ISSN: 2318-8413 DOI: 10.18554/refacs.v8i0.5028 REFACS

Social Work in health in Portugal and the challenges of Covid-19

O Serviço Social na saúde em Portugal e os desafios da Covid-19

El Trabajo Social en la salud en Portugal y los desafíos del Covid-19

Received: 12/07/2020
Approved: 08/11/2020
Published: 13/11/2020

Maria Irene Carvalho[1]

This is a reflection carried out between May and July 2020, considered 28 documents, and which aimed to present the practice of social health workers in the context of Covid-19 in Portugal. The following topics were addressed: *Relationship of Social Work with the health system in Portugal*; *The National Health Service and the right to health: what do we have ?*; *Consolidated competences of Social Work in health*; *What has changed in the Social Health Service with Covid-19?*; *Social Work in a hospital context*; *Social Work in the integrated continuous care policy*; and *Before and after Covid-19*. Covid-19 changed the routines and practices of social workers, posing challenges that have never been experienced before. These professionals became public health agents, communicating, informing and mediating the responses of health institutions with the responses of the community. The use of new technologies enabled teleworking and intervention, changing the intervention processes. In turn, social workers were more oriented towards meeting the emergency needs of the pandemic and less towards promoting human and social development.
Descriptor: Social Work; Health; Coronavirus infections.

Esta é uma reflexão realizada entre maio e julho de 2020 considerado 28 documentos e que teve como objetivo apresentar a prática do assistente social em saúde no contexto da Covid-19 em Portugal. Abordou-se as seguintes temáticas: *Relação do Serviço Social com o sistema de saúde em Portugal*; *O Serviço Nacional de Saúde e o direito à saúde: o que temos?; Competências consolidadas do Serviço Social na saúde*; *O que mudou no Serviço Social da saúde com a Covid- 19?; Serviço Social em contexto hospitalar; Serviço Social na política de cuidados continuados integrados;* e *O antes e o depois da Covid-19*. A Covid-19 alterou as rotinas e as práticas dos assistentes sociais colocando desafios até agora nunca experienciados. Estes profissionais tornaram-se agentes de saúde pública, comunicando, informando e mediando as respostas das instituições de saúde com as respostas da comunidade. O uso das novas tecnologias possibilitou o trabalho remoto e a intervenção, alterando os processos de intervenção. Por sua vez, os assistentes sociais, se orientaram mais para a satisfação das necessidades emergenciais da pandemia e menos para a promoção do desenvolvimento humano e social.
Descritores: Serviço Social; Saúde; Infecções por coronavírus.

Esta es una reflexión llevada a cabo entre mayo y julio de 2020 considerando 28 documentos y destinada a presentar la práctica del trabajador social en salud en el contexto de Covid-19 en Portugal. Se abordaron los siguientes temas: *Relación del Trabajo Social con el sistema de salud en Portugal; El Servicio Nacional de Salud y el derecho a la salud: ¿qué tenemos?; Competencias consolidadas del Trabajo Social en la salud; ¿Qué ha cambiado en el Trabajo Social en la salud con el Covid-19?; Trabajo Social en el contexto hospitalario; Trabajo Social en la política de cuidados continuos integrados;* y *El antes y después del Covid-19*. El Covid-19 ha cambiado las rutinas y prácticas de los trabajadores sociales, planteando retos nunca antes experimentados. Estos profesionales se han convertido en agentes de salud pública, comunicando, informando y mediando las respuestas de las instituciones de salud con las de la comunidad. El uso de las nuevas tecnologías ha hecho posible el teletrabajo y la intervención, cambiando los procesos de intervención. A su vez, los trabajadores sociales estuvieron más orientados a satisfacer las necesidades de emergencia de la pandemia y menos a promover el desarrollo humano y social.
Descriptores: Trabajo social; Salud; Infecciones por coronavírus.

1. Social Worker. Master and PhD in Social Work. Associate Professor at the Social Service and Social Policy Unit at the Higher Institute of Social and Political Sciences at the Universidade de Lisboa, Portugal. ORCID: 0000-0002-1921-3212 E-mail: mcarvalho@iscsp.ulisboa.pt

INTRODUCTION

Covid-19 is a disease caused by the SARS-COV-2 coronavirus. These viruses cause a variety of diseases in mammals and birds, such as enteritis in cows and pigs, upper respiratory diseases in chickens and potentially lethal respiratory infections in humans[1]. SARS-COV-2 was unknown until recently as an agent of human disease. In December 2019, this particular type of coronavirus appeared in humans at a fish market in the city of Wuhan, China.

The disease caused by the novel SARS-COV-2 coronavirus (DGS, 2020a) was named COVID-19[2]. In February of 2020, this virus had already infected at least 11,844 people in China[3], becoming an epidemic. From an epidemic, it quickly spread to a pandemic state.

A state of pandemic was declared by the World Health Organization (WHO) on March 11, 2020. A pandemic requires the elaboration of a conceptual framework for global governance and requires public health promotion activities that imply the exercise of authority[4].

Most countries in the world have combined public health policies with other measures, such as closing border and issuing emergency measures that have resulted in forced quarantine for all citizens, except those who perform functions in essential areas of health, security and food[2]. These measures seek to protect citizens and, above all, the sustainability of health systems, taking into account logistical and professional resources of each country. Thus, this study aims to present the practice of social health workers in the context of Covid-19 in Portugal.

METHOD

This is a reflection carried out between May and July of 2020, on the main historical and evolutionary milestones of construction of the health system and Social Work in Portugal, pointing out the changes that occurred after Covid-19, notably in professional hospital practices and care integrated.

Reference documents and articles in the area were used as basis, as well as laws, decrees and contingency plans for Covid-19, in addition to other documents about the health system in Portugal.

The law of integrated continuous care and the emergency plans for Covid-19 stand out as the specific emergency plans for hospital health and integrated continuous care[2,5].

RESULTS

For this reflection, 28 documents were used and focused on seven thematic areas, namely: *Relationship of Social Work with the health system in Portugal*; *The National Health Service and the right to health: what do we have?*; *Consolidated competences of Social Work in health*; *What has changed in the Social Health Service with Covid-19?*; *Social Work in a hospital context*; *Social Work in the integrated continuous care policy*; and *Before and after Covid-19*.

DISCUSSION

Relationship of Social Work with the health system in Portugal

The emergence of the Social Services in Portugal is influenced by leading figures in medicine, especially from the Escola Nacional de Saúde Pública, from the legacy of Ricardo Jorge and Sousa Martins, Silva Carvalho, Alfredo da Costa and others[6].

At the end of the 1920s and due to the Spanish flu pandemic in Portugal, these and other prominent figures in social medicine started a campaign for the institutionalization of social professions (social workers and social workers) and nursing[6].

In 1926, a decree reorganized public health services and considered it essential to create a special corps of visiting nurses for infectious diseases. In this context, courses were developed to train health visitors, both in childcare posts in Lisbon and in medical schools[6].

In 1935, the training of social workers at the Escola de Serviço Social de Lisboa started. The training time was three years (with legal and social preparation to occupy management functions in companies, medical social and childcare services, and others), thus separating from the training of health visitors at the Instituto Ricardo Jorge, with preparation for the anti-epidemic fight, childcare and social surveys[6].

In the preface to the work: *O diagnóstico Social de Mary Richmond*[7] of 1946, there is an indication that, in 1940, social workers exercised their profession in: Assistance Inquiry Centers, at Santa Casa da Misericórdia de Lisboa, at the Family Assistance Institute; Oncology and Maternal Institute; Health centers; Dispensaries in the fight against tuberculosis and fight against air pollution; Social Medical Services of Social Security Funds; Centers for combating rheumatism; High schools, hospitals, cardiac care; Minors' chains and tutorials.

From the 1940s onwards, social workers began to insert themselves into the hospital structures that had been built, such as the Hospital Universitário de Coimbra (1941), the Hospital Júlio de Matos (1942) and the Instituto Português de Oncologia de Lisboa (1948)[8].

The insertion of these professionals in a hospital environment continued in the following decades with the promulgation of the hospital organization law, Law No. 2011 of April 2, 1946[6,8]. This law typifies health responses: central, regional and sub-regional hospitals; consultation and assistance posts; convalescence and readaptation centers; hospices; mobile brigades of assistance, assistance and placement of patients; specialized hospitals for treatment of infectious diseases, children's diseases and others. In the same law, Social Work was considered to be an integral part of hospital services, and the State was responsible for providing assistance to private initiatives [...] intended to prepare nurses, assistants, visitors and other Social Work agents.

In the 1960s, social assistance separated from health, as pointed out in Law No. 2120, of July 19, 1963[8]. In this law, it is assumed that hospital activity should be coordinated, in order to integrate central, regional and sub-regional hospitals, consultation posts, convalescence centers, emergency rooms and auxiliary services into a functional plan. Special attention was also given to the creation of medical, pharmaceutical, social work, nursing and administrative careers.

In 1968, the Hospital Organization Law recognizes again that hospitals have both a medical and social aspect, with Social Services included in assistance services, which competence was: collaborate with medical services in the study of patients, support the understanding of social causes and consequences of diseases; whenever possible, intervene in states of crisis or lack of patients, establishing contact with internal and external services appropriate to each case[9].

In 1971, the health and assistance system was reformed, with the first draft of the future National Health Service appearing. Decree-Law No. 414/1971[10], established the legal regime that allowed the progressive structuring and regular functioning of careers, namely that of Social Work. In 1973, the Ministry of Health created under Decree-Law no. 584/1973[11], of 6 November, created Social Assistance. In 1974, Social Assistance was integrated into the Ministry of Social Affairs[9].

The National Health Service and the right to health: what do we have?

The creation of the National Health Service was decisive for the construction of the public and universal health system, considering health as a fundamental human right. The democratic revolution of 1974 allowed for the construction of the first National Constitution, which instituted the right to health, followed in the next years by the construction of the National Health Service published in Law No. 56/1979[12]. This law created and modernized health and challenged social workers to intervene in the health system.

During this period, there were a series of changes in the health system and in Social Work in health, one of the most important of which was the publication of the statutes of health centers in 1983, in Normative Order No. 97/1983, of 22 April[13], which defined the number of

social workers (SW) per inhabitant (one SW per 30,000 inhabitants) and their duties, namely: participate in definition, implementation and evaluation of health policy; cooperate with all health center services aimed at the individual, family and community; collaborate on health education projects, especially food, family planning, alcoholism and drugs; participate in recovery and rehabilitation; and monitor patients admitted to nursing homes; in addition to coordinating actions of volunteers[13].

However, in 2000, the reform of Primary Health Care places Social Work in the Shared Assistance Resources Unit, configuring some of these competences of community intervention.

From this moment onwards, social workers carry out activities in numerous areas and services, highlighting the activities in support of FHU (Family Health Units) and PHCU (Personalized Health Care Units), in the area of Family Health, and ensure the Citizen's Office[6].

In the area of community health, they perform functions in: Integrated Continuous Care Teams, School Health and Public Health Projects. They also include: Children and Youth Protection Commissions, Local Early Intervention Teams, Social Network, Social Insertion Income, Functional Coordinating Units (*Unidades Coordenadoras Funcionais - UCF*), Adult Violence Prevention Teams (*Equipes de Prevenção da Violência no Adulto - EPVA*); The Support Centers for Children and Youth at Risk, Refugee Support Centers, Palliative Care Support Teams, Parenting and Childbirth Preparation, National Registry of Vital Will, National Registry of Non-Donors, in addition to technical advice to the Executive Board ACES and its Clinical Council[14].

In hospitals, social workers are integrated into: Inpatient Services; Extern consult; Day Hospital; Emergency Service; Discharge Management Team; In-Hospital Support Team in Palliative Care (*Equipe Intra-Hospitalar de Suporte em Cuidados Paliativos - EIHSCP*); Citizen's Office; Ethics Committee; Quality and Humanization Commissions; Functional Coordinating Units for Maternal, Neonatal and Child and Adolescent Health (*Unidades Coordenadoras Funcionais de Saúde Materna, Neonatal e da Saúde da Criança e Adolescente - UCF*); Adult Violence Prevention Teams (*Equipes de Prevenção da Violência no Adulto - EPVA*); Support Groups for Children and Youth at Risk, among other sectors and assistance services[14].

In 2006, the integrated care network was created to ensure continuity of care at home. In this way, the work of social workers in integrated care networks is defined in Decree-Law No. 101/2006, which includes a support team for national coordination. Social workers are part of the Regional (*Equipes Regional - ECR*) and Local Coordination (*Equipe de Coordenação Local - ECL*) teams of home care, Hospital Discharge Management Teams, Care Providers Units, and Integrated Continuous Care Home Teams, under the responsibility of the Health Care area. Primary Health[14].

Other services were created such as: Palliative Care Network that integrates units and teams both in hospitals (Inpatient Palliative Care Units and Clinical Services Consultation Teams) and in Health Center Groupings - ACES and Community Support Teams in Palliative Care, and are also part of the National Commission for Palliative Care. Social workers are also part of mental health teams in: psychosocial rehabilitation, hospitalization, community intervention and intervention in addictive behaviors and dependencies[14].

Social Work contributes to the health of populations by orienting intervention to the needs of the patient, taking into account the environmental and contextual impacts on health and well-being, namely: health promotion, disease prevention, primary care, care in situations acute, specialized care (maternal and child health, HIV/AIDS, mental health, addiction and others), rehabilitation and integration at home and in community networks, long-term care and palliative care. Currently, there are 1032 social workers working in the National Health Service, divided into hospital care (52.4%) and primary care (42.9%).

Consolidated competences of Social Work in health

Social Work is an area of knowledge in the social sciences that is influenced by social and health issues, by guidelines of the policy and development of health systems, as well as by roles assigned and achieved by the profession[15].

For Social Work professionals, it is important to understand that health is a "state of complete physical, mental and social well-being and not just the absence of illness or infirmity"[16]. This notion of health refers to the situational condition in which people find themselves and to their physical, mental and social well-being. So, health means not only the absence of disease or illness, but a process of optimizing opportunities, and it should be understood as a resource for life and not as a positive concept, which emphasizes social, personal and, of physical capacities[6].

Social workers are challenged by this notion of health and by social determinants, that is, by structural aspects and policies, having responsibilities in the prevention of health problems and in promoting health of populations. Social determinants refer to circumstances in which people are born, live and work, in addition to the systems in place to support health care. These circumstances, in turn, are shaped by a broader set of economic forces and social policies[17].

Health is a central dimension of people's lives, which must be recognized and supported as a fundamental human right and an instrument for the promotion of peace in the world. As such, it is essential to guarantee universal access to health resources, including disease prevention and health promotion.

For Social Work, health is a matter of human rights and social justice, as people have the right to enjoy social conditions for human health and access services and other resources to promote health[18]. These principles are not always implemented, given the conditions of economic, social and cultural inequality, which influence access to health care, resulting in health inequities[19].

Within this framework, the International Federation of Social Work (IFSW) has defined some principles by which professionals should practice health professions: act in training, research and policy formulation; consider the right to health by reinforcing people's participation in defending equitable distribution of resources that sustain health, including minimum income, food security, drinking water, adequate housing, clothing, education and sustained relationships[18]. Local, national and global health and social policies are fundamental for promoting the health of populations, and it is necessary to develop interconnected actions between international institutions, governments and civil society[6].

Social Work was inserted in the health field with merely emergency and assistance skills. However, when assuming the right to health and with the creation of the National Health Service, its competencies have started new opportunities, for the fair distribution and resources and for reduction of health inequities. Currently, professionals develop preventive, diagnostic, therapeutic and rehabilitation services for the promotion of well-being and health, with various services in the health system, namely: public health, primary care, specialized care, social health care, and emergencies[20]. In the set of functions of social workers in health, the following stand out[21]:

- Provide information on rights and act as defenders of patients and families in the health system - Social advocacy;
- Develop communication processes with patients and families by becoming professionally involved with them, listening to their concerns empathetically and without judgment, demonstrating knowledge and competence about the social impacts of the disease on the patient/family and communities;
- Promote active listening processes, where they are privileged actors in listening to patients and families, especially in their concerns related to health and health care, namely: continued care for death and dying, in sadness and loss, in sexuality, in mental health and relationships;
- Carry out internal and external mediation processes, with intercession between the various roles and expectations from the health team, the patient, the family and the outlined intervention plan;

- Participate in discharge planning, for the return of patients to their home or other social and health response, relocating patients to the community, articulating and coordinating resources and support from the community and providing support and assistance to caregivers or other family members;
- Promote access to support services in the community and act as mediators in facilitating access to community services, between patients and family members and between patients and the health team;
- Participate in the management and promotion of the effectiveness of health services, since discharge planning is seen as a key dimension to reduce the length of stay in hospital and potentially prevent the readmission of patients;
- Develop health education processes and participate in these actions in multidisciplinary work groups;
- Participate in humanization of services, in the control of hospital infections, in the integrated continuous care network, among others;
- Carry out interventions in crisis situations that generate problematic behaviors, which is an increasing part of their role;
- Perform other functions, especially tasks essential to achieving access to health that other professionals do not wish to perform.

To exercise these functions, in addition to specific disciplinary skills, professionals must have knowledge of: the medical field in which they are practicing their profession; health systems; health inequities and health disparities in relation to social determinants of health; on topics associated with loss, grief and death and also knowledge that allows providing a biopsychosocial-spiritual perspective to health care. But also knowledge about strategies to create and support other health service providers, management and coordination and supervision of the team, conflict management, facing not only the social and emotional needs of patients but the multidisciplinary health teams.

What has changed in the Social Health Service with Covid-19?

In any pandemic situation, it is important to follow the recommendations of the World Health Organization (WHO)[2,22]. This international agency recommends that countries develop a strategic orientation plan for the health sector. Thus, with the guidelines of the World Health Organization and the European Center for Disease Prevention and Control as references, the Directorate-General for Health in Portugal adopted early on "a strategic tool for preparing and responding to a potential virus epidemic" called the *Plano Nacional de Prepapração e Resposta para o COVID-19*[5] (National Preparedness and Response Plan for COVD-19). This plan outlines three phases to deal with a pandemic: the preparation phase, the response phase and the recovery phase. At the same time, on March 18, 2020, the State of Emergency was decreed, which was in force until May 2, following the state of calamity[23].

In this context of public health emergency and crisis, it is important to highlight the role that Social Work professionals, as well as professional associations, have in this type of situations. Thus the International Federation of Social Work (IFSW)[18] has warned of the need for measures directed to Social Work professionals, especially those on the front lines in order to combat the spread of the disease and support communities that are affected or afraid of the COVID-19. For this association, this implies working at several levels[24]:
- Decisions are made to defend the involvement of the community (along with other professionals) in planning, safety protocols, as well as supporting people with anxiety and in social isolation to keep calm;
- In the dissemination of adequate information and facilitate contexts, in which, people act in solidarity;
- In protecting and supporting the most vulnerable groups included in the planning and responses;

- In the participation of the community organization to ensure the availability of essential goods such as food and drinking water;
- Assuming that social workers need to protect themselves and be active in their jobs.

Social Work professionals have a central role in prevention and mitigation, insofar as these professionals are agents of change, resource enhancers, contributing to act in crisis and overcome people's difficulties. The "professional has an active role in valuing the event and the actions taken at the level of the intervention process"[25].

The Association of Social Work Professionals has also made some recommendations, based on orders, ordinances and technical information from the Portuguese Republic, according to Order No. 2836-A/2020[26] and technical information 14/2020[27], and Code of Ethics for Social Workers in Portugal and in the recommendations of other professional associations and orders, such as the General Council of Social Workers in Spain, on intervention in an emergency context. These recommendations include specific measures in the area of health and teleworking[28].

In Portugal and with regard to the emergency health intervention plan for social workers, some topics are identified to minimize the social and economic impacts of the pandemic, namely:
- Assess psychosocial factors that interfere in the health of people, groups and communities with special attention to groups and situations identified as at risk and vulnerability;
- Provide treatment and support to large numbers of people, while maintaining essential health care;
- Support the continuity of health care and other essential services; maintaining confidence and security of the population, through the implementation of measures based on the best evidence.

The document of the Association of Social Work Professionals (*Associação dos Profissionais de Serviço Social - APSS*) also defines three strategic lines for adapting Social Work in the face of the emergency[28]:
- The first strategic line of the definition of intervention procedures in situations of prophylactic isolation defines a set of competences for those who coordinate, for those who are in direct action and or in teleworking in health units;
- The second strategic line of prevention in the community associated with the contingency of COVID-19 defines criteria for social intervention in view of the urgent social risk, especially for people who need support measures to ensure safe isolation or social exclusion, namely those who live alone, or without support network, exhaustion of caregiver, people in situation of dependency and disability, single-parent families without a network, people in situation of homelessness, domestic violence, among others considered on a case-by-case basis;
- The third strategic line of guidance for networking focused on the Emergency of COVID-19 focuses on intersectoral articulation and strengthening collaboration between services and the promotion of alternative community resources including those focused on remote monitoring[28].

Regarding teleworking, it is also recommended that professionals follow the next principles:
- Promote public health, adopting an exceptional type of work;
- Maintain professional practice of social workers, centered on the fundamental acts and of an emergency nature, favoring maintenance of continuity of activities and mission of organizations;
- Adjust professional acts of social workers to teleworking methodology;
- Promote coordination with teams from different organizations in order to speed up responses to the needs of users and the informal support network;
- Promote social detachment, protecting Social Service professionals, users and other professionals from the pandemic, reducing the risk of infection[28].

Also according to this document, and following the guidelines of the social workers 'code of ethics, intervention in this context must follow the principles of confidentiality, maintaining information security, with the professionals having added obligations when communicating information about users' processes by via electronic.

Social Work in a hospital context

Hospitals are at the forefront of combating the COVID-19 pandemic. The measures taken are numerous, but some are more relevant with an impact on Social Work, in particular:

- Information measures on the disease and forms of transmission and prevention were implemented, both for employees and for the general public;
- Intervention procedures were defined in situations of prophylaxis and preventive isolation in the community associated with COVID-19;
- Prevention equipment and products, masks, gloves, glasses, hospital gowns, among others, were made available;
- All training activities, internships, volunteer activities and scientific events were suspended;
- The circulation of non-employees were prohibited and non-urgent treatments and consultations were suspended and rescheduled;
- The number of visits to hospitalized patients was limited (at first) and the suspension of the number of visits to hospitalized patients (after the situation worsened) and telephone contacts or e-mails were disseminated for the population to contact hospital services;
- Services were restructured adapting them to this new reality, increasing the number of available beds in view of the increased need for hospitalization;
- In some hospitals, tents were installed to welcome and isolate patients with COVID-19.

These spaces can accommodate a maximum of 12 people. They will not be admitted to these tents because it is not a field hospital. In this space, cases are monitored that address emergency cases and are screened as potentially suspicious for the novel Coronavirus. These cases will be installed in a place created with comfort conditions while waiting for the results of the laboratory analysis.

- Transfers of patients from other Hospital Units in the Emergency Department were suspended;
- Retired doctors were hired without being subject to age limits;
- The work was readapted using teleworking whenever possible;
- Social Work has reorganized itself to: provide information to family members about the situation of hospitalized patients, preparing for discharge and the safety of the patient and family.

Social Work in the integrated continuous care policy

The Directorate-General for Health (*Direção Geral da Saúde - DGS*)[5] issued some guidelines for integrated care units (including residential structures for the elderly) to define measures to protect employees and particularly vulnerable people, the elderly and the sick. This document addresses some fundamental areas, such as:

- The creation of accessible information mechanisms is recommended, disclosing the contingency plan with self-care measures, for personal and family protection, keeping the information updated among all employees, collaborators and users;
- A multidisciplinary meeting was held to analyze the National Contingency Plan and promote an open debate on it;
- Clarified possible doubts on how to work together to develop an institutional contingency plan;
- Posters about COVID-19 and main precautions to be taken and placed in strategic points of the institutions (reception; entrance of each floor; dining room; offices of professionals);

- Clarification sessions developed focusing on the theme of COVID-19, its origin, how does it spread, what are the repercussions of it on daily life, what precautions to take and also what lines of support to contact in case of doubts health line 24 -SNS[24];
- General hygiene rules and respiratory etiquette were promoted, such as procedures for employees who have contact with the disease and disseminated individual protection practices for patients, the multidisciplinary team and the institution's employees (hand hygiene, respiratory labels and use of equipment personal protection - such as masks and gloves);
- Isolation spaces designed for users/other professionals infected (or suspected of being infected) with COVID-19 with the multidisciplinary team;
- Employees and employees with special needs were protected and absenteeism from employees and collaborations was taken into account;
- Measures were taken to restrict visits by family members and others to users, in order to prevent the spread of contagion, promoting alternatives for contact between family members and users - telephone, video calls;
- Suspended curricular internships in case they represent a risk/threat (source of contagion/spread of COVID-19);
- Measures taken so that employees and collaborators reduce the number of close contacts, while keeping the institutions functioning;
- Defined new schedules for employees, with 15 days of quarantine;
- Additional employees identified, training them to perform essential tasks, replacing others, and strategies and procedures defined in view of the absence of employees and collaborators, as well as considering the need to make the workplace and working hours more flexible;
- The director of the unit allocated resources to protect employees, collaborators and users to prevent the spread of the virus and to promote more frequent cleaning of the facilities and to provide advice at this level.
- Coordinate the plan in collaboration with external and community aid organizations and assess the impact on the institution and share good practices with other institutions.

These measures were not and are not easy to implement, because many of the Continuing Care Units do not always have human, logistical and other resources that make it possible to structure an emergency plan of this magnitude.

The main difficulties in this sector are the reorganization of the teams and the lack of materials for individual protection, due to the scarcity of human resources, especially considering the need to replace employees, due to isolation, and the difficulties in creating isolation spaces for patients and staff.

Before and after Covid-19

Before Covid-19, the issues that most worried social workers were privatization of public services and provision of services within the scope of the market that led to the dismantling of health systems. This change decapitalizes public services in economic terms and in terms of social capital and human resources, with the “flight” of health professionals from the public sector to the private sector.

Despite the idea of bankruptcy in the public health system, what is being seen is the increase in private companies that invest, making the health sector highly profitable. Social Work is challenged by this reality, mainly because the private sector does not guarantee a universal right. This structural change in health systems has an impact on the professional dynamics itself.

Health becomes a commodity that can be sold and bought, and its allocation is based not on necessity, but on the ability to pay, increasing health inequities. Thus, Social Work focuses on strengthening the individual responsibility of families, reinforcing the responsibilities of family members to care for their members in situations of illness.

Public services have become scarce and overcrowded. The increase in needs leads professionals to assume multiple roles, performing bureaucratic tasks, especially on the front

lines, to respond to immediate needs. This accumulation of tasks disqualifies other activities, such as: counseling or advocacy and integration into the community.

The length of stay of patients has decreased, increasing the pressure for continuity of care in the community. The economic crisis and this tension make it difficult to hire social workers. This process leads to the dissatisfaction of professionals, who are sometimes replaced by other professionals. On the other hand, health centers and hospitals in large centers, hospital centers or family health units were added, which made social workers closer to the target population to be served.

With the Covid-19 pandemic, state-funded health systems are challenged to respond to public health problems. The health system crisis became secondary, as the public system assumed the costs of the pandemic, refusing private partnerships, except for Covid-19 tests. Any patient with Covid-19 symptoms would have to go to a public hospital.

Social workers are at the forefront in combating the pandemic, especially in protecting patients with comorbidities. Social Work has been called not only for the disease prevention phase, but also for its mitigation, so that its competences have been reconfigured to become public health agents. Communicative skills were reinforced as well as the use of information technologies. This competence was developed to ensure that families were informed about what was going on with their families.

The articulation between institutional health responses and the community was strengthened, but their action became emergency and again "assistentialist", centered on meeting basic needs, but no longer outlines the social emergency, as it is embedded in the "outfit" of human rights. On the other hand, the realization of rights is no longer carried out "face to face", but organized through new technologies.

CONCLUSION

Health, like Social Work, is influenced by contextual and structural aspects, such as: economic crisis and structural adjustments of the neoliberal economy. The health system has undergone changes resulting from neoliberal policies centered on new public management, marketization with increased partnerships between the State and the private sector (intra-institutional and interprofessional work) and accountability, that is, in the evaluation and orientation for the quality of services and management for effectiveness.

There was an impact on the action of Social Work in health, since health policies started to be guided no longer according to needs, but according to social risk, evidence-based practice, centered on responsibility and personal empowerment and personalization of intervention.

However, in the last months of 2020, the biggest challenge has been intervention in the context of a public health emergency at Covid-19. Although some of these measures and functions reinforce the importance of the profession in health, they may not be the ones desired, as they focus on processes to satisfy emergency needs.

Covid-19 has impacts on all dimensions of people's lives and that is why not only public health measures, but social and economic measures are required. Social workers are challenged to question their emergency practices now and in the future, that more than such emergency practices, they must participate in the co-construction of policies in the short and long term to allow people and communities to thrive after the Covid-19.

This study focuses on the analysis and reflection on Social Work in health and, in particular, in the context of Covid-19, it presents limitations that result from the methodology used, that is, the analysis of documents. In order to effectively reveal this issue in more depth, it would be pertinent to approach the field of action, highlighting the reports of the experiences of these professionals. This will certainly be an opportunity for future investigations in the near future, since the pandemic entered the so-called second phase (in September of 2020) posing other challenges to the health system and professionals.

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CONTRIBUTION
Maria Irene Carvalho contributed with the outline, data collection and analysis, writing and revision.

How to cite this article (Vancouver)
Carvalho MI. Social Work in health in Portugal and the challenges of Covid-19. REFACS [Internet]. 2020 [cited in *insert day, month and year of access*]; 8(Suppl. 3):1086-1098. Available from: *insert access link*. DOI: *insert DOI link*.

How to cite this article (ABNT)
CARVALHO, M. I. Social Work in health in Portugal and the challenges of Covid-19. **REFACS**, Uberaba, MG, v. 8, p. 1086-1098, 2020. Suppl. 3. Available from: *insert access link*. Access in: *insert day, month and year of access*. DOI: *insert DOI link*.

How to cite this article (APA)
Carvalho, M.I. (2020). Social Work in health in Portugal and the challenges of Covid-19. *REFACS*, 8(Suppl. 3), 1086-1098. Retrieved in *insert day, month and year of access* from *insert access link*. DOI: *insert DOI link*.