Health policy 163 (2026) 105495

Contents lists available at ScienceDirect

Health policy

journal homepage: www.elsevier.com/locate/healthpol

Health and care workforce preparedness in response to the influx of Ukrainian refugees: a qualitative study from the Czech Republic

Zuzana Kotherová [a,b,*], Karolína Dobiášová [a,b], Jolana Kopsa Těšinová [b], Elena Tulupova [b]

[a] Charles University, Faculty of Social Sciences, Institute of Sociological Studies, U Kříže 8, Prague 158 00, Czech Republic
[b] Charles university, First Faculty of Medicine, Institute of Public Health and Medical Law, Karlovo náměstí 40, Praha 2, 128 00, Czech Republic

ARTICLE INFO

Keywords:
Health workforce
Care workforce
Crisis
Czech republic
Ukrainian refugees
Workforce governance
Refugee workforce integration

ABSTRACT

Background: Health and care workforces across Europe face overlapping crises that test their resilience and governance capacities. In the Czech Republic, the COVID-19 pandemic was swiftly followed by a major influx of Ukrainian refugees, creating new pressures on both frontline healthcare workers and intercultural care workers.
Objective: To explore, from the perspectives of frontline healthcare workers and intercultural care workers, how governance capacities and gaps shaped workforce functioning, adaptation, and resilience during the refugee response in the CR, and what lessons this experience offers for strengthening workforce governance in times of multiple crises.
Methods: Thirty semi-structured interviews with frontline healthcare workers and three focus groups with 20 intercultural care workers (September 2022–June 2023) were analysed thematically within a multi-level governance framework.
Results: Fragmented coordination, lack of intercultural training, and limited psychosocial and managerial support undermined resilience. Intercultural care workers played critical but unrecognised roles bridging linguistic and cultural gaps, while refugee health workers remained underused due to rigid qualification rules and limited pathways for integration. Despite strong moral commitment and informal collaboration, reliance on individual initiative rather than structured governance weakened equity and preparedness.
Conclusions: Preparedness depends on governance that sustains the human and cultural dimensions of care. Strengthening coordination across levels, formally recognising intercultural roles within health organisations, and enabling refugee health worker integration through flexible qualification procedures are timely and achievable governance priorities for building resilient and inclusive health workforces across Europe.

Research in context box:

What is already known about the topic?

Health and care workforces across Europe face persistent shortages and growing pressures that intensify during crises. Intercultural care workers (ICWs) are known to facilitate communication and trust in migrant care but remain poorly integrated, undertrained, and undervalued. Evidence is scarce on how frontline health workers (FHWs) and ICWs function when multiple crises overlap and interact.

What does this study add to the literature?

This qualitative study examines the experiences of FHWs and ICWs in the Czech Republic during two consecutive shocks—the COVID-19 pandemic and the rapid influx of Ukrainian refugees. Using a multi-level governance framework, it identifies key weaknesses in coordination, intercultural competence, and workforce support mechanisms. The findings show how ad hoc, bottom-up adaptations compensated for institutional gaps but also reinforced dependence on individual initiative. The study highlights the underused potential of Ukrainian health professionals and the systemic neglect of intercultural roles within workforce governance.

What are the policy implications?

Policymakers should anticipate concurrent crises by investing in coherent, multi-level coordination and inclusive workforce

* Corresponding author at: Charles university, Faculty of Social Sciences; U Kříže 8, Prague 158 00, Czech Republic.
E-mail addresses: zuzana.kotherova@fsv.cuni.cz (Z. Kotherová), karolina.dobiasova@fsv.cuni.cz (K. Dobiášová), jolana.tesinova@lf1.cuni.cz (J.K. Těšinová), elena.tulupova@lf1.cuni.cz (E. Tulupova).

https://doi.org/10.1016/j.healthpol.2025.105495
Received 22 September 2025; Received in revised form 3 November 2025; Accepted 6 November 2025
Available online 8 November 2025

governance. Formal recognition, training, and sustainable funding for ICWs are essential for equitable and responsive care. Simplifying procedures for recognising foreign qualifications and embedding intercultural education across health professions can strengthen preparedness and resilience across European health systems.

1. Background

Health and care systems across Europe face persistent workforce pressures. Ageing populations, chronic disease, and staff shortages have intensified workloads, emotional strain, and burnout among health and care workers (HCWs) [1–12]. Despite multiple policy initiatives, governance has proved insufficient to address these systemic challenges.

Forced migration adds further complexity, as caring for refugees requires not only clinical capacity but also emotional labour, intercultural communication, and navigation of administrative and linguistic barriers [13,14]. Yet health systems and training frameworks remain designed for majority populations and routine conditions, lacking flexibility to respond to crisis-related needs [15,16].

These vulnerabilities became visible in the Czech Republic (CR) between 2020 and 2023 during two consecutive shocks—the COVID-19 pandemic and the arrival of over 350 000 refugees from Ukraine [17]. The dual crisis exposed limited preparedness and weak coordination across governance levels. Health and care delivery relied mainly on frontline health workers (FHWs) in hospitals and primary care, complemented by emerging intercultural support.

Two groups were central: FHWs—including general practitioners, emergency staff, and clinicians in low-threshold outpatient clinics (UA POINTs)—and intercultural care workers (ICWs), often bilingual migrants employed by NGOs or municipalities who supported refugees and providers through interpretation, mediation, and navigation. While FHWs represent a recognised workforce group, ICWs remain weakly institutionalised [18]. In the literature, similar actors—intercultural mediators, cultural brokers, or community health workers—perform translation, cultural interpretation, and trust-building [19–21]. Unlike community HCWs embedded in primary care or public health, ICWs operate in migrant-receiving, high-income settings, focusing on cross-cultural mediation rather than prevention. Their marginal position reflects broader governance gaps in integrating culturally diverse care roles [22].

This reveals a governance gap in managing the interaction of frontline and intercultural roles during overlapping health and care crises.To examine these challenges, this study applies the concept of HCW governance as the set of processes aligning workforce management with system goals [23–25]. Governance is understood not only as regulation but as coordination among state, organisational, and professional actors across macro, *meso*, and micro levels, including the sociocultural dimension relevant to gender, migration, and equity [24].

Accordingly, the study aimed to explore, from the perspectives of FHWs and ICWs, how governance capacities and gaps shaped workforce functioning, adaptation, and resilience during the refugee response in the CR, and what lessons this experience offers for strengthening workforce governance in times of multiple crises.

2. Methods

2.1. Data collection

Thirty individual interviews were conducted between September 2022 and June 2023 with FHWs. Informants were purposively selected for diversity in background and location. Most were based in the cities of Prague and Brno, where refugee inflows were highest. Interviews lasted 30–120 min and were held either in person or online, depending on informant preference.

A semi-structured topic guide was used to ensure consistency. The guide was developed based on literature and prior research. It included thematic blocks covering respondent background; experiences with Ukrainian refugees and other migrants; accessibility of care; communication challenges; provider–patient relationships; and intercultural training.

Three focus groups were conducted between November 2022 and March 2023 with a total of twenty ICWs. Informants were recruited through NGOs and municipal integration centres. Eligibility criteria included at least one year of experience working as an ICW and recent involvement in supporting Ukrainian refugees in the health system. ICWs are employed by municipalities, integration centres, or non-governmental organisations. They provide assistance in communication, basic social counselling, and cultural mediation to help overcome language and sociocultural barriers. Most informants were female, reflecting the gender distribution in the profession (Table 1).

2.2. Data analysis

All interviews and focus groups were audio-recorded, transcribed verbatim, and anonymised. A thematic analysis was conducted across the full dataset using an inductive approach, focusing on issues related to the health workforce. Initial coding was carried out independently by two researchers, followed by iterative discussions to refine and consolidate codes into broader themes. The analysis was grounded in informants' accounts, allowing key themes to emerge. The inductive thematic analysis resulted in seven overarching themes. The conceptual framework of the multilevel governance of the health workforce [23–25] was applied in the discussion phase to interpret and contextualise the findings. This approach enabled a deeper understanding of how individual, organisational, and systemic factors interacted in shaping the experiences of both groups, FHWs and ICWs. In direct quotations, nurses are denoted by the letter 'N' and physicians by the letter 'P'.

For contextual information see Box 1.

2.3. Ethical considerations

All informants were informed about the purpose of the study, data handling procedures, and voluntary nature of participation. Written and verbal consent was obtained prior to data collection. The study received ethical approval from the Ethics Committee of the First Faculty of Medicine, Charles University.

3. Results

The inductive thematic analysis resulted in seven overarching themes related to the roles, challenges, gaps, and adaptive responses of the HCWs; these are presented in detail in this section.

3.1. UA POINTs as partial relief and added burden

The influx of refugees put acute pressure on the Czech healthcare system, especially in large cities. All types of facilities—emergency departments, GP practices, and hospitals—reported increased workloads but no staff reinforcements: 'There is no one to do it. Those who remain are working at the very limit of their capacity' (FHW_N1). While some informants noted a lack of motivation among physicians: 'Sometimes doctors try to turn away Ukrainian refugees so that they don't have to take on an additional workload….' (ICW_1_3), others described intense moral mobilization and professional solidarity: 'The desire to help and to do something resonated terribly within the medical community' (FHW_P1).

To alleviate pressure, the Ministry of Health rapidly mobilized hospital staff and established low-threshold outpatient clinics with at least one Ukrainian- or Russian-speaking professional, known as UA POINTs

Table 1
Informants characteristics.

Characteristics of FHWs				
Informant identification	Profession	Gender	Healthcare facility	Length of experience
FW_P1	Physician	Female	GP practice	12 years
FW_P2	Physician	Female	GP practice	15 years
FW_ P3	Physician	Male	GP practice	10 years
FW_ P4	Physician	Male	GP practice	37 years
FW_ P5	Physician	Male	GP practice	23 years
FW_ P6	Physician	Male	Hospital, UA Point, hospital emergency	2 years
FW_ P7	Physician	Male	GP practice	28 years
FW_ P8	Physician	Male	GP for children and adolescents practice	40 years
FW_ P9	Physician	Female	GP for children and adolescents practice	20 years
FW_ P10	Physician	Female	Hospital emergency	4.5 years
FW_ P11	Physician	Male	Hospital emergency	3 years
FW_ P12	Physician	Male	GP practice	25 years
FW_ P13	Physician	Male	Hospital emergency for children	32 years
FW_ P14	Physician	Female	GP for children and adolescents practice	24 years
FW_ P15	Physician	Female	GP for children and adolescents practice and UA Point	28 years
FW_ P 16	Physician	Male	Hospital emergency	4 years
FW_ P17	Physician	Male	Hospital emergency	2 years
FW_P18	Physician	Male	Hospital emergency	2 years
FW_ P19	Physician	Male	Hospital emergency for children	6 years
FW_ P20	Physician	Male	Hospital emergency	26 years
FW_N1	Nurse	Female	UA Point	30 years
FW_N2	Nurse	Female	GP practice	12 years
FW_ N3	Nurse	Female	Hospital emergency room	32 years
FW_ N4	Nurse	Female	Hospital emergency room	7 years
FW_ N5	Nurse	Female	Hospital emergency room	4 years
FW_ N6	Nurse	Female	Hospital emergency room for children	20 years
FW_ N7	Nurse	Female	UA Point for children	28 years
FW_ N8	Nurse	Female	Hospital emergency room for children	32 years
FW_ N9	Nurse	Female	GP practice	39 years
FW_ N10	Nurse	Female	GP practice	25 years
Characteristics of ICWs				
Informant identification	Number of focus group, online/in-person		Age group	Gender	Languages in which I work
ICW_1_1	1, online		25–34	Female	Russian
ICW_1_2	1, online		25–34	Female	Ukrainian
ICW_1_3	1, online		35–44	Female	Ukrainian, Russian
ICW_1_4	1, online		35–44	Female	Russian
ICW_1_5	1, online		25–34	Female	Ukrainian, Russian
ICW_1_6	1, online		35–44	Male	Russian
ICW_1_7	1, online		45–54	Female	Russian
ICW_2_1	2, in-person		35–44	Female	Ukrainian Russian
ICW_2_2	2, in-person		25–34	Female	Russian
ICW_2_3	2, in-person		25–34	Female	Russian
ICW_2_4	2, in-person		35–44	Female	Russian
ICW_2_5	2, in-person		35–44	Female	Ukrainian, Russian
ICW_3_1	3, online		35–44	Female	Russian
ICW_3_2	3, online		25–34	Female	Ukrainian, Russian
ICW_3_3	3, online		35–44	Female	Russian
ICW_3_4	3, online		35–44	Female	Russian
ICW_3_5	3, online		35–44	Female	Russian
ICW_3_6	3, online		35–44	Female	Ukrainian, Russian
ICW_3_7	3, online		35–44	Female	Ukrainian, Russian
ICW_3_8	3, online		35–44	Female	Russian

(see Box 1). According to most informants, UA POINTs were perceived as an innovative and generally well-accepted intervention: 'The UA POINT that takes care of these children has helped us a lot with the inflow of refugees' (FHW_N7). Nonetheless, their rapid implementation was not accompanied by adequate coordination or communication support, which in practice amplified the workload and stress experienced by staff. 'It was definitely a problem because no one told us in advance, and we weren't prepared. It wasn't organized. We had to improvise…' (FHW_N1). Consequently, many HCWs resorted to improvisation, working beyond official hours to create bilingual information materials: '… after practice hours, [we were] writing emails in Czech and Ukrainian…' (FHW_N7).

3.2. Rapid insurance inclusion as support, its implementation as strain

Following the outbreak of the war in Ukraine, Ukrainian refugees were swiftly integrated into the Czech public health insurance system, which FHWs and ICWs viewed as a key step for maintaining access to care and financial security. As one physician explained, "…the health insurance system works well. We had several meetings with the insurance company, where they assured us that they wouldn't regulate it in any way" (FHW_P7). Another informant emphasized: "Ukrainian refugees have a card from the General Health Insurance Company [*the most important insurer in the country, authors note*], and are entitled to everything like Czechs. I don't see a problem there" (FHW_N3).

However, uncertainties regarding administrative procedures and the formal validity of insurance documents persisted among some healthcare workers. As one ICW noted, "…healthcare workers are often not sufficiently informed about refugee insurance. They don't accept valid documents of public health insurance when it's not the plastic 'card', and they ask for additional papers they shouldn't, like confirmation of payment of public health insurance" (ICW_1_4). These procedural ambiguities added administrative burden and emotional strain for FHWs and ICWs.

3.3. Navigating language barriers without support

All informants identified language barriers as the main challenge in providing care to refugees, limiting FHWs' ability to conduct consultations efficiently. Consultations often took significantly longer due to communication difficulties and patients' limited understanding of the system: "Normally, I have patients for ten minutes, but with a foreigner who doesn't understand, it can take half an hour" (FHW_P2). Most professionals lacked access to professional or even basic telephone

Box 1
Czech Health System Profile and War Crisis Response Context (Authors based on [6,26–28]).

The Czech Republic has a statutory health insurance system with universal coverage, strong state oversight, and high public funding (86 % of total expenditure). Health spending (8.8 % of GDP in 2022) is below the EU average, yet access remains broad. The absence of gatekeeping allows direct specialist access, contributing to one of the highest consultation rates in the EU (7.8 per capita) but weakening care coordination. Avoidable mortality and life expectancy remain below EU levels.

The health workforce density is near the EU average but ageing, with over one-third of doctors aged 55 or older. Persistent shortages affect primary care, rural areas, and key specialties, while the inflow of nursing graduates ranks among the lowest in the EU. Limited mental-health support and high burnout further undermine workforce sustainability and system resilience.

During the COVID-19 pandemic, excess mortality exceeded the EU average, revealing systemic fragility. Following the war in Ukraine, refugees were granted full access to public health insurance and essential services. To sustain service delivery, the Ministry of Health created 23 low-threshold outpatient clinics (UA POINTs) in eight of the fourteen regions, each employing at least one Ukrainian- or Russian-speaking professional. All UA POINTs closed by January 2024 despite ongoing GP shortages and communication barriers. During the war response, intercultural care workers were vital for interpretation, mediation, and patient navigation, yet their roles remain informal, underfunded, and excluded from workforce planning frameworks.

interpretation: “If we had at least an interpreter on the phone, it would help” (FHW_P3). The Ministry of Health introduced an interpretation hotline, but it was rarely used or widely known.

Some hospitals equipped emergency and UA POINT staff with electronic translators or printed materials containing common Ukrainian and Russian phrases: “We were issued pre-printed sentences in Ukrainian, and the management bought us a device, something like Google Translate, but you speak into it, and it translates immediately” (FHW_P5). In other settings, communication often relied on Ukrainian assistants, medical students, or auxiliary staff—often migrants already living in the CR—who interpreted informally during care, coordinated by. FHWs themselves. While some appreciated this support: “The greatest help for us were the Ukrainian cleaners” (FHW_N6), others expressed concern about the risks linked to non-professional interpretation: “A lot got lost in translation… If the translators were familiar with medical terminology, it would definitely be easier” (FHW_P17).

3.4. ICWs as essential yet marginalised workers

The inflow of Ukrainian refugees sharply increased the need for intercultural work, which ICWs viewed as indispensable for patients and staff. They provided linguistic interpretation, cultural mediation, and guidance in navigating the Czech healthcare system: “Patients from Ukraine sometimes do not understand the healthcare system in the CR. For example, a GP issues a referral but does not explain what to do with it. Then they come to us, and I explain it to them…” (ICW_1_5), often extending their role beyond interpreting to help FHWs avoid misunderstandings between the Czech and Ukrainian contexts: “In Ukraine, when patients ask, doctors tell them everything. Here, they don’t. A cardiologist will only talk about the heart, and nothing more, because they don’t have the time. Ukrainians don’t know that, and the doctors don’t know that they don’t know—and that’s where the conflict arises” (ICW_2_5).

ICWs often acted as key intermediaries in situations of tension or mistrust between health professionals and refugee clients: “I often had to mediate because clients were angry, so I had to calm down one side and then the other” (ICW_1_7). They were also often asked to translate complex clinical content—a responsibility they perceived as ethically and professionally problematic: “I had to translate pre-surgical complications into English, and that was very stressful. If something happens, it will be on me” (ICW_2_5). Some physicians assumed ICWs were fully proficient in medical terminology, which was rarely the case: “Sometimes, they think the interpreter is an expert in medical vocabulary… which, of course, is not the case” (ICW_1_5).

ICWs also reflected on how insufficient preparation and the absence of targeted training increased risks, particularly in clinically and emotionally sensitive settings: “We must not scare the patient before the procedure. We need a training course for that” (ICW_2_2). They repeteadly described being marginalised within the system; lacking formal status in outpatient settings weakened their professional recognition: “In larger hospitals, they are very happy… at GPs, I was told that I was hindering them” (ICW_1_1), while project-based funding threatened service continuity.

3.5. Physicians’ informal and community-driven responses

The inflow of Ukrainian refugees created demand among physicians for shared information and professional support. Informants were dissatisfied with the Czech Medical Chamber, the mandatory self-governing body for all physicians. The Chamber holds statutory responsibility for providing professional guidance and support. Informants expected the Chamber to take an active role in disseminating information and guidance on refugee care: “In an ideal world, the Chamber would send out a brochure: ‘You are treating a UA patient, here are the key cultural differences…’” (FHW_P1). However, no such support was reported.

Professional associations, by contrast, responded promptly and were valued for their activities. The Society of General Practitioners was frequently cited for webinars and shared materials, while informal physician networks also emerged as peer-support spaces for mutual learning: “We have a Facebook group for GPs where we exchange various experiences. For example, we shared documents or anamnesis questionnaires in Ukrainian, or discussed how vaccination works in Ukraine, etc.” (FHW_P2). These professional and grassroots initiatives provided practical support that partly compensated for the lack of systematic assistance from formal institutions.

3.6. Ukrainian HCWs: potential unmet by systemic barriers

UA POINTs and GP clinics employed Ukrainian physicians and nurses, but unrecognised qualifications confined them to administrative rather than clinical roles. Informants highlighted that complex recognition procedures hindered the integration of Ukrainian health professionals. One general practitioner described employing a Ukrainian physician as a substantial reinforcement for their team: “We have a doctor from UA who speaks English, Ukrainian, and Russian, and we employ her in an administrative role, where she helps with patient anamnesis. Although her diploma is recognized, she cannot sit for the licensing exam—she would have to work for six months in a hospital without pay, which she cannot afford because she has four children” (FHW_P7).

Many informants suggested that including Ukrainian health professionals in clinical teams would greatly ease the work of Czech HCWs, reduce linguistic and cultural barriers, and enhance patient-provider communication. As one ICW put it: “The difference is that there is no communication barrier. A doctor who speaks the same language doesn’t even need a translator” (ICW_2_1). These findings highlight the underused potential of Ukrainian HCWs and the need for systemic measures to support their integration.

3.7. Unprepared and overwhelmed: HCWs facing intercultural challenges

HCWs reported that working with refugees brought exceptional emotional strain. Clinical encounters required heightened emotional labour, often beyond standard professional boundaries, and were for many deeply traumatic: ‘There were people with children in their arms, without papers, without documentation. Seeing these people in this

situation was very psychologically scarring for us' (FHW_N6). Divergent expectations shaped by prior experiences in Ukraine often caused misunderstandings between patients and physicians: 'They want CT scans, antibiotics, food supplements, and they are very rude and aggressive when they don't get it' (FHW_P1). These encounters contributed to frustration and exhaustion among FHWs professionals: 'They escalate the aggression… many times I came home completely exhausted' (FHW_N10).

Most HCWs felt unprepared for intercultural care due to missing training: "In both undergraduate and postgraduate education, intercultural training was entirely absent. It is not part of any curriculum" (FHW_P11). ICWs confirmed these gaps, noting frequent misunderstandings among HCWs: "Doctors do not realize the difference between the mental and physical condition of voluntary migrants and refugees, who are traumatized" (ICW_1_1).

4. Discussion

This discussion interprets how coordination and accountability operated across levels of health workforce governance [23,25], shaping adaptive capacity during the refugee response in the CR (Fig. 1).

The first finding illustrates how a timely macro-level decision effectively supported workforce functioning. The rapid inclusion of refugees in the public health insurance system secured access to care and reduced administrative uncertainty for providers. Health insurers responded promptly at the *meso* level, but incomplete communication about required documentation caused residual confusion. Even successful national measures require coherent procedures and clear information flows to operate effectively at the frontline [29–30].

A second finding highlights how governance gaps at the macro level triggered mobilisation at the *meso* level, as organisations and professional actors compensated for missing coordination. National authorities responded quickly, but implementation was fragmented—a pattern seen across EU systems post-COVID [29,31,32]. Measures such as UA POINTs and interpretation hotlines were introduced rapidly, yet hospitals and primary-care providers received little guidance. Each hospital developed its own procedures, shifting strain to the *meso* level. As most FHWs were unaware of the hotline or unable to use it, providers relied on bilingual staff or auxiliary personnel to interpret—pragmatic but inconsistent solutions that raised concerns about accuracy and professional boundaries. These cases show how central decisions without communication and support structures risk becoming symbolic rather than functional policy [29,30].

After fragmented implementation at the national level, another pattern emerged—macro-level silence in the face of evident workforce needs. Meso and micro actors mobilised informally, exposing both adaptability and systemic fragility. ICWs became key intermediaries bridging linguistic and cultural divides, yet their work operated outside formal structures, without regulation, training, or sustainable funding. This dependence on temporary, project-based initiatives illustrates how vertical misalignment leaves essential mediating functions unsupported [1,29,30].

This informality reflects a broader European pattern: boundary-spanning actors [33] remain weakly professionalised and excluded from workforce policy [19,20,22,34]. Their project-based contributions are essential for equity and crisis preparedness but lack institutional continuity and supervision. The resulting precarious position of ICWs—often performing complex clinical and emotional mediation beyond their preparation—underscores the need to extend workforce governance to intercultural and community-based functions [21,30,34].

A similar missed opportunity concerned Ukrainian health professionals. While shortages are most acute among nurses [32], policy attention focused mainly on physicians. Complex and unpaid recognition procedures prevented many from practising, leaving their clinical capacity unused despite employers' willingness to integrate them. This rigidity illustrates the limits of adaptive governance within traditional regulation. Experiences from Poland's provisional licensing scheme show that flexible approaches can expand workforce capacity and strengthen linguistic and cultural competence. Both cases—ICWs and Ukrainian professionals—reveal how macro-level silence constrains bottom-up innovation and exposes the fragility of crisis responsiveness [34,35].

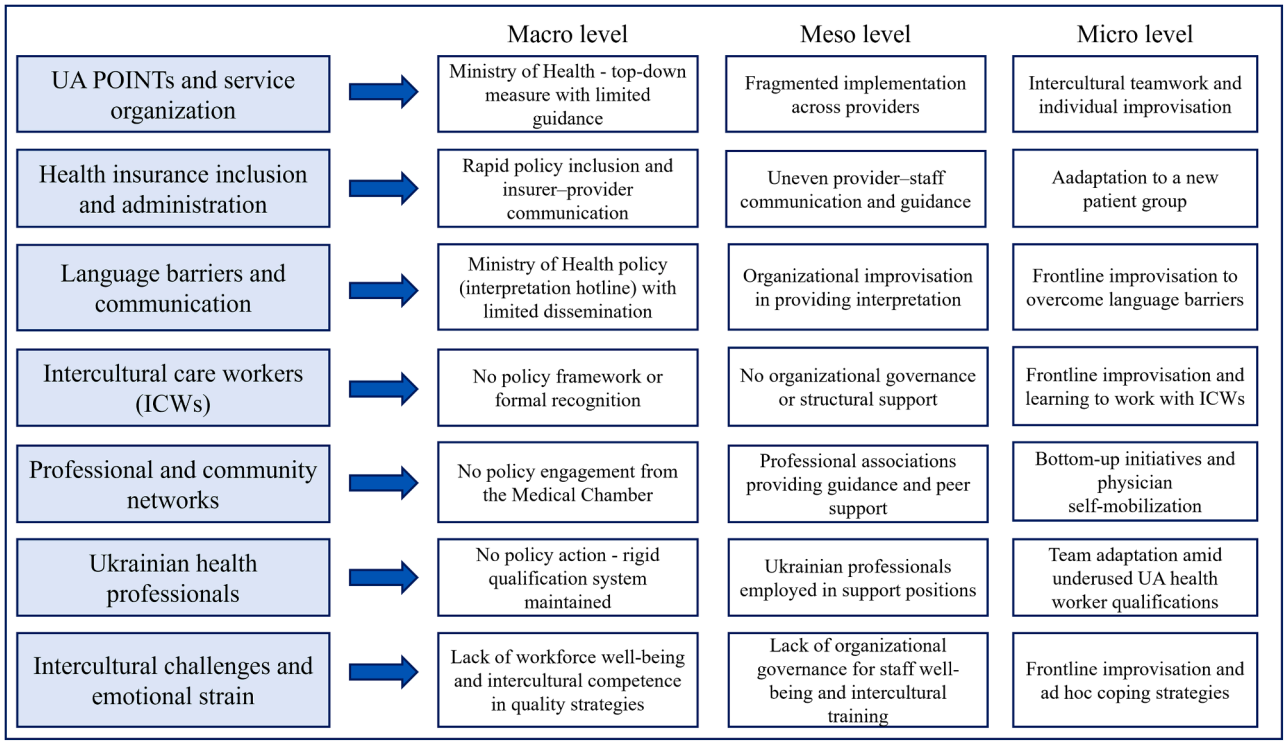

Fig. 1. Multi-level governance of the health workforce during the refugee response in the Czech Republic.

A third finding highlights cross-cutting governance gaps that weakened preparedness across all levels—most notably the absence of intercultural training and structured well-being support. Despite their evident relevance, no targeted capacity-building or upskilling initiatives were introduced. Key actors such as the Ministry of Health and the Czech Medical Chamber failed to provide methodological guidance, leaving adaptation to professional associations and informal peer networks. These bottom-up efforts demonstrated resilience but also exposed systemic fragmentation and weak institutional learning.

The psychological toll on both FHWs and ICWs was widely acknowledged yet met with no formal response. High workloads, emotionally charged encounters, and exposure to trauma produced exhaustion and moral distress, but few employers implemented preventive or support measures. Macro-level governance remained silent despite international evidence that workforce mental health is essential for system resilience [1,22,32,36,37]. Recent national reports also document a marked decline in HCWs' mental well-being in the CR [3–9]. This absence of psychosocial support and intercultural preparation underscores a governance model still reliant on individual resilience rather than institutional responsibility.

Taken together, these findings show that preparedness cannot be reduced to resources or emergency plans [1,29,38]. It depends on governance systems that can sustain the human, relational, and cultural dimensions of care work [21,32,39]. Integrating these dimensions into formal frameworks would strengthen both crisis responsiveness and long-term workforce sustainability [35].

What are the implications for workforce governance and preparedness? At the macro level, clearer coordination between national authorities, insurers, and professional bodies is needed to ensure coherent mobilisation and guidance during crises [40]. Simplifying qualification recognition could accelerate the integration of foreign-trained HCWs and help mitigate persistent workforce shortages [1,2]. At the *meso* level, intercultural work and professional interpretation should be formally recognised, sustainably funded, and embedded within multidisciplinary care teams. Education reforms must include intercultural competence as a standard part of undergraduate and postgraduate training. Systematic mental-health support for HCWs should be built into workforce management at *meso* level [13,36] and quality systems to sustain resilience and retention at macro level [31].

4.1. Limitations

This study has several limitations. As a qualitative inquiry based on purposive sampling, the findings are not statistically generalisable. Efforts were made to ensure variation in professional background and location, yet the views of some actors—especially system managers and policy-makers—are missing. This limits insight into macro-level governance and strategic decision-making. The analysis mainly captures organisational and sociocultural aspects, with less attention to system-level and sectoral mechanisms. The transnational level, central to the multi-level framework, did not appear in the data, suggesting limited visibility in practice. The study also focuses on a specific period of overlapping crises and may not reflect longer-term institutional dynamics. Still, the consistency and depth of informant accounts provide valuable evidence on preparedness gaps, role recognition, and workforce resilience.

5. Conclusions

This study analysed how overlapping crises tested health workforce governance in the Czech Republic. While rapid responses maintained access to care for refugees, fragmented coordination and ad hoc measures limited institutional learning. Experiences of frontline and intercultural care workers showed that weak governance hindered the integration of intercultural roles and Ukrainian professionals, restricting system adaptability and transformation. Although based on a single-country case, the findings illustrate transferable lessons for European health systems, showing that inclusive, multi-level workforce governance is a prerequisite for sustained coordination, resilience, and trust in times of permacrisis.

CRediT authorship contribution statement

Zuzana Kotherová: Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Conceptualization. **Karolína Dobiášová:** Writing – review & editing, Writing – original draft, Validation, Methodology, Formal analysis, Conceptualization. **Jolana Kopsa Těšinová:** Writing – review & editing, Validation. **Elena Tulupova:** Writing – review & editing, Validation.

Declaration of competing interest

I have nothing to declare.

Acknowledgements

Funding sources: Research was supported by the NPO "Systemic Risk Institute" grant (LX22NPO5101), funded by European Union - Next Generation EU (Ministry of Education, Youth and Sports, NPO: EXCELES).

References

[1] World Health Organization (WHO), Health and care workforce: global strategy on human resources for health: workforce 2030 (EB156/15). Report by the Director-General, 156th session of the Executive Board. https://apps.who.int/gb/ebwha/pdf_files/EB156/B156_15-en.pdf, 2024 (accessed 7 June 2025).
[2] de Vries N, Boone A, Godderis L, Bouman J, Szemik S, Matranga D, de Winter P. The race to retain healthcare workers: a systematic review on factors that impact retention of nurses and physicians in hospitals. Inquiry J Health Care Organ Provis Financ 2023;60. https://doi.org/10.1177/00469580231159318.
[3] Štěpánek L, Patel MS, Horáková D, Juríčková L, Býma S. High prevalence of burnout syndrome in Czech general practitioners: a cross-sectional survey. Prev Med Rep 2023;36:102502. https://doi.org/10.1016/j.pmedr.2023.102502.
[4] Chrdle A, Bártlová S, Chloubová I. The doctor's view of a nurse's role during the COVID-19 pandemic: qualitative research. J Nurs Soc Stud Public Health Rehabil 2024;15(3–4):89–98. https://doi.org/10.32725/jnss.2024.007.
[5] Dobešová Cakirpaloglu S, Cakirpaloglu P, Skopal O, Kvapilová B, Schovánková T, Vévodová Š, Greaves JP, Steven A. Strain and serenity: exploring the interplay of stress, burnout, and well-being among healthcare professionals. Front Psychol 2024;15. https://doi.org/10.3389/fpsyg.2024.1415996.
[6] Ministerstvo zdravotnictví České republiky [Ministry of Health of the Czech Republic]. Koncepce rozvoje zdravotnictví ČR do roku 2030 s výhledem do roku 2050 [Strategic development framework of healthcare in the czech republic until 2030 with a vision to 2050]. Praha: MZ ČR; 2024. https://zdravi2030.cz/. a (accessed 11 August 2025).
[7] Cermakova P, Wolfova K, Frycova B, Novak D, Kuklova M, Pekara J, Kucera M, Janouskova M, Seblová J, Seblová D. Depression in healthcare workers in Czech Republic during COVID-19 pandemic. Popul Med 2023;5(Supplement):1247. https://doi.org/10.18332/popmed/165369.
[8] Štěpánek L, Horáková D, Král N, Štěpánek L, Býma S. Burnout syndrome among general practitioners in the Czech Republic: a repeated survey study. BMC Prim Care 2024;25:421. https://doi.org/10.1186/s12875-024-02675-z.
[9] Shivairová O, Bártlová S, Hellerová V, Chloubová I. Nurse's mental health during Covid-19 pandemic, cent. Eur J Nurs Midwifery 2023;14(1):795–804. https://doi.org/10.15452/cejnm.2022.13.0009.
[10] Kuhlmann E, Lotta G, Dussault G, Falkenbach M, Correia T. The workforce crisis in healthcare: moving the debate to bridge evidence and policy. Int J Health Plann Manage 2024;39(3):607–13. https://doi.org/10.1002/hpm.3792. c.
[11] World Health Organization, (accessed 1 August 2025). Health workforce – overview. Geneva: WHO; 2024. https://www.who.int/health-topics/health-workforce.
[12] Zapata T, Azzopardi-Muscat N, McKee M, Kluge H. Fixing the health workforce crisis in Europe: retention must be the priority. BMJ 2023;381:947. https://doi.org/10.1136/bmj.p947.
[13] Nagarajan R, Ramachandran P, Dilipkumar R, Kaur P. Global estimate of burnout among the public health workforce: a systematic review and meta-analysis. Hum Resour Health 2024;22(1):30. https://doi.org/10.1186/s12960-024-00917-w.
[14] Jelínková M, Dobiášová K, Kopsa Těšinová J, Koščík M. Physicians' experiences with intercultural differences in communication with Ukrainian refugees during the Russian-Ukrainian armed conflict. J Czech Physicians 2023;162(2–3):76–83.
[15] Rechel B, Mladovsky P, Ingleby D, Mackenbach JP, McKee M. Migration and health in an increasingly diverse Europe. Lancet 2013;381:1235–45. https://doi.org/10.1016/S0140-6736(12)62086-8.

[16] Claeys A, Berdai Chaouni S, Tricas-Sauras S, De Donder L. Culturally sensitive care: definitions, perceptions, and practices of health care professionals. J Transcult Nurs 2020;32(5):484–92. https://doi.org/10.1177/1043659620918100.
[17] Ukraine refugee situation. https://data.unhcr.org/en/situations/ukraine; 2023. accessed 11 August 2025.
[18] Tulupova E, Dohnalová E, Těšinová JK. Role a postavení interkulturních pracovníků v poskytování zdravotní péče uprchlíkům a migrantům v Česku [Role and status of intercultural workers in healthcare provision for refugees and migrants in the Czech Republic]. Cas Lek Cesk 2025;164:25–31.
[19] Theodosiou A, Aspioti M. Research report on intercultural mediation for immigrants in Europe. Mediation TIME; 2015. https://migrant-integration.ec.europa.eu/library-document/research-report-intercultural-mediation-immigrants-europe_en (accessed 1 July 2025).
[20] Glenton C, Javadi D, Perry HB. Community health workers at the dawn of a new era: 5. Roles and tasks. Health Res Policy Syst 2021;19(Suppl. 3):128. https://doi.org/10.1186/s12961-021-00748-4.
[21] Scott K, Beckham SW, Gross M, Pariyo G, Rao KD, Cometto G, Perry HB. What do we know about community-based health worker programs? A systematic review of existing reviews on community health workers. Hum Resour Health 2018;16(1):39. https://doi.org/10.1186/s12960-018-0304-x.
[22] World Health Organization (WHO). What do we know about community health workers? A systematic review of existing reviews. Human Resources for Health Observer Series No. 19, Geneva: WHO; 2021. https://www.who.int/publications/i/item/what-do-we-know-about-community-health-workers-a-systematic-review-of-existing-reviews (accessed 1 August 2025).
[23] Kuhlmann E, Brînzac MG, Burau V, Correia T, Ungureanu MI. Health workforce protection and preparedness during the COVID-19 pandemic: a tool for the rapid assessment of EU health systems. Eur J Public Health 2021;31(Suppl. 4):iv14–20. https://doi.org/10.1093/eurpub/ckab152.
[24] Barbazza E, Langins M, Kluge H, Tello J. Health workforce governance: processes, tools and actors towards a competent workforce for integrated health services delivery. Health Policy (New York) 2015;119(12):1645–54. https://doi.org/10.1016/j.healthpol.2015.09.009.
[25] Kuhlmann E, Larsen C. Why we need multi-level health workforce governance: case studies from nursing and medicine in Germany. Health Policy (New York) 2015;119(12):1636–44. https://doi.org/10.1016/j.healthpol.2015.08.004.
[26] OECD. /European observatory on health systems and policies, Czechia: country health profile 2023, state of health in the EU. Brussels: OECD Publishing, Paris / European Observatory on Health Systems and Policies; 2023.
[27] Ministerstvo zdravotnictví České republiky [Ministry of Health of the Czech Republic]. Personální situace a vzdělávání v primární péči [The current state of personnel and education in primary care]. Praha: MZ ČR; 2025. https://mzd.gov.cz/tiskove-centrum-mz/ministerstvo-zdravotnictvi-predstavilo-aktualni-data-z-primarni-pece-a-kroky-na-podporu-jeji-dostupnosti/ (accessed 10 September 2025).
[28] Těšinová JK, Doležal T, Policar R. Medicínské právo [Medical law]. 2nd ed. C.H. Beck, Prague; 2019.
[29] Greer SL, Zimmermann J, Sagan A, Cooney K, Figueras J. What could the EU do to build resiliant health systems and resiliant healthy societies? Eurohealth (Lond) 2023;29(3):14–21. https://eurohealthobservatory.who.int/publications/i/what-could-the-eu-do-to-build-resilient-health-systems-and-resilient-healthy-societies.
[30] Kuhlmann E, Batenburg R, Wismar M, Dussault G, Maier CB, Glinos IA, Azzopardi-Muscat N, Bond C, Burau V, Correia T, Groenewegen PP, Hansen J, Hunter DJ, Khan U, Kluge HH, Kroezen M, Leone C, Santric-Milicevic M, Sermeus W, Ungureanu M. A call for action to establish a research agenda for building a future health workforce in Europe. Health Res Policy Syst 2018;16:52. https://doi.org/10.1186/s12961-018-0333-x.
[31] Burau V, Mejsner SB, Falkenbach M, Fehsenfeld M, Kotherová Z, Neri S, Wallenburg I, Kuhlmann E. Post-COVID health policy responses to healthcare workforce capacities: a comparative analysis of health system resilience in six European countries. Health Policy 2024;139:104962. https://doi.org/10.1016/j.healthpol.2023.104962.
[32] Kuhlmann E. European parliament: directorate-general for economy, transformation and industry, the health workforce crisis in the european union – policy options for improving the sustainability of healthcare systems and employment and working conditions in the healthcare sector. European Parliament; 2025. https://data.europa.eu/doi/10.2861/3098897.
[33] Kuhlmann E, Lotta GS, Burau V, Correia T, Falkenbach M, Ungureanu M-I, Wallenburg I, Cylus J, Lehmann U. Community health workers: a comparative assessment of capacities of a global policy approach in selected European health systems [preprint]. d. SSRN; 2025. https://ssrn.com/abstract=5413155. or doi. 10.2139/ssrn.5413155.
[34] Těšinová JK, Dobiášová K, Jelínková M, Tulupova E, Koščík M. Professionals' and intercultural mediators' perspectives on communication with Ukrainian refugees in the Czech healthcare system. Health Expect 2024;27:e14171. https://doi.org/10.1111/hex.14171.
[35] Kuhlmann E, Rees GH, Falkenbach M, Williams GA, Wismar M. Moving towards a resilient health and care workforce: how to institutionalize health workforce planning and forecasting, european observatory on health systems and policies. Copenhagen: WHO Regional Office for Europe; 2025. cLicence: CC BY-NC-SA 3.0 IGO.
[36] Kuhlmann E, Falkenbach M, Brînzac MG, Correia T, Panagioti M, Ungureanu MI. The mental health needs of healthcare workers: when evidence does not guide policy. A comparative assessment of selected European countries. Int J Health Plann Manage 2024;39(3):614–36. https://doi.org/10.1002/hpm.3752. b.
[37] Zapata T, Azzopardi-Muscat N, Falkenbach M, Wismar M. From great attrition to great attraction: countering the great resignation of health and care workers. Eurohealth (Lond) 2023;29(1):6–10. b, https://iris.who.int/server/api/core/bitstreams/488b01ab-a066-4558-a345-476570fe2802/content.
[38] Correia T, Ricciardi W, McKee M. Preparing for the 'next pandemic': why we need to escape from our silos. Int J Health Plann Manage 2024;39:973–9. https://doi.org/10.1002/hpm.3757.
[39] Kuhlmann E, Czabanowska K, Brînzac MG, de León EA, Falkenbach M, Ungureanu MI, Wismar M, Zapata T, Correia T. New WHO priorities in the European Region and health workforce competencies: a rapid assessment of capacities and gaps in public health competencies frameworks. Int J Health Plann Manage 2025;40(4):802–9. https://doi.org/10.1002/hpm.3934. b.
[40] Kuhlmann E, Falkenbach M, Brînzac MG, Correia T, Panagioti M, Rechel B, Sagan A, Santric-Milicevic M, Unggureanu MI, Wallenburg I, Burau V. Tackling the primary healthcare workforce crisis: time to talk about health systems and governance—A comparative assessment of nine countries in the WHO European region. Hum Resour Health 2024;22:83. https://doi.org/10.1186/s12960-024-00965-2.