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Exercise of the right of healthcare workers to rest in the context of fighting Covid-19: experience of PRC, USA, EU countries

Ejercicio del derecho de los trabajadores sanitarios al descanso en el contexto de la lucha contra el Covid-19: experiencia de la República Popular China, Estados Unidos y países de la UE

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Abstract
The COVID-19 pandemic is a complex global crisis in which countries must be prepared for a virus outbreak in advance. The consequences of the pandemic have a detrimental effect on international relations, the world economy, and are accompanied by forced restrictions on the constitutional rights of citizens. The main goal was to realize the right of healthcare workers to rest in the conditions of fighting COVID-19, minimizing risks, and current organizational costs while maximizing the efficiency of employees' working time. The initial position is that excessive exploitation of healthcare workers without appropriate time for a rest increases the risks not only of the healthcare worker being infected by the patient, but also the likelihood of medical mistakes because of fatigue. It has been objectively proven that the right to have a rest, in the context of COVID-19, exists not only as a declarative provision of the labour law in the form of the employee's inalienable right, but also as a mandatory element to of a battle against spreading the virus, as well as part of management strategy in the field of the provision of medical services. At the same time it is responsibly realized that the countries affected by the pandemic deal with an acute shortage of human resources in the medical field. That is why many employees have to work overtime, without days off, with an unstable schedule, as well as without scheduled leave. A comprehensive analysis of options for the legal regulation of work and rest was conducted in medical institutions, which are forced to reform in the face of the COVID-19 pandemic. Besides, there are additional effective organizational measures to help to make the work significantly easier for the current workers; and additional government benefits that will ensure an adequate level of compliance with the constitutional right of healthcare workers to rest, identified in the given research. The results of the study can be useful for governmental organizations in the field of healthcare, heads and HR managers of medical institutions in the process of building long-term strategic plans to fight against COVID-19.

Keywords: COVID-19 Pandemic, Working Hours, Organization of Work, Right to Rest, Social Benefits, Foreign Experience.

Resumen
La pandemia de COVID-19 es una crisis global compleja en la que los países deben estar preparados con anticipación para un brote de virus. Las consecuencias de la pandemia tienen un efecto perjudicial sobre las relaciones internacionales, la economía mundial y van acompañadas de restricciones forzadas a los derechos constitucionales de los ciudadanos. El objetivo principal era realizar el derecho de los trabajadores de la salud a descansar en las condiciones de la lucha contra COVID-19, minimizando los riesgos y los costos organizacionales actuales mientras maximiza la eficiencia del tiempo de trabajo de los empleados. La posición

inicial es que la explotación excesiva de los trabajadores de la salud sin un tiempo adecuado para descansar aumenta los riesgos no solo de que el trabajador de la salud sea infectado por el paciente, sino también la probabilidad de errores médicos debido a la fatiga. Se ha demostrado objetivamente que el derecho al descanso, en el contexto de COVID-19, existe no solo como una disposición declarativa de la ley laboral en la forma de derecho inalienable del trabajador, sino también como un elemento obligatorio de lucha contra la propagación del virus, así como parte de la estrategia de gestión en el ámbito de la prestación de servicios médicos. Al mismo tiempo, se reconoce responsablemente que los países afectados por la pandemia enfrentan una grave escasez de recursos humanos en el campo médico. Es por eso que muchos empleados tienen que trabajar horas extras, sin días libres, con un horario inestable, así como sin licencia programada. Se realizó un análisis integral de opciones para la regulación legal del trabajo y el descanso en las instituciones médicas, las cuales se ven obligadas a reformarse ante la pandemia COVID-19. Además, existen medidas organizativas efectivas adicionales para ayudar a hacer el trabajo significativamente más fácil para los trabajadores actuales; y beneficios gubernamentales adicionales que aseguren un nivel adecuado de cumplimiento del derecho constitucional de los trabajadores de la salud al descanso, identificado en la investigación dada. Los resultados del estudio pueden ser útiles para organizaciones gubernamentales en el campo de la salud, jefes y gerentes de recursos humanos de instituciones médicas en el proceso de construcción de planes estratégicos a largo plazo para luchar contra COVID-19.

Palabras clave: Pandemia COVID-19, Horas de Trabajo, Organización del Trabajo, Derecho al Descanso, Beneficios Sociales, Experiencia en el Extranjero.

Introduction

The topic of the study concerns the emergency situation caused by the outbreak of COVID-19 in the world and the resultant negative consequences that arose due to the need to counter the pandemic. Healthcare workers are at the forefront of the fight against coronavirus, so their right for life, proper working conditions and the right to rest are at stake. The example of the Far East (China, Republic of Korea, Taiwan) allows tracing a whole set of preventive measures and the involvement of a huge number of labour resources (Wang, Ng & Brook, 2020). The problem of providing rest time for healthcare workers is not as acute as in the EU or the US due to the actual possibility of recruiting sufficient staff. Besides in China assistance in combating COVID-19 is an urgent civic duty for citizens, which has helped mobilise more than 40,000 healthcare workers to the epicentre of the epidemic, Wuhan, in record time (WHO, n./d.).

Meanwhile developed democracies (USA, EU countries) have some problems. First of all, it is inflexible labour legislation. The situation is complicated by the procedure for trade unions, which drags out bureaucratic formalities and makes it impossible to quickly adopt laws to respond to COVID-19 (Negri, 2020). Governments are forced to content themselves with by-laws, which have mostly advisory legal force, such as the Italian Decree No. 18 dated March 17, 2020, "On Measures to Strengthen the National Health Service and for Economic Support for Families, Employees and Businesses Related to the COVID-19 Epidemiological Emergency" (Normattiva, 2020), amendments to the Canada Labour Code (Parliament of Canada, 2020), Families First Coronavirus Response Act, and Family and Medical Leave Act in the USA (U.S. Department of Labor, n./d.a; n./d.b).

In accordance with the above issues, the objectives of the study are formed around the legal elements of the regulation of working hours and rest time of healthcare workers. Since it is a long procedure of law-making and cumbersome procedure of implementation and enforcement of the law in a developed democracy of the United States and the European Union at the level of laws, the effectiveness of such a model should be questioned. As the Italian experience shows, delays in responding to a pandemic are unacceptable (Hussain et al., 2020).

The focus is on the fact that management in the field of healthcare at the level of medical institutions is much more effective, which can be entrusted to the management of institutions and local self-governments. Thus, the main task was to assess the forms of organisation of working time and rest time of healthcare workers. The assessment was performed in the following areas:

— risk of infecting with COVID-19;
— amount of staff required per 100 beds;
— allocated rest time;
— time required for self-isolation in case of infection and the procedure for enlisting it as a rest time, including compensation for this period;
— number of overtime hours.

From the point of view of healthcare workers themselves, in case of over-exploitation, the task was to find ways to stop the violation of their labour rights and other freedoms. It is pointed out that the most effective way of protection is judicial one (Katzenmeier, 2020).

Thus, the scope of the article is wide and generally concerns the implementation of emergencies related to the COVID-19 pandemic. The material can also be used by the expert in healthcare institutions when choosing plans for hourly and uninterrupted medical care of patients with COVID-19.

Literature review

Most researchers emphasise that since December 2019, COVID-19 infection has been widespread among healthcare workers, sanitation workers and scientists who study the virus. To reduce the risks it was proposed to replace human labour with artificial intelligence, because the technology that learns, adapts and responds to situations, finds optimal positions in the fight against COVID-19 and acts as a powerful tool against this pandemic (Preethika et al., 2020). There is no doubt that advanced artificial intelligence technologies can make a breakthrough in medicine, as well as significantly relieve healthcare workers, which is in line with the purpose of the given study.

Some studies have clearly concluded that the most effective means of relieving healthcare workers in a pandemic are the most effective quarantine and other protective measures taken by countries. Accordingly, it was proposed to take more stringent measures to reduce the growth of the number of infected people, then there will be fewer patients,

and healthcare workers will have less work (Garg et al., 2020).

Equally important measures are directly appropriate anti-epidemiological protection of workers, this will help to decrease the number of healthcare workers unable to work due to illness, self-isolation or quarantine (Hussain et al., 2020).

As for now, there are more unresolved issues than answers to the above questions, and therefore it is necessary to proceed from the current situation, considering real needs and opportunities in the staffing of healthcare institutions (Asia, 2020).

At the same time there are different ways of legal regulation in different countries. It is emphasised that in order to overcome the epidemic, European governments tried to combine legal instruments based on the law on healthcare, and instruments reserved for emergencies in the country. Both systems offer similar tools, but both work with different limitations of state power and compensation mechanisms (Negri, 2020).

For example, in Germany before the COVID-19 pandemic, there was no legal regulation governing the distribution of scarce medical labour resources in the event of a pandemic. By now the German government developed federal plans to counter the pandemic, which could only partially solve the problem. The main problem was that the legal force of federal plans to counter the pandemic is recommendatory, and therefore the employment relationship could be resolved under the labour law and according to medical ethics (Taupitz, 2020).

Some authors emphasise on the relevance of legal regulation of the private sector of medical services. Due to COVID-19, the labour market was disturbed; there was no more support of various business entities that rely heavily on this market. The current level of uncertainty created by COVID-19 exacerbated the relationship between employers and employees due to the need for the employer to reduce their losses, thus exacerbating the need to ensure employment security and employee's health. It is necessary to emphasise on the activities of private clinics and laboratories in this regard, which, due to the pandemic, are forced to engage in the treatment and laboratory examination of patients with COVID-19. Unlike state and municipal medical institutions, private clinics do not have guaranteed state support, which poses a risk of violation of labour rights of healthcare workers in private medical institutions (Abio, 2020).

One of the options of protecting the labour rights of healthcare workers is the proper distribution of the existing resources. It is noted that most cases of becoming infected among healthcare professionals in Italy were due to the asymptomatic course of the disease in patients. It is proposed to communicate with the public to inform about the procedure for self-isolation. Besides, it is proposed to introduce special regimes of contagious isolation wards and the wards of individual hospitals that will operate only for counteraction to COVID-19. Such measures will optimize the workforce to combat COVID-19, as well as establish a special mode of operation of individual health care facilities (Chirico, Nucera & Magnavita, 2020).

An effective option for the correct distribution of existing resources is to optimise the workspace. Some authors are reviewing workspace schemes to increase social distance through the COVID-19 pandemic, with an emphasis on the placement and orientation of workplaces for infectious disease prevention. This is especially important for our study, because this optimization approach allows reducing the number of forced unpaid leaves and reduces the current cost of staffing the clinic (Oppong, 2020).

The problem of physical and moral condition of healthcare workers remains unsolved, which leads to the study of the need to ensure normal working hours and rest. For example, in Italy healthcare workers are in a difficult psychological situation. This is due to the mental barriers that follow the loss of colleagues and patients, the fear of transmitting the virus to their families, suffering of the need to choose between three patients (the collapse of the medical system in Italy in March-April 2020). Due to such psychological difficulties, there is a more urgent need to provide at least temporary rest to healthcare workers (Bellizzi et al., 2020).

Particular attention is paid to the risk of infection, as it has been scientifically proven that healthcare workers can be exposed to COVID-19 even on the 13th day after a previous positive COVID-19 test in a patient who has been in contact with them. Such infection occurs in cases of the asymptomatic disease (including the last day of isolation). Thus, it was proposed to significantly expand the possibility of providing emergency unpaid leaves in order to provide effective self-isolation in case of serious suspicion of infection (Baker et al., 2020).

Analysing the risks and effectiveness of management systems, the researchers concluded that more effective work schedule to combat COVID-19 is a twelve-hour workday. This is due to the fact that it is easier to organise a team work of healthcare workers who will be able to work for twelve hours in one team of colleagues (Eufinger, 2020). It is noted that in Germany, this principle of work, with a proper organizational approach, does not violate the requirements of Part 3 of Section 14 of the German Working Time Act (Arbeitszeitgesetz - ArbZG). This provision allows extending working hours to 48 hours per week, continuously for six months, or for 24 weeks. In total, at least four shifts of the team of healthcare workers who will have contacts with infected persons must be formed in a medical institution specialized in counteracting COVID-19. It should be noted that after the expiration of the six-month period, the law formally obliges medical institutions to stop overtime exploitation of healthcare workers (MAYR, 2008). In the wake of this, German phased COVID-19 response programs, from this point of view, should take into account a limited six-month period, or a period of 24 weeks, respectively, i.e. form a six-month legislative pandemic maximum (Eufinger, 2020).

A deeper organisational approach offers options for effective optimization of working time of healthcare workers with the help of staffing models and comprehensive statistical modelling. According to the author's estimates, the pandemic staff significantly reduced the labour shortage, and the effect gradually increased as the probability of infection increased. The maximum effects were observed during the 4th week for each probability of infection with a reduction in staff of 17%, 32% and 38% with a probability of infection of 0.10, 0.25 and 0.40, respectively. Thus, there is a critical need to replace the affected part of the medical staff after a month of work in an emergency (Mascha et al., 2020).

As it may be seen, most scholars study possible violations and options for granting the right to rest, but leave the problems of the mechanism of legal support for the right of healthcare workers to rest unexplored, and didn't conduct comparative research to identify the most effective level of legal regulation (national, local, institutional).

Methods and Materials

Most studies on the rational use of working time and rest time used methods of statistical processing of the results of Mascha et al. (2020), OECD (2020) report, WHO (n./d.) report. Statistical research allows revealing a pattern of the objective reality of the impact of the coronavirus pandemic on various spheres of social activity. When comparing statistics, you can find more effective ways to manage and legally regulate labour relations with healthcare workers.

Laboratory studies are mandatory in medical research, so we needed existing WHO studies on the likelihood of COVID-19 infection among healthcare workers under certain conditions (WHO, n./d.).

We used regression analysis in our research (Kochetov et al., 2012). Based on the method of regression analysis, we developed a pentagonal function, which reflected the main indicators of risk and efficiency of working time in the COVID-19 pandemic, taking into account the required rest time.

The initial data for comparison were taken in studies by Mascha et al. (2020) and OECD (2020) statistics, using the ratio of threshold data, in percentage, where 100% is equal to one. One is the maximum number relative to the threshold data. Thus, 100% probability of infection is equal to one, respectively 25% = 0.25, 10% = 0.1.

In case of providing time for rest, the value of three weeks is the maximum for both cases, is a threshold and therefore both equal 1. For rest time, the threshold number would be no rest time (the number is 1), so in relation to the absence provided available data rest time, in relation to the time used for work is 40% and 30%, respectively (values of 0.4 and 0.3), while all the time this value of active time per day (16 hours) is equal to 1.

The value of overtime hours is approximate, and is equal to the threshold value only in case of 8-hour working time, because a comparison made in the same conditions will show a shortage of manpower (so, conditional 0.5 and 1).

The results on staffing per 100 beds were obtained from the analysis of data by Mascha et al. (2020), which is based on the principle of one healthcare worker per two beds. The author emphasized the possibility of saving labour resources up to 20% in case of a 12-hour working day, so the threshold will be an 8-hour working day of 50 employees per 100

beds (threshold number – 1), and 80% of this value – respectively, 0.8 in the schedule (savings of 20%).

In our opinion, the analysis of official documents and agreements on the procedure for providing rest time for healthcare workers needs further research.

Results

The problem of providing rest time for healthcare professionals, in the context of COVID-19, is becoming critical. According to Rowan Gossedge, Chair of the BMA East of England Junior Doctors Committee, because of a busy schedule some doctors had nothing to do but to rent blankets and rest in chairs or on the office floor. Others had to take a five-minute break in their cars, in the parking lot, where they have to pay for parking – simply because they have nowhere to rest, refresh and be alone away from the intensive environment of the ward (Rimmer, 2020).

Of course, the problem concerns not only intensive care workers, but also all hospital staff, including caregivers, support staff, administration and ambulance teams. All of them will face the problem of long-term response to COVID-19. Transparent and thoughtful communication can help build trust and a sense of control. Ensuring that workers feel that they have adequate rest, their personal needs (such as caring for an elderly family member) are met, and they are supported both as healthcare workers and as individuals will help maintain individual and collective productivity in the long run. Releasing clinicians and administrative team members from other tasks and responsibilities allows them to focus on urgent needs. As Adams and Walls (2020) emphasise, providing food, breaks, stress relief time, and adequate rest time can be as important as ensuring protocols and safeguards, as pandemic days turn into weeks and then months.

In the context of a pandemic and a shortage of qualified medical personnel, countries are trying to overcome the crisis in various ways, based on the resources and opportunities that currently exist.

For example, Italy recruited retired workers, as well as medical students in their final year of study as the way to solve the situation. The main goal was to recruit about 20 thousand additional employees (OECD, 2020).

France also decided to mobilize its "sanitary reserve" (réserve sanitar) to temporarily increase the supply of healthcare workers. The reserve includes medical workers (doctors, nurses, paramedics), non-nursing hospital staff, psychologists, professionals of regional health care institutions and others – this reserve included about 3,800 people as of early March 2020. They can be public sector employees, private sector employees, freelancers, retirees or paramedic and medical students (Gouvernement, 2020).

In Korea, additional healthcare workers were recruited to Daegu, where clusters of cases were found to provide a rapid, targeted response to the crisis (Kim et al., 2020).

The United Kingdom is also trying to call for retired doctors and nurses, although the number of volunteers, at least at the beginning, has been quite low.

In the Netherlands; former and retired healthcare workers, as well as medical students, work voluntarily in hospitals. Medical military units provide specialized assistance. They found new volunteers in food banks and the like, who will distribute food packages to the elderly or purchase food (OECD, 2020).

It is believed that attracting additional personnel reserves is one of the effective methods of protecting the labour rights of existing healthcare workers. The Organization for Economic Co-operation and Development (OECD) in its statistical report of April 16, 2020 emphasizes: "Health system policy regulation can be organized according to three main "S" priorities: staff mobilization, increasing stocks and optimizing space. The priority of staff mobilization is realized through inactive medical professionals, adaptation of functions and capabilities of health care facilities, as well as taking measures to protect the health of healthcare workers" (OECD, 2020).

Thus, the priority areas of fight against coronavirus, which will in no way diminish the rights of healthcare workers, are as follows:

- Protection of existing employees from being infected with the virus.
- Mobilization of specialists to combat COVID-19.
- Formation of an extended employment pool.

However, it is not always possible to attract additional staff, especially when it comes to volunteers, as in the United Kingdom (Walker,

2020). Therefore, the way out of the situation can be a clear regulation of work and rest.

In general, the legislation allows for various forms of exercising the right to rest. Thus, the US Families First Coronavirus Response Act (FFCRA) and the Family and Medical Leave Act (FMLA) provide additional leave for an employee who:

1. Is a subject of federal, state or local regulations on the introduction of quarantine or isolation related to COVID-19;
2. Received a recommendation from a health care provider to be self-quarantined because of COVID-19;
3. Found symptoms of COVID-19 and are awaiting a medical diagnosis;
4. Takes care of a person who is subject to federal, state or local regulations on the introduction of quarantine or isolation related to COVID-19;
5. Takes care of his/her child, whose school or preschool establishment is closed for reasons related to COVID-19.
6. Suffers any other similar disease specified by the US Department of Health and Human Services (U.S. Department of Labor, n./d.a; n./d.b).

Germany demonstrates a slightly different experience as a country with effective experience in combating COVID-19, because the German medical system was able to withstand the flow of patients even at peaks of virus. This is partly due to the fact that the German Working Time Act (Arbeitszeitgesetz - ArbZG) allows employees to work for forty-eight hours a week in the event of emergencies, including "urgent treatment and care" (MAYR, 2008).

According to it at the legislative level regulated working hours and rest periods are a necessary step towards respect for the right to work and the right to have a rest. Considering the problem of regulating the working hours of healthcare workers through the prism of planning, the real reflection of such an instrument of influence is the work schedule of full-time healthcare workers. First of all, these are employees who have daily contacts with COVID-19 patients: junior medical staff and infectious disease doctors. Also, special attention should be paid to the intensive care unit, as highly specialised staff is not easily replaceable.

For example, in the United States when creating schedules of working hours of healthcare workers several scenarios are considered: the standard schedule and the schedule in a pandemic. The standard schedule takes into account the existing forty-hour work week and an eight-hour shift (with a three-shift organization of work of the healthcare institution). The schedule in a pandemic provides for seven shifts of twelve hours per week, while the rest time of the healthcare worker takes the form of a free working week (with a two-shift schedule of organisation of work of the healthcare institution) (Mascha et al., 2020). It is possible to conclude that in the context of the COVID-19 pandemic, the right to rest is implemented in the United States through a free working week and 12 hours between shifts during the working week.

In a pandemic an employee has a 42-hour workload, if the weekly calculation (the recommended period of 24 weeks has 12 working weeks, including seven days of 12 hours, which reflects the following calculation formula: 7x12=84 hours, which must be divided by 2, as one week is free) is regarded. Regarding the monthly calculation, the additional workload can be offset by an additional two or three days off of for the rest of the days in the month by four weeks (4x7=28 days in four weeks, the rest of the reporting month is 2-3 days, except for the second calendar month in the year).

Comparing the experience of the United States and Germany, it is possible to conclude that Germany has a more pragmatic approach to the regulation of working hours and rest time at the legislative level, as there are frequent cases of overtime of medical staff in the conditions of emergency medical care. In his comprehensive comparative study of 8-hour and 12-hour work shifts of healthcare workers, Griffiths et al. (2014) note that extending shifts to 13 hours or more has become common. Violation of the rationing of working hours is not always recorded, and therefore there is a risk of disregarding overtime, which leads to a lack of overtime pay and reduction of the necessary rest time to restore the required level of efficiency until the next shift.

The likelihood of infecting healthcare workers with COVID-19 also remains a significant problem. The compilation of statistical data published in reliable sources allowed drawing some patterns and establishing the risks and efficiency of the two comparable systems of organization of working time and leisure time in the COVID-19 pandemic (Table 1).

Table 1. Forms of organization of working time of healthcare workers

Distribution of working hours and rest per week	Work in three shifts of 8 hours each	Work in two shifts of 12 hours
Work according to the standard schedule up to 40 hours a week	Sequence of night and day shifts	Shifts do not alternate, the employee works seven nights (days) in a row
Work in the conditions of labour shortage up to 48 hours a week	Working two shifts in a row is applied	Possible extension of the shift for overtime to 14 hours
Forms of rest for healthcare workers per week	Two days off a week	A week of rest after a week of work

The main advantage of a 12-hour working day is that working week by week makes it possible to detect possible infection of a healthcare worker in advance and provide time for isolation. Ideally, a healthcare worker's working time should be one working week after two weeks off to withstand at least a 14-day self-isolation regime and not place an additional burden on the existing coronavirus testing system.

Some advantages and disadvantages of the systems are presented schematically (Figure 1).

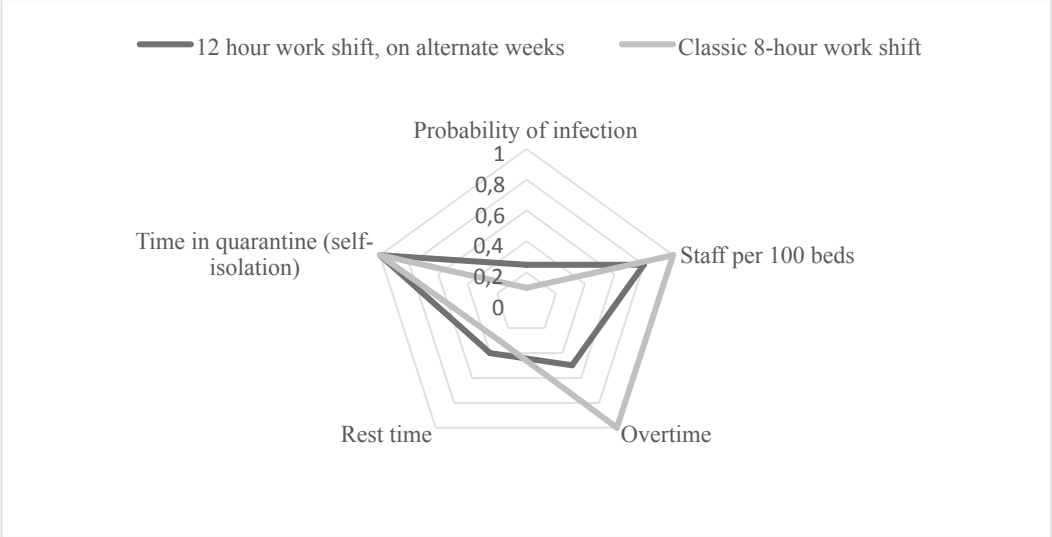

Figure 1. Schemes of risks and efficiency of use of working time in the conditions of the COVID-19 pandemic, taking into account required rest time

It turns out that the application of the classical system requires a much bigger amount of staff. In addition it will be required to resort to overtime because of the necessity of closing the intervals between shifts, as well as to deal with the likelihood of two shifts in a row due to infection of the employee and the need to urgently replace him/her. From another point of view, the likelihood of becoming infected with the virus increases due to the longer period of time of contact with infected persons when using 12-hour working time. The time in quarantine (self-isolation) remains the same – three weeks for both cases, including weekends, obviously, the 12-hour work shift scheme is more efficient, as the weekend can be counted in the employee's quarantine time.

The widespread use of the 12-hour work shift could be one of the reasons for the effective response to COVID-19 in Germany, especially given the provisions of the Working Time Act (Arbeitszeitgesetz - ArbZG), which extended the working week to forty-eight hours in a pandemic (MAYR, 2008).

The only danger is the probability of infection, which reaches 25% in cases of 12-hour work shift. Numerous WHO studies scientifically proved that increasing the time and number of patient-physician contacts increases the likelihood of coronavirus infection (WHO, 2020). Too many long-term contacts with these patients lead to moderate and severe consequences, so are unacceptable. Therefore, working 2 shifts in a row, up to 16 hours, objectively increases the probability of infection to 40% and is extremely risky, which is an obvious disadvantage of the eight-hour system of

labour organization, even given that 12 hours of work gives 25% probability of infection.

The way out of the situation of staff shortage of infectious disease clinics may also be to provide additional benefits and facilities for employees. This is especially applicable to those health workers who have certain social responsibilities - caring for the children, ill relatives or disabled, having big families, etc.

For example, Italy, Spain, the Netherlands and parts of Canada have taken steps to ensure that healthcare workers have priority access to childcare centres, which would still remain open under certain conditions. This is necessary for healthcare workers to continue to work, even when schools and childcare centres are closed. Following the closure of infant schools in early March to curb the spread of COVID-19, France organised a social system exclusively for healthcare workers. Infant schools in hospitals remain open and accept children of healthcare workers, taking appropriate security measures. Exceptions are also provided for children of medical staff in relation to early schooling. The local school and health authorities are working together to identify and to care for the children of parents mobilised to work in healthcare. Such countries as Canada and the United States allowed pharmacists to sell certain medications without prescriptions, so that physicians could focus on more important cases and lower the amount of medical consultations (Bryant, 2020).

Discussion

As a result, the discussion on the possibility of applying different schemes of working time includes the typical 8-hour and 12-hour working schedules of healthcare workers as fundamental. An extremely important parameter was the rest time, which is more effective with a 12-hour distribution of working time. This is due to the fact that a week of continuous rest allows full restoring of power of the employee, as well as the fact that there is no alternation of night/day shifts, which will allow the healthcare worker to choose the time of work (night or day), that is exercise his/her inalienable constitutional right.

According to Negri (2020), there are several areas of legal regulation of rest time in a state of emergency caused by COVID-19, namely:

1) Healthcare legislation.
2) Legislation on emergency management.
3) Labour legislation

This list could be expanded due to administrative acts of local self-governments in the field of medical services and administrative acts of responsible persons of medical institutions.

Katzenmeier (2020) stated that any restrictive or emergency measures related to COVID-19 should not only justify the purpose and means, but also be proportionate to the potential harm they cause or may cause, and this point seems reliable. The purpose of limiting the constitutional rights of citizens and the right of healthcare workers to rest is, in particular, to return to normal living conditions as soon as possible. In the wake of it healthcare workers should immediately sue in case of a gross violation of their labour rights. And in cases of mass violation, they should follow the advice of Katzenmeier (2020) and take legal recourse not for specific cases, but against the legal regulation itself. Disputes can be initiated in higher administrative courts, as well as in constitutional courts, avoiding courts of general jurisdiction to save procedural time. In order to receive targeted compensation for overtime, it seems necessary to initiate a civil case after the case is resolved by a constitutional or higher administrative court.

It should be emphasised that complications may arise if the employer has additional obligations in the employment contract or as a result of a collective agreement. For example, Muller (2020) invites employers to urgently review collective and individual employment agreements, to make temporarily necessary changes in terms of employment. It should be noted that such measures will help create the necessary standards of workload and regulate the duration of the working day of healthcare workers. The author, however, emphasises that workers have the right to refuse work if they are aware that they are in "imminent danger". It is possible to use this right if the clinic does not provide proper measures to protect healthcare workers. Therefore, it was quite logical to amend the current legislation. As an act of response to a critical situation, the Families First Coronavirus Response Act (FFCRA) entered into force in the United States, which provides for additional forms of employee benefits. The law requires the payment of sick leave to all employees (regardless of length of office) who are unable to work because of COVID-19-related government orders, and other circumstances caused by the coronavirus (U.S. Department of Labor, n./d.a).

Thus, in the implementation measure to fight against COVID-19 any government proceeds from two things: optimisation of available resources (including labour), as well as finding new labour resources in case of aggravation of the situation, and an action plan in case of full collapse of the medical system. At the same time, a public or private medical institution, being guided by current legislation and government regulations, is forced to regulate the working hours and rest time of healthcare workers in such a way as not to limit the rights of its employees, while ensuring the provision of medical services.

Conclusion

Based on the given data it is possible to come to the following conclusion: the most effective method of managing the situation in a pandemic is to increase the involvement and distribution of additional resources, especially labour ones. The secret of China's success is in the mobilisation of a large number of labour resources, with the subsequent localisation of the epicentres of the virus outbreak.
It was concluded that in developed democracies (USA, EU countries), methods of extended distribution of resources are impossible due to numerous bureaucratic barriers and rather strict labour legislation. Countries that chose a path or involving volunteers did not receive appropriate volunteer support, so the entire burden of fighting coronavirus has become the responsibility of existing healthcare workers. To avoid a collapse of the healthcare system in developed democracies, we developed risk and efficiency schemes for working time for a COVID-19 pandemic, taking into account the necessary rest time.

The main problem faced in determining the effective method of distribution of working time and rest time was that increasing duration of one shift increases the likelihood of being infected with the virus. But in general, the 12-hour working schedule looks more efficient and convenient. It was separately noted that the 8-hour working schedule requires more human resources, and therefore it is possible that workers will go to work for two shifts in a row, which will ultimately increase the likelihood of being infected with the virus. So, the advantage of using 12-hour working schedule is that the probability of working in two shifts in a row is excluded. In addition, the healthcare workers will have two weeks of full rest per month and will have the right to choose the time of work (night or day shift), which will allow them to adapt to particular working conditions. The right to choose working conditions and the right to have a proper rest are an integral constitutional guarantee of developed democracies, so this form of legal regulation of labour at the local and institutional levels is in line with the objective of our study.

Furthermore, over-exploitation of workers can lead to them leaving the healthcare service, which is unacceptable, given the situation with an acute shortage of qualified medical personnel in most countries of the world in a pandemic. A flexible and efficient judicial system is needed to address such critical situations. It is necessary to emphasise that there are different levels of resolution of labour disputes related to working hours and rest time. In developed democracies, the specific cases and the procedure for the organisation and regulation of working time and rest time should be both appealed against. This is a long process, and, as it is believed, the state and local self-governments, owners of private medical institutions, should make certain concessions to healthcare workers in the form of additional social benefits and guarantees.

Finally, it should be noted that the issue of the right of healthcare workers to have a rest in the fight against COVID-19 requires further scientific research. Further research on the issue of observance of the right of healthcare workers to rest can be conducted in the field of standard employment contracts and agreements. It is worth paying attention to the legal provisions of the contract which deal with rest time and the legal regulation of force majeure, such as COVID-19.

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