COVID-19 highlights risks of healthcare and social care workers attending work while ill

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AS COVID-19 affects healthcare and social care systems around the world, reports of infection among healthcare and social care workers (HSCWs) continue to accumulate. These include outbreaks in hospitals, primary care, aged care, disability care, community and home care services, and draw attention to the risks of HSCWs contracting COVID-19 and also subsequently acting as vectors for transmission. Reducing this possibility is a key component of reducing the impact of SARS-CoV-2.[1]

The risks of occupational acquisition of COVID-19 when employees attend work with SARS-CoV-2 infection have been highlighted.[2] This behaviour raises particular problems for healthcare facilities and settings. In Australia at the time of writing (22 May 2020), where community transmission rates for COVID-19 are relatively low, several major outbreaks relate to possible cases of HSCW-mediated transmission.[3,4] In the following discussion we consider HSCWs, in alignment with the national Work Health and Safety Act 2011,[5] to be any person who works as part of a healthcare or social care service, practice or business. This includes employees, contractors, sub-contractors, students, volunteers, administrative staff and clinicians.

While extensive literature explores the productivity and performance implications of attending work while unwell (presenteeism), workers with an infectious illness also pose a public health hazard, which is amplified in healthcare and other care settings because of the presence of vulnerable populations.[6] Rates of infectious illness presenteeism (IIP) reportedly range from 35% to 97% of workers and are higher among doctors and nurses than for workers in other professions.[7] While discussions of IIP generally refer to workers with relevant symptoms, in the COVID-19 context, workers who are infected but asymptomatic may also contribute to transmission risk.

Studies of influenza transmission suggest that while many workers are compliant with sick leave recommendations, substantial transmission occurs in the workplace. A recent cohort study of HSCWs with laboratory-confirmed influenza found 14.1% continued to work while ill,[8] and previous studies have shown HSCWs felt pressure to work while unwell with influenza-like illness, despite being aware of the risks to patients and colleagues.[9]

In a pandemic, the isolation of infectious cases required to mitigate transmission presents challenges for those without access to paid sick leave (PSL). PSL can increase the likelihood of workers staying at home with infectious illnesses and reduce rates of IIP, especially in settings where financial considerations might compel staff to continue working or return to work earlier than is desirable. In modelling studies, the availability of PSL and addition of extra 'flu leave' days have acted to substantially modify workplace transmission rates.[10]

While PSL is important, other factors also affect HSCW attendance at work when unwell. These include assessments of one's own health, economic and lifestyle stresses, the work environment, contract conditions, professional culture and individual characteristics.[7,9] Both job demands and job security are particularly important influences in shaping presenteeism behaviour. These factors may combine in ways that simultaneously weaken health and wellbeing but drive motivation to continue working.[11]

Structural and system elements can also function as antecedents for IIP. For example, in a fee-for-service payment environment, health professionals in private practice may constitute a high-risk group. In addition to personal, professional or collegial disincentives to be absent from work, if the health professional is a practice owner, they may have difficulty ensuring business continuity during absences as a result of continuing financial overheads.

IIP is a multidimensional problem. Explanations are often layered and context specific – and vary between different types of HSCWs.[12] For example, medical personnel describe difficulties finding replacement staff and concern for the impact of absence on patients and colleagues, as well as sociocultural norms related to the perception that taking sick leave is a weakness.[9] HSCWs at long-term care facilities where PSL is not universal describe the inability to afford lost pay.[13]

Most pandemic plans emphasise workforce surge capacity and screening, testing and protection of HSCWs. However, few consider the individual, organisational, workplace and system barriers that may contribute to IIP-related risks of HSCW-mediated transmission. Pandemic planning and response strategies would benefit from

incorporating approaches to resolving behavioural responses such as IIP, which have the potential to increase disease transmission in healthcare and social care settings. At the facility level, organisational culture should be reviewed to assess specific weaknesses that may increase the likelihood of IIP. The adoption of measures that acknowledge the complex causes underlying IIP – such as additional sick leave, PSL for casual workers, targeted education and training, and enhanced job security – will assist in supporting HSCW decisions to stay at home when unwell during a pandemic.

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