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Care and protection for healthcare workers during a COVID-19: a descriptive qualitative study in Indonesia

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ABSTRACT

This study aimed to explore the perspectives of care and protection of healthcare workers during the pandemic COVID-19 using a descriptive qualitative study in Indonesia. This study used a qualitative descriptive approach in COVID-19 National Referral Hospitals. Purposive sampling was used to collect the sample. There were 45 respondents, with 22 men and 23 women taking part in this study. The qualitative data were analyzed using the content analysis. Three themes that emerge from the data analysis: health protection, legal protection, and incentive schemes. Health protection including calculation of the medical team's workload and lack of a systematic procedure for medical team quarantine. There was a lack of legal basis for medical practice in long-term disaster services. Dimension of incentive scheme, including incentives shift from rewards to demands, changes in incentive regulations, and discrepancy in incentive calculation. By stressing protection and rewards for each level of the medical profession, it is hoped to boost motivation in actively participating and supporting the service of COVID-19 patients in critical conditions across Indonesia.

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1. INTRODUCTION

Maintaining safe and high-quality care during the COVID-19 pandemic relies on frontline healthcare professionals' physical and psychological well-being. In addition to the risk of their infection, medical personnel endure fatigue, complex triages, family separation, and losing patience and stigma from others. Furthermore, around 5–16% of patients with COVID-19 need to be admitted to intensive care units [1]. Over 28 days, there is an extremely high rate of intensive care unit (ICU) death (62%) [2], which is higher than the risk of significant acute respiratory distress syndrome (ARDS) [3]. There is a severe lack of human healthcare personnel, intensive care beds, and limited laboratory capacity. As of May 1, 2020 Indonesia has 2,321 anesthesiologists to service a population of over 272,000,000 people. As a result, an anesthesiologist is

responsible for 117,190 residents. Anesthesiologists' shortages also exist in America; one anesthesiologist for 4,300 people [4].

Since the pandemic of COVID-19 [5], healthcare staff have been working endless hours. Healthcare personnel and patients hospitalized for other reasons are more susceptible to super-spreading occurrences. COVID-19 infection risk is higher among healthcare workers that deal closely with patients, such as intensive medical teams [6]–[9]. Risks of infection among healthcare workers can be minimized by taking appropriate protection within healthcare facilities [10]–[13]. It is accomplished mainly through the use of personal protective equipment (PPE), which includes a cap and gown, gloves and boots, a surgical mask and eye protection or goggles. Moreover, caring for COVID-19 patients generates significant emotional stress, leading to anxiety and post-traumatic disorder [14]. These disorders affect healthcare personnel and their capacity to make decisions and connect with patients [15]. It is important to remember that the stress at work is exacerbated by the same interruptions and uncertainty that the general public is experiencing right now [16].

Many countries provide health service incentives to anticipate the increase in capacity generated by the COVID-19 pandemic. For example, Germany offers €50,000 for each additional ICU bed. Russia compensates hospitals up to RUB200,000 for each COVID-19 patient treated through its Moscow territorial health insurance scheme. In the Netherlands, general practitioners earn an additional €15 per hour for out-of-office services [17]. In Indonesia, all medical professionals have the right to legal protection if they do their duties in line with professional standards and standard operating procedures [19]. Concerning the COVID-19 pandemic, the Minister of Health's Decree HK.01.07/MENKES/278/2020 on the Provision of Incentives and Death Compensation for Health Workers who Handle COVID-19. However, the incentives for health workers dealing with COVID-19 do not include residents, internships, and consultant physicians [18], [19]. Therefore, this study aimed to explore the perspectives of care and protection of healthcare workers during the pandemic COVID-19 using a descriptive qualitative study in Indonesia.

2. RESEARCH METHOD

2.1. Design

This study employed a qualitative descriptive approach. It investigated the medical team's perceptions of health protection and insurance in COVID-19 National Referral Hospitals. This qualitative research conducted an in-depth interview between July 19 and September 18, 2020.

2.2. Sample

The sample in this study is a medical team with the following inclusion criteria: general practitioners, internship doctors, anesthesia residents, anesthesiologists, and consultants in intensive care, actively engaged in delivering COVID-19 services and willing to be respondents. Purposive sampling was used to collect the sample. There were 45 respondents, with 22 men and 23 women taking part in this study. The respondents' mean age was 29 years (SD=8). Respondents were given the code 2.2.1–2.2.45.

2.3. Interview guidelines

The researcher developed the interview guide based on literature analysis and discussion with experts. This interview guide was then evaluated to verify that the interview flowed in the direction of the study goals. Interviews were conducted using semi-structured interview techniques and included general questions such as the following: i) How do you prepare as a medical team to deal with COVID-19 patients? ii) What do you think about care for healthcare professionals during this pandemic COVID-19? iii) What do you think of protection for healthcare professionals during this pandemic COVID-19?

2.4. Data collection

The institutional review board approved this study of the affiliated university (No. KE/FK/0742/EC/2020). It was conducted following the Helsinki Declaration. Before data collection began, participants were given a detailed overview of the study and its procedures. Those interested in participating were asked to complete a written consent form. They described how the information acquired would be utilized for research purposes and how it would be coded to secure their data. The interview was performed using qualitative analysis, and it took them between 40 and 50 minutes to complete. The data was recorded with a tape recorder and then transcribed with the permission of the respondents.

2.5. Data analysis

The qualitative data were analyzed using the content analysis method proposed by [20]. The similarities and differences between the code, categories, and theme were determined by comparing them. The study's findings were validated using the Lincoln and Gaba criteria [21]. The long-term participation of

researchers in data collecting and review and the utilization of revisions and supervisors and participants have assured the quality of the findings. Voice recorders were used to guarantee that data was neutral and objective.

Additionally, given the researchers' prior clinical expertise, we make an effort to avoid allowing our ideas and beliefs to impact the study's design, avoid bias, and wait until the conclusion of the analysis to examine comparable studies. The interviews were conducted and analyzed with other persons who had mastered qualitative studies but were not participating in the data collection and were asked to assist in the appraisal. In addition to the written interview style, two interviews were taped. To ensure that the study is transferable, the researchers thoroughly explained this analysis and its phases to the participants.

3. RESULTS AND DISCUSSION

Three themes that emerge from the data analysis: health protection, legal protection, and incentive schemes. The three themes have their aspects that describe management system issues from distinct angles as shown in Table 1.

Table 1. Theme and dimension

Theme	Dimension
Health protection	Calculation of the medical team's workload.
	Lack of a systematic procedure for medical team quarantine.
Legal protection	The lack of legal basis for medical practice in long-term disaster services
Incentive scheme	Incentives shift from rewards to demands.
	Changes in incentive regulations.
	The discrepancy in incentive calculation.

3.1. Theme 1: Health protection

The absence of assistance and supervision of physical and mental health can create exhaustion and burnout. Working hours must also be scheduled correctly to avoid fatigue within the medical team. The medical team is off duty for two consecutive days, with a minimum of 12 hours of rest following one work shift. However, there has been no regulation limiting medical teams' working hours until now, which means they can perform duties for an extended period.

> *"...and the mechanism for calculating workloads is still in need of improvement..."* (2.2.1)
> *"... some health staff may face increased workloads, particularly if patient numbers are increasing..."* (2.2.1)
> *"... yes, occasionally what makes you more exhausted is a workload that is different from the norm."* (2.2.2)

Health protection includes regulations and comprehensive supervision of health protocol implementation, ensuring that all medical teams can handle PPE management during usage, assignment, and release.

> *"Because time is ticking, the idea of creating changes in all sectors, including human resource management, has been implemented. We started with nothing and are now attempting to work on various issues, including human resource management. It includes the incentive calculation."* (2.2.3)

Health protection for the medical team includes providing treatment if they are infected by COVID-19 while providing services. Lack of a systematic procedure for medical team quarantine. Not all institutions where informants work have explicit rules and regulations for the medical team's quarantine while providing care to COVID-19 patients, increasing the risk of exposure to families.

> *"... quarantine for healthcare personnel does not require that they be accommodated in hotels or hospitals."* (2.2.3.)
> *"Quarantine regulations also change sometimes and are not closely monitored..."* (2.2.4.)

Hospital services for COVID-19 are provided at around 70% of teaching hospitals, which means that health insurance must protect the medical team and the students. It minimized risk burnout activities by

encouraging strict observation of student health in the primary teaching hospital and network hospitals (if necessary).

> *"We know that 70% of our services in teaching hospitals are provided by residents, which means we work long hours."* (2.2.6)
> *"As a result, they avoid excessive activities that contribute to early burnout."* (2.2.7)
> *"That is why we considered sending it to a network hospital, which would need advocacy. We must ensure that the hospital has developed appropriate health regulations for students."* (2.2.6)

The protection of their psychological status is another consideration of the medical team's health insurance. According to the interview findings, the medical team experienced physical exhaustion or burnout while performing their duties and psychological exhaustion. The health insurance obtained is not well-mapped, particularly in terms of psychological or mental health insurance.

> "*Many medical teams were shocked and worried about their health or the task at hand when they first encountered this circumstance. Yes, it has an impact on mental health, but it is designed to be invisible."* (1.2.20)
> *"... there are shifting emotions and panic when confronted with this. Health insurance is only BPJS; it has never been fully defined for psychological and mental health."* (1.2.11)

3.2. Theme 2: Law protection

Legal protection is one of the issues raised by informants. The presence of a long-lasting disaster produces an increase in burden; the legal basis of practice should fulfil rights properly. According to informants, however, there is still a lack of a sound legal foundation for a medical practice to deliver long-term disaster relief.

> *"In terms of legislation, it is true that different statutes and regulations, such as the Health Law and the Hospital Law, protect health employees, correct? However, it remains in the normative position in its capacity. However, the actual thing is that there have been many intimidations."* (2.2.8)
> *"The legal protection for medical staff is weak, and we still think that there is a great lack of safety for students."* (2.2.7)

The COVID-19 pandemic provides the most comprehensive possibility for every health worker to contribute as a volunteer actively. Volunteers in emergencies are exempt from the norms governing medical practice, such as requiring all medical teams to obtain permission to practice but only having a registration certificate.

> *"Yes, temporary practice permissions can normally be obtained in consultation with the local health authority. However, pandemic occurred for a long time, it should be a credential system exist."* (2.2.8)

3.3. Theme 3: Incentive scheme

The next theme is the incentives scheme. The first dimension is the concept change from incentives to demands. According to the informant, there was inequity in the provision of incentives at definitive and emergency hospitals. The medical staff at the definitive hospital is compensated for the added task of caring for COVID-19 patients. In contrast, the medical team at the emergency hospital is compensated as a matter of need.

> *"Then, at this specific hospital, these volunteers or other health care professionals receive not just incentives, but also a reasonably fixed-wage as an appreciation. It is different from field or emergency hospitals, where the incentive is an additional reward."* (2.2.3)

There is no definitive regulation of incentives, resulting in frequent changes in the regulation of incentive systems.

> *"... almost the same, but regulatory settings can change at any time."* (2.2.31)
> *"It can change three or four times in a month depending on the situation."* (2.2.23)
> *"We do not have a regulation for this yet, but it is comprehensive."* (2.2.4)

The policy change has resulted in different incentive calculations between hospitals.

> *"…. Human resource management generally refers to human resource management in definitive hospitals. However, this management is different from definitive hospitals, which have quite settled the management system, and other types of hospitals."* (2.2.4)

The fourth dimension is the lack of transparency in the calculation of incentives in several hospitals.

> *"This is not clear. It is just sad that there is covid incentive money. Okay, not clear when, how much. I think it counts because it is not clear."* (1.2.2)

Fifthly, the incentives based on zoning, work time, type of activity and profession are calculated differently. The fifth dimension is related to the sixth dimension, which is fairness in incentive distribution.

> *"In our KMK, we do not limit specialists or health personnel."* (2.2.3)
> *"...indeed, all those who work at the emergency room are divided, regardless of the number of patients, but they can be submitted quickly according to the timetable."* (1.2.12)
> *"Not based on the level of risk, the type of service, or the working hours. There is no confidence about how incentives will be distributed, and there is no clarity about how payments and services will be distributed from covid claims."* (1.2.20)
> *"Internship doctors are still doctors, and their hours should not be reduced."* (1.2.11)

This incentive program was initially designed solely for specific medical teams who work closely with COVID-19 patients. The provided incentive system solely calculates based on the type of profession, and the computation is per person per month. Meanwhile, the developed incentive system does not have a different risk of exposure based on numerous factors, such as work area zoning, daily job duration, and actions taken for COVID-19 patients. It can cause internal tension inside the facility. Several medical teams only care for patients for a few hours per day, while others with the same level of education care for patients for more extended periods. Meanwhile, medical teams that do not work in areas at risk of exposure, but undertake activities linked to COVID-19, cannot claim their performance for reward purposes. These constraints can potentially lead to conflicts inside the institution, including the limitation of incentive beneficiaries.

> *"In terms of who can obtain it, what I do know is that there are four doctors on the front line whose authority is recognized: internal medicine, pulmonary, anesthesiology, and paediatrics."* (2.2.3)
> *"... the basis was not decided based on performance or zoning, but on the day on which the individual visited the patient or took direct action against the patient."* (2.2.3)
> *"Thus, the philosophical foundation is to value health care personnel who may be exposed to COVID-19. If this radiology specialist does not read X-rays in an isolation room with COVID-19 patients, he cannot be recommended."* (2.2.3)
> *"Will this incentive did not foster division because it is only available to a select few, but dealing with COVID-19 from start to finish involves a large number of people?"* (2.2.2)

Another dimension is delayed delivery. Several medical teams at health service agencies said incentives were delayed.

> *"As far as I know, it has not come out because they are still confused. If I hold OKA, we are alone; if I do not go to the ICU, we are divided. As far as I know, the incentive problem has not come out."* (1.2.14)
> *"There is the discourse, notification exists, but not yet actuality."* (1.2.2)
> *"I have not until now."* (1.2.13)
> *"As if a ghost, suspended between being and not existing. The emergency room and IKA departments have received it, but anaesthesia has not."* (1.2.28)

The findings of this study indicate that health protection for medical personnel dealing with COVID-19, particularly critical patients in the ICU, is not effectively organized. There was a lack of support and supervision for physical and mental health, resulting in fatigue and burnout. When it comes to delivering services to COVID-19 patients with critical conditions, health insurance encompasses both the physical and the psychological. Because dealing with these patients presents numerous obstacles, including unknown effective therapy, rapid deterioration, fever, disorientation, cough, weakness, and even death. There is evidence that health insurance for workers impacts the quality of care [22]. In order to reduce psychological stress, the

medical team should do periodic psychological assessments, prepare effectively and adjust rapidly to new environments. They should also express feelings, speak with coworkers, and conduct physical activities to help them relax [23].

Health insurance is also deemed adequate if confirmed by COVID-19. Due to the potential exposure to family members, some respondents proposed giving health insurance to families who reside with the medical team that provides services to COVID-19 patients with critical conditions. This reflects the absence of a quarantine protocol for health professionals who give services to COVID-19 patients. Therefore, the prospect of close contact with the family presents exposure to family members living with the medical team. Moreover, the risk of exposure for families and the medical team will also rise when critical conditions are provided through COVID-19 services. This could be due to the hospital's lack of proper infrastructure, logistics, and a system to deliver services to COVID-19 patients in urgent situations.

This study emphasizes the importance of legal protection. The presence of a long-lasting disaster produces an increase in burden; the legal basis of practice should fulfil rights properly [24]. However, there is still a lack of an adequate legal basis for medical practice in long-term disasters. Then, prioritizing scarce resources during a pandemic might potentially result in legal action against doctors and hospitals [25]. The proposal and existing immunity laws offer limited protection, exclude recklessly and rash acts beyond ordinary negligence, and still allow for judicial action in more extreme cases.

The findings of this study indicate several issues with recipient validation, computation, the time required for acceptance, and the type of profession receiving incentives. When the incentive scheme is viewed as an award from the president, it becomes a motivator for the medical team to provide services for COVID-19 patients [26]. It is feared that a shift will occur due to the high number of incentives in comparison to the medical team's overall income [27]. Thus, based on the data presented, the incentives provided may be no longer as motivating as they were when this incentive scheme was initially created. Financial incentives are a source of extrinsic motivation and arise when a person can expect reciprocity or benefits in the form of things delivered if they undertake a specific action [28].

Different incentive programs exist for both definitive and emergency hospitals. The healthcare staff at the definitive hospital tends to receive more revenues due to incentives and monthly payments. The medical team that works in an emergency hospital is compensated differently; they do not receive a fixed monthly wage and are solely compensated on an incentive basis. Additional policies aimed at incentivizing these two types of hospitals should be developed. However, when the pandemic conditions change, the effect of incentives changes, and the income of doctor's declines, making the planned incentives less critical when compared to pre-pandemic income [29]. Doctors' salaries declined in Indonesia and the USA during the pandemic, 60% drop in visits [30]. In addition, in the US, the financial compensation for residents' services is minimal compared to other health employees, ranging from $15 to $20 per hour [30].

4. CONCLUSION

To face a disaster, the government is obliged to provide health protection, law and incentives to every medical profession. The medical team that provides services in a biological crisis, particularly for volunteers, must have a clear direction to follow legal protection and obvious health protection. A method of assessing the qualifications and competencies of the health care team which delivers biological disaster services is required from the center to health care facilities. In addition, incentive programs should be clarified, computations should be fairer, and processes should be transparent. By stressing protection and rewards for each level of the medical profession, it is hoped to boost motivation in actively participating and supporting the service of COVID-19 patients in critical conditions across Indonesia.

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