work shall preferably be made by negotiation between employers' and workers' organizations concerned."

To address the problem of "brain drain" for developing countries, health sector considerations must be central to any labour migration governance arrangements, from the public health and economic perspectives. For countries of origin and destination alike, fair migration frameworks and dialogue on gender-responsive and rights-based bilateral agreements may provide further avenues to explore.

Labour rights and protection, as well as social security measures, are key to providing quality health care and ensuring protection of health workers, their families and the overall population during this pandemic and beyond. Health workers, like all other workers, need to be covered by regulations that protect their health and safety, provide adequate financial compensation for loss of income and cover the costs of medical treatment in case of sickness.[80]

To ensure standards, quality and alignment with public goals beyond the COVID-19 outbreak, relevant international labour standards should be applied.

ILO tools relevant to health workers

- ILO Guidelines on decent work in public emergency services (2018)

- WHO-ILO Guidelines on occupational safety and health in public health emergencies: A manual for protecting health workers and responders (2018)

- ILO WASH@Work (2016)

- ILO- WHO HealthWISE - Work Improvement in Health Services (2014)

- ILO-ICN-WHO-PSI Framework guidelines for addressing work-place violence in the health sector (2005)

- ILO Guidelines on occupational safety and health manage-ment systems (2001)

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79 COVID-19 and R205: what role for workers' organizations? (Geneva, 2020)

80 ILO: Improving Employment and Working Conditions in Health Services: Report for discussion at the Tripartite Meeting on Improving Employment and Working Conditions in Health Services (Geneva, 2017).

▶ Annex. ILO Conventions and Recommendations

Key ILO Conventions and Recommendations relevant to the health sector

- Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87)
- Right to Organise and Collective Bargaining Convention, 1949 (No. 98)
- Equal Remuneration Convention, 1951 (No. 100)
- Discrimination (Employment and Occupation) Convention, 1958 (No. 111)
- Nursing Personnel Convention, 1977 (No. 149)
- Nursing Personnel Recommendation, 1977 (No. 157)
- Labour Relations (Public Service) Convention, 1978 (No. 151)
- Occupational Safety and Health Convention, 1981 (No. 155)
- Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187)
- Violence and Harassment Convention, 2019 (No.190)
- Violence and Harassment Recommendation, 2019 (No.206)

International labour standards on social protection

- Medical Care Recommendation, 1944 (No. 69)
- Social Security (Minimum Standards) Convention, 1952 (No. 102)
- Employment Injury Benefits Convention, 1964 (No. 121)
- Medical Care and Sickness Benefits Convention, 1969 (No. 130)
- Medical Care and Sickness Benefits Recommendation, 1969 (No. 134)