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Rubery, Jill, Isabel Távora, Abbie Winton, Eva Herman, and Alejandro Castillo. 2025. "Bargaining on the Front Line: What Role Did Collective Bargaining Play in Protecting/Advancing the Interests of Front-Line Workers during the COVID-19 Pandemic?" *International Labour Review* 164 (3): 1–18. https://doi.org/10.16995/ilr.18856.

International Labour Review

Bargaining on the front line: What role did collective bargaining play in protecting/advancing the interests of front-line workers during the COVID-19 pandemic?

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Abstract. *Drawing on 12 case studies across 10 countries of how trade unions and collective bargaining institutions supported front-line workers in healthcare, social care and food retail, this article finds that pre-existing or new collective bargaining or social dialogue forums provided important avenues for employee voice on pandemic management. Trade unions also supported marginalized front-line workers through multiple tactics, though most initiatives predated the pandemic and often depended upon gaining active state support, which was not always possible. Trade unions were thus pursuing sword-of-justice objectives, though they were sometimes less open to revaluing front-line work already covered by collectively negotiated grading structures.*

Keywords: *front-line workers, COVID-19, collective bargaining, social dialogue, value of labour, healthcare, social care, retail.*

This article is also available in French, in *Revue internationale du Travail* 164 (3), and Spanish, in *Revista Internacional del Trabajo* 144 (3).

1. Introduction

The COVID-19 pandemic drew public attention to the position of front-line workers (FLWs), that is those who had to continue to work, often for longer hours or more intensively, to keep society and the economy functioning or provide care for those infected. Without FLWs, the sick could not be cared for and the population could not be fed or provided with basic utilities. FLWs were less likely than other workforce groups to face economic risks incurred through job and income losses. In many other areas, however, their experience was worse; they were more exposed to infection, faced extended working hours and intensified pressures at work and often encountered additional family problems. These ranged from isolation from their families owing to infection risks to increased care responsibilities caused by school and nursery closures or family sickness that had to be managed alongside intensified wage work. These workers thus needed support and protection during the pandemic, not only for themselves and their families but also to ensure that essential services did not collapse. This spotlight during the pandemic on FLWs also revealed the poor working conditions and low value accorded to some essential services (Eurofound 2022a; ILO 2023; Samek Lodovici et al. 2022).

The pandemic experience therefore presented collective bargaining actors with a range of issues relating to FLWs, from pandemic risks to poor pay and conditions, that they could be expected to address. As Behrens and Pekarek (2023, 127) argue: "The pandemic is akin to a stress test for these IR [industrial relations] institutions, enabling us to study their protective effects under conditions of exceptional uncertainty." If collective actors cannot step up in a crisis, then what is collective bargaining actually for? As FLWs faced some of the greatest workplace challenges during the pandemic, it is important to investigate whether collective bargaining institutions and trade unions met this specific challenge.

There are parallels here with the insider–outsider debates over trade unions' roles and their impact on labour markets. The key issue is whether they are developing their role as a sword of justice, as Gumbrell-McCormick and Hyman (2013) argue is essential for both overall equality and trade union renewal, or are being forced back into a narrower role as protector of insider interests, thereby exacerbating labour market dualism (Palier and Thelen 2010). This debate has primarily focused on trade union actions to extend collective protections to precarious or atypical employment groups. These, as Gumbrell-McCormick and Hyman (2013) argue, may take multiple forms, involving multiple actors from traditional and new forms of collective worker representation. Research has increasingly shown that union actions may be less a function of their orientation and more dependent on opportunities to draw on supportive institutions and resources so that different routes to solidarity and labour market dualization can be identified (Carver and Doellgast 2021; Doellgast, Lillie and Pulignano 2018). Consequently, variations can be expected across sectors, industrial relations systems and national contexts.

The issue of support for FLWs links to but also differs in some respects from the debate on precarious work. Some FLWs, such as private sector social care workers or retail workers, are on precarious contracts outside collective regulation or covered only by weak collective agreements. Others, such as nurses, may usually be considered insiders, covered by collective bargaining or by state-regulated employment. Therefore, action to improve the position of FLWs may involve both extending collective and regulatory coverage to more FLWs and challenging the valuation of FLWs' labour within existing collective agreements and regulated structures. Furthermore, as the state either directly controls or funds some key FLW segments, the policies and actions of the state have key importance, especially during a pandemic.

There have been several major reports on the conditions experienced by FLWs in the pandemic – by policy bodies (Eurofound 2022a; ILO 2023; Samek Lodovici et al. 2022) and by researchers investigating inequalities in FLWs' experiences, particularly by age, race, migration status and gender (EHRC 2022; Purkayastha et al. 2021; Reichelt, Makovi and Sargsyan 2021). In contrast, academic research on collective actors' efforts to protect FLWs has been limited. The emerging employment relations literature on pandemic responses

has mainly focused on national-level developments or general comparisons between organized and non-organized workers. For example, Brandl (2023) explores the growth of tripartite dialogue during the pandemic, even in some countries with limited traditions of national social dialogue. However, this dialogue sometimes appears to have been used more to develop a sense of national unity in uncertain times than to negotiate specific policies. Meardi and Tassinari (2022) consider how experiences during the pandemic in relation to nationally coordinated collective bargaining and social dialogue compare with previous experiences during crises, particularly the financial crisis. They find that, in contrast to the normal social dialogue focus during crises on cutting jobs and costs, the COVID-19 crisis provided "trade unions with discursive resources opening up opportunities to move from the concession bargaining of previous decades to more assertive roles" (Meardi and Tassinari 2022, 83). Behrens and Pekarek (2023) make a similar argument, namely that the pandemic revealed the capacities of collective actors to step outside their standard wage bargaining and job protection roles to address wider protective issues. Their analysis of a large survey of individuals' pandemic experiences finds that those in organizations with a collective voice – whether through works councils or collective bargaining – received better and more active protection than those in organizations without formal voice mechanisms. They also find that FLWs were particularly vulnerable to being employed in sectors or firms without such mechanisms.

Comparative studies across countries of responses by collective bargaining institutions to the pandemic have found rather mixed evidence. For example, a Eurofound (2022a) report covering ten European countries finds innovation to have be mainly related to healthcare issues and telework, while the seven-country review by Molina and Pedersini (2022) observes highly varied collective bargaining responses, with limited action to support FLWs beyond those employed in public sector healthcare. Molina and Pedersini (2022) note only two exceptions: Belgian trade unions' efforts to raise social care wages to the level of healthcare workers' wages, and the higher wage rises negotiated for low-paid workers in German collective agreements. A report for the European Parliament (Castellazzi 2022) also highlights the new collective agreement for social care workers with the voluntary care sector employers in Germany. Another Eurofound (2022b) report, this time on the health sector, finds that pre-existing forums of collective bargaining and social dialogue were associated with negotiations or consultation over pandemic arrangements. However, some pre-existing forums were bypassed and, in some countries, new forums emerged where they had been absent before the pandemic.

The study we draw on here, commissioned by the ILO to provide supporting material for its report on collective bargaining throughout the COVID-19 pandemic (ILO 2022), investigated the underexplored roles played by collective bargaining actors in supporting and protecting FLWs during the peak pandemic phase and its immediate aftermath. The project addressed the overarching question of what role collective bargaining played in protecting FLWs in healthcare, social care and food retail, focusing on three core front-line occupational groups: nurses, care workers and retail assistants. These sectors had diverse collective bargaining arrangements: healthcare was covered by sector-level bargaining or by statutory regulation; social care often involved unorganized private sector providers; and food retail was partly covered by company or store-level agreements. The study also had a wide geographical coverage, with 12 case studies (4 per sector) spread across 10 countries spanning Africa, Australasia, Europe and North and South America.

Critical to any assessment of employer and trade union actions during the pandemic is the role of the state in shaping the context in which collective bargaining for FLWs had to operate and in acting as a constraint on or as an enabler of solutions. Although always a key influence on employment relations, the state's role takes on even greater importance where it is both the funder and sometimes the employer, as in much of healthcare and social care, and when in a crisis it has ultimate responsibility for the delivery of vital services. Moreover, during the pandemic the state's adopted policies shaped the context in which FLWs were working; these ranged from emergency powers to restrict workers' rights to

policies on childcare provision or sickness protection. Thus, although the study for the ILO primarily focused on collective bargaining, its scope in practice encompassed all forms of social dialogue and trade union action or influence that were encountered. The case study analysis required a comparative understanding of the strengths and weaknesses in collective bargaining institutions – at the national level and in FLW sectors – as well as the capacities and orientations of the state, from chaotic to hostile to supportive, in regard to both collective bargaining and the position of FLWs. This approach provides a wider focus on how collective actors could influence the response to the pandemic and thereby mitigate its impact on FLWs. At the same time, it also recognizes the roles played by the state and employers in constraining or supporting actions to protect and improve conditions. That wider perspective is used here to deepen the analysis of trade union actions to support FLWs.

Our analysis thus addresses two main issues. First, it considers whether extant collective bargaining structures for the FLWs in question passed the stress test (Behrens and Pekarek 2023) by facilitating dialogue and/or delivering additional protections to their FLWs and also whether the pandemic opened up new opportunities in relation both to bargaining topics (Meardi and Tassinari 2022) and to new forums for social dialogue (Brandl 2023; Eurofound 2022b).

Second, it draws on and contributes to the dualization and insider–outsider debates by exploring whether, in these FLW case studies, trade union responses followed an inclusionary sword-of-justice path or a vested-interest exclusionary approach to both protection rights and the value of labour. Variations in actions and outcomes are explored in relation to the roles played by both collective bargaining institutions (national and case-specific) (Doellgast, Lillie and Pulignano 2018) and the state, as enablers of or constraints on union strategies to develop more inclusive arrangements.

2. Methodology

The study involved 12 case studies across 10 countries, 4 in each selected sector of healthcare, social care and food retail, these sectors being chosen for their central importance in the pandemic and their divergent organizational, ownership and collective bargaining structures, or lack of them.

Owing to the project's constrained timetable, cases had to be identified, undertaken and written up between March and June 2021. Cases were identified from online reports, newspaper articles, ILO databases and advice from international trade union organizations on where collective bargaining was believed to be active in managing the pandemic and protecting FLWs. The final selection was made in conjunction with the ILO to achieve as wide a geographic diversity as possible. The research focused on the specific cases and the key agents involved, some of whom were identified through social media. Interviews were conducted remotely with social partners, policymakers and key informants. In total, 44 case study experts and key actors were interviewed, plus several experts from international trade union organizations. Both trade unions and employers were always invited for interview, but whereas trade unionists were interviewed in all cases (29 interviews), employers were interviewed in only 6 cases (11 interviews) and policymakers and experts in 3 cases (4 interviews). Although the employers' response was disappointing, the focus here is on trade unions' responses to the pandemic and their efforts to protect FLWs. This focus minimizes the significance of this sample imbalance. The intensive localized analysis was contextualized through analysis of secondary sources on national and sectoral collective bargaining and national policy regimes affecting welfare and other relevant protections for workers and including any new permanent or temporary COVID-induced support policies. Social media were used to monitor the outcomes of ongoing negotiations. The project also drew on doctoral research undertaken by two of the authors, which was updated and developed for the project.

The case studies provided a range of different product market structures and wage-setting institutions, as summarized in table 1. They revealed strong differences both among and within sectors, reflecting the different sectoral and national collective bargaining arrangements. In healthcare, the most regulated sector, public sector pay and conditions

Table 1. Context of case studies in health, social care and food retail

	Case study main focus	Industry characteristics	Pre-pandemic wage-setting system
Health			
Ireland	Public sector nurses	Most healthcare delivered in public hospitals, but private medicine offered in public hospitals (40% of population privately insured).	Healthcare workers covered by central public sector agreement (which is mainly also followed by private hospitals). National Joint Council for the health service (not pay bargaining).
Kenya	Public sector nurses in Kiambu county	Majority public sector provision but devolved to 47 counties.	Doctors and nurses negotiated national collective agreements in 2017, but only doctors' agreement was implemented. Agreements at national level need agreement at county level.
Portugal	Public sector nurses	Mainly public provision but decentralized; hospitals have some autonomy and contracts not issued under public sector law.	Public sector pay set by statute. Collective bargaining only allowed since 2008 and organized by occupation; no comprehensive agreement for nurses before the pandemic. Private hospitals agreements mainly follow the public sector.
Slovakia	Public and private sector nurses	Mix of public (60%) and private provision and insurance.	One collective agreement for public sector, one for private sector, for health professionals only. Since 2015, pay has been mainly set by a legal mechanism.
Social care			
Ireland	Public sector social care workers	Mainly private and voluntary sector (public sector < 20%).	Collective public sector agreement (mainly minimum wage in private sector).
New Zealand	Public and private sector social care workers	Residential care mainly private; domiciliary care mixed.	Since 2017, pay equity agreement led by the government and trade unions has applied to both public and private sectors.
Norway	Public and private sector social care workers	Mainly public (private < 20%).	Collective agreements in both public and private sectors; private sector slightly lower pay.
United Kingdom (Scotland)	Private sector social care workers	Mainly private (public about 30% in Scotland, lower in England).	No collective agreements but a forum established to discuss possible sectoral bargaining. Contractors required to pay the Real Living Wage.[1]
Food retail			
Canada	Retail assistants in one large supermarket chain	Two large chains account for half of the market; multinational discounters for a quarter.	Fragmented collective bargaining; agreements often at store level and variations by province.
Chile	Retail assistants of a large multinational with 44% food retail market share	Four retail chains (multinational and local) have over 90% of the market.	Fragmented collective bargaining by company; separate agreements for each union within companies.
Hungary	Retail assistants in one medium-sized multinational supermarket chain	Large presence of multinationals in addition to some local retailers.	Limited collective bargaining in retail; one known company agreement.
United Kingdom	Retail assistants in one large supermarket chain	Four large chains account for 65% of market; multinational discounters for 18%.	Fragmented collective bargaining; some national company-level agreements but some companies not covered by collective bargaining.

Note: [1] A wage rate calculated and set by the Living Wage Foundation, which is based on the cost of living and is higher than the government-set national living wage (Baluch 2021).

Source: Authors' compilation.

were set by collective bargaining (Ireland) as part of a coordinated national bargaining system, by a legal mechanism (statute in Portugal) or by a combination (Slovakia), with private sector providers largely following the public sector. In Kenya, the 2017 national collective bargaining agreement for nurses had not been implemented before the pandemic, in contrast to the doctors' 2017 agreement, and still required ratification at the county level. This non-implementation of the nurses' agreement together with problems of unpaid wages, linked to Kenya's debt problems and the devolution of health responsibilities to its counties (Irimu et al. 2018; Onwong'a 2019), led to extended industrial action and protest before and during the pandemic. Public sector pay in Ireland and Portugal had been negatively affected by austerity policies after the 2008 financial crash, whereas the Slovakian state had been improving pay for nurses following major shortages and mass resignations.

In social care, collective bargaining covered public sector workers in all four cases, but in Ireland, New Zealand and Scotland most care work was done by a largely unorganized private sector. There was no collective bargaining in the Irish private sector. However, in Scotland, under its Fair Work Convention, a forum had been established before the pandemic to explore opportunities for sector-level bargaining. Meanwhile, in New Zealand in 2017, a new five-year pay equity agreement had been negotiated between the state and the trade unions, providing major pay increases. Norway had a much smaller private sector that was fully covered by the national coordinated bargaining system.

Food retail agreements existed in all four cases but were either company agreements (Hungary and United Kingdom) or below-company-level agreements (at the store level or the level of a group of stores in a region) (Canada and Chile). None was sector-level, in part because all four cases were located in countries with weak and fragmented collective bargaining, particularly in Chile, where multiple individual union agreements were found even at the store level. In Hungary, the case covers one of the last remaining collective agreements in retail, a consequence of the hostile environment for collective bargaining under the Orbán Government.

3. Findings

The first findings section maps the collective bargaining and/or social dialogue found in these FLW case studies for managing the pandemic, focusing particularly on whether it involved established or new and emerging forms of collective dialogue and/or involved new areas for negotiation and consultation. The second section considers the extent of action to improve FLWs' position through more inclusive protections and/or higher value of FLWs' labour.

3.1. Collective bargaining and social dialogue during the pandemic

In line with the Eurofound (2022b) health sector report, these case studies showed how pre-existing forums for collective bargaining or social dialogue enabled collective negotiation and consultation during the pandemic, thereby, for the most part, passing the Behrens and Pekarek (2023) "stress test" in demonstrating employment relations institutions' ability to step up to provide new forms of protection during crises. Existing collective bargaining forums provided mechanisms for crisis negotiations or consultations, although not all led to formal collective agreements. Some formally constituted forums were mobilized into more activity. For example, the Irish National Joint Council for the health service met weekly instead of every two months and negotiated three formal redeployment agreements for health workers, including nurses, as well as more informal arrangements. In Norway, the two centralized bargaining forums for the public and private sectors made agreements on the conditions for relaxing working-time regulations and other rights to address the pandemic situation under new emergency legislation. In food retail, formal agreements were made in the Chilean and Hungarian cases. In Hungary, existing good relationships were said to have been vital in securing an agreement, given the hostile environment for collective bargaining.

Elsewhere negotiations were more informal. In the Canadian supermarket case, this was in part because agreements could not be reopened before expiry, while in the UK supermarket the employer tended to implement agreed actions without waiting for a formal collective agreement. In both cases, the relationships formed through collective bargaining allowed issues to be raised and actions agreed that the company then voluntarily implemented.

As per Eurofound's findings, there were cases where the pandemic also led to new or temporary repurposing of embryonic social dialogue forums at the sector or company level. Thus, new national forums for social care that had been formed to negotiate the 2017 pay equity agreement in New Zealand (see below) and under the auspices of Scotland's Fair Work Convention to explore sector-level bargaining possibilities were mobilized, both formally and informally, to enable joint discussions and lobbying on the management of the pandemic.

Two examples of new social dialogue forums or collective bargaining were found in the Chilean supermarket and the Kenyan healthcare system. In the former, a new "all-union" consultative body was constituted to agree on changes needed in the pandemic; this was necessary because in Chile all collective agreements are between the employer and a single union; yet, several unions were active in the supermarket. In the Kenyan case, the pandemic also catalysed more social dialogue: three levels of tripartite working groups were formed to discuss pandemic management with different healthcare unions, but only the doctors' union was invited to the top-level strategy discussions, the nurses' union being involved only in lower-level committees. One county, Kiambu, finally negotiated a collective agreement for nurses; this came after major strikes and several years of failed national negotiations by nurses, caused in part by devolution to counties of the responsibility for healthcare (Tsofa et al. 2017). This agreement was said to have been facilitated by good relations at the county level between the Kiambu county government and the nurses' union.

However, as Eurofound (2022b) discovered, some existing tripartite forums and relationships were bypassed by the state. This occurred in healthcare in Portugal and Slovakia, resulting in limited discussion with unions or workers over the management of the pandemic and no real bargaining. Consequently, trade unions had to resort to campaigns and protest to have any influence on the management of the pandemic. Nevertheless, for the most part, collective bargaining institutions did help to promote opportunities for discussion and bargaining over new forms of protection needed for FLWs in the pandemic context.

Perhaps the most important stress test for collective bargaining institutions during the crisis occurred when states' emergency measures threatened standard worker employment protections or rights. In six cases, state emergency measures during the pandemic limited or cancelled some employment rights for FLWs. In Norway, an emergency law gave the state the power to reduce rights, but negotiations through the national collective bargaining institutions ensured both the protection of rights and that any agreed emergency measures were time-limited. This effective response was enabled by the institutionalization of collective bargaining and trade union rights in Norway. In Kenya, a memorandum of understanding was negotiated with the Central Organization of Trade Unions (COTU); although it provided some important protections (for example, mandated personal protective equipment (PPE)), it also suspended rights to collective bargaining. The nurses' union had not been consulted and left COTU in protest, and strikes continued. In Chile, the state used the emergency to suspend collective bargaining, but in practice this suspension was not enforced, after significant industrial action and protests. In Hungary, Portugal and Slovakia, emergency measures suspended some employment rights: in Hungary, employers were allowed to bypass the Labour Code and provide no rest days; in Portugal and Slovakia, health professionals were not allowed to resign or take leave, and in Portugal they could be redeployed. These measures were not successfully challenged at the national level. In Hungary, the food retail companies' collective agreement maintained rest days for its staff, in contrast to other supermarkets, according to the union interview. Collective bargaining actors thus played important roles in pushing back against these authoritarian threats and the weakening of rights, but with varying success.

The pandemic-oriented forums – in line with the findings of Meardi and Tassinari (2022) – did expand the issues for consultation and negotiation to include redeployment, working time, protection for those falling sick or needing to isolate and support for additional childcare responsibilities. These dialogues led to formal or informal agreements. However, where there was no actual social dialogue, unions were only able to campaign, in some cases successfully, for policy changes.

Examples of topics covered by formal agreements included in Norway whether COVID-19 should be considered an occupational disease (Pelling 2021), and in Ireland not only redeployment within the public sector but also potential transfers to the private care home sector to avert a major infection crisis. These agreements protected staff's terms and conditions, allowed exemptions on health grounds and ensured that all changes were temporary. Such early-stage trade union involvement resulted in high levels of trade union engagement with many aspects of pandemic management, including establishing a helpline to alert management to problems in PPE distribution and devising job descriptions for new roles in test and trace. However, unions were not involved in managing the pandemic within the private sector, since there was no collective bargaining or other social dialogue forum where they could engage.

Three more formal collective agreements on managing the pandemic focused on new topics. For example, the Kiambu county agreement for nurses brought them into the national health insurance fund, a benefit that had only been agreed nationally for doctors, as well as covering workers for health insurance injury benefits, providing access to enhanced life insurance, work injury benefits and accident insurance cover. It also ensured that new temporary hires would no longer be employed on worse conditions. This is the main example of a new agreement that came about partly to resolve ongoing major issues, including non-payment of wages, that were exacerbated and highlighted by the pandemic.

Both the Chilean and Hungarian supermarket agreements focused on the right to take time off, without immediate loss of pay, because of sickness or vulnerability to the virus or because of childcare responsibilities. In the Chilean case, the new forum negotiated a company agreement for paid time off for parents with children under two. This was in line with government guidance, but the agreement extended this provision to parents of older children if they faced challenging childcare problems. The Hungarian agreement provided for immediate income protection for those who were sick or needed to provide childcare because schools closed, but the hours had to be repaid over subsequent months. This reflected the Hungarian union's weak position owing to changes in the Labour Code under the Orbán Government (UNI Europa 2020).

In other case studies, mainly informal dialogue was facilitated by existing bargaining or new social dialogue forums, whether bipartisan or tripartite. In the UK supermarket case, unions reported daily negotiations over changes to working practices, an arrangement that facilitated rapid decision-making to keep up with the almost daily changing government guidance. The union effectively took on an advisory role on issues outside the scope of pre-existing collective negotiations, such as virus prevention measures. In line with other major food retailers, the supermarket implemented full-wage sick pay as a voluntary measure after discussions with the union. This was vital to control infection, since the statutory sick pay scheme provided the second-lowest protection in the European Union (TUC 2020). In the Canadian food retail case, this was not an issue, thanks to a relatively generous national, though temporary, COVID-19 sick pay scheme, but active discussion of PPE and other healthcare measures was facilitated by the relationships built between the employer and the union through collective bargaining.

New or emergent social dialogue institutions or forums provided important protections in four cases (Chile, Kenya, New Zealand and Scotland). In Kenya, the new tripartite consultative committees did enable some issues to be resolved early in the pandemic, such as providing healthcare workers with curfew passes to enable them to get to and from work. However, the labour shortage and unpaid wages problems were not resolved and strikes continued.

In Chile, the new all-union forum provided opportunities to discuss new shift and working-time arrangements in the company to adjust to reduced opening hours to contain infection. Unions reported that their concerns were listened to and informal agreements reached. The new tripartite social dialogue forum in Scotland under the Fair Work Convention highlighted the absence of health and safety protocols and, importantly, negotiated a scheme for full-wage sick pay, necessitated by the United Kingdom's very low statutory sick pay. This agreement led to the state setting up a fund to reimburse employers' expenditure, but employers were not obliged to implement the full-wage sick pay and the scheme was not universally utilized. In New Zealand and Scotland, the forums also enabled PPE issues to be raised. PPE became an important issue in New Zealand: trade unions reported having had to argue for equal attention to PPE in social care as in hospitals. The new forum in New Zealand also provided opportunities to negotiate informal agreements on the redeployment and reskilling of healthcare assistants to new roles in testing and vaccination.

In some case studies, trade unions claimed in interviews to have influenced government policies through campaigns where there were no negotiations or consultation. Health trade unions in Portugal and Slovakia claimed to have little choice but to campaign, since their established forums were effectively bypassed, any meetings being called only to inform unions and workers of new policies. Both sets of trade unions campaigned on the payment of bonuses (discussed in the next section) and for COVID-19 to be regarded as an occupational disease in order to give FLWs access to better sick pay and long-term support. However, this was only successful in Portugal. In another example of a failed protection attempt, the Irish trade unions sought to persuade the state to provide childcare for key workers, Ireland being one of the very few EU Member States not to do so. The campaign did lead to the Government exploring this option, but by that stage the childcare workforce opposed the reopening of care because of health risks (McGreevy 2020).

The lack of formal agreements may in part reflect the countries' general unpreparedness for a crisis of this type and the consequent emergence of new issues outside the normal bargaining agenda. However, voluntary agreements on measures were facilitated by the mutual interests of employers and unions on issues such as reducing infection risks. In many instances, the key problems lay with state policies and not with the immediate employer. Nevertheless, there were some instances of conflict, notably in Kenya, as well as examples where dialogue was bypassed in favour of top-down decision-making.

3.2. Responses by collective actors to pandemic-induced heightened awareness of FLWs' poor pay and working conditions

The pandemic both created new risks for FLWs and shone a spotlight on the relatively low value attached to their labour (Müller 2019; OECD 2020), even though they faced the greatest risk to their health (ILO 2023) and citizens had to rely on these workers for their basic survival needs. This context presented a significant opportunity for unions to take steps to remedy long-standing inequalities in FLWs' access to protections and appropriate pay.

Our focus here is on two key issues, namely the protection of FLWs during sickness and the value attached to FLW labour. These were two of the most highlighted inequalities in the treatment of FLWs. The public debate recognized the paradox that those most at risk of infection could have low sick pay entitlement and therefore might need to work when infected, further spreading disease. Likewise, there was increased awareness that the value attached to FLW jobs did not reflect their importance to national security. These were thus two issues on which trade unions could be expected to act in line with their sword-of-justice mission and in step with the public mood.

The lack of access among FLWs to decent sick pay before the pandemic mainly concerned private sector social care workers (except in Norway, where all had full sick pay), retail assistants and Kenyan nurses. However, in several cases (Canada, Ireland and, in part, New Zealand) this long-term labour market inequality for FLWs was taken off the pandemic social dialogue agenda because the state had pre-emptively provided much more generous sick pay, albeit restricted to the pandemic period and often to COVID-related absence.

Where statutory sick pay remained inadequate – in Chile, Hungary and the United Kingdom (including Scotland) – trade unions did take up the issue and were largely successful in securing better sick pay protection during the pandemic, thanks to the identified mutual benefits for employers and workers of better sick pay to limit infection. Nevertheless, improvements were limited to the duration of the pandemic. This was indicative of the weakness of company-level bargaining in retail in Chile, the United Kingdom and particularly in Hungary, where the negotiated income protection for those who fell sick had to be paid back in future unpaid hours. Here, the weakness was exacerbated by the state's hostility (Bernaciak and Trif 2023; Trif and Szabó 2023) to workers' rights and collective bargaining. In Scotland, the devolved Government was supportive of long-term change towards better sick pay in social care, but its scope for long-term action was restricted by its budget set by the UK Government. Only the Kenyan nurses in a single county were able to secure a more permanent agreement to be included in the national health insurance scheme to which doctors already had access. This was only achieved through protests and strikes by the nurses' union that began before and continued during the pandemic (Irimu et al. 2018).

A comparable picture emerged in relation to action on the low value attached to FLWs' labour. Our research revealed that employers tended to deflect attention from long-term undervaluation by offering short-term bonuses as a reward for extra – but presumed temporary – risks. This occurred in six of the cases, motivated in some cases by labour shortages during the pandemic. Bonuses in healthcare in Portugal and Slovakia and social care in Scotland were all introduced by the state without any collective bargaining. However, Slovakian trade unions claimed that this policy had been influenced by their six-month campaign for bonuses; and in Portugal, trade unions campaigned unsuccessfully against the narrowness of the criteria for eligibility and the limited nature of the bonus schemes. The motivation in Scotland to pay bonuses for social care and indeed healthcare was in part political, to differentiate the Scottish approach from the UK Government's (Northern Ireland and Wales also paid bonuses; it was only the nurses and social care workers in England who received no bonus). In contrast, the bonuses in food retail were mainly initiated by the employer, except in the Hungarian case, where they were part of the collective agreement. In Canada, these bonuses took the form of company premium rates – at around 2 Canadian dollars per hour. Unions campaigned for them to be extended or made permanent; they were unsuccessful, in part because collective agreements could not be reopened. Consequently, the bonuses lasted only two months, being used primarily when labour was in short supply. In the UK food retail case, the regular annual bonus was trebled in the first year of the COVID-19 pandemic but then abolished to help pay for a new wage agreement in 2021 (see below).

In general, there was little evidence among the cases of pandemic-led new initiatives to raise the value of FLWs' labour. Even when outcomes seemed positive, gains were either short-lived or driven by other motives. For example, in the Chilean food retail case, the supermarket's agreement to reasonable wage settlements during the pandemic was revealed to be intended primarily to smooth the implementation of a new policy to remove significant sales commissions from retail cashiers in order to reduce costs and enable flexible staffing based on multiskilling. Similarly, the UK food retail case appeared to provide a key example of an employer responding positively to pressure to raise the value of FLWs by agreeing to the union's long-term demand for a market-leading £10 an hour minimum rate (yet abolishing the annual bonus at the same time). This employer-driven initiative may, however, have been more aimed at problems of labour shortages and pre-empting national minimum wage increases. Indeed, the gains were short-lived, as the company's collective bargaining agreement has since failed to keep pace with the market as other retailers have increased wages at faster rates.

Despite the absence of entirely new initiatives to raise the value of labour, the changed context did facilitate the implementation of previous commitments to raise the value of FLWs' labour (or maintain it in a context of declining real wages). The new context in some

cases reduced state or employer opposition to implementing long-delayed commitments to raise the relative pay of some FLW groups. For example, the nurses in Kiambu county were finally able to gain the benefits negotiated in 2017 because at least one part of the state – the Kiambu county Government – recognized the need to implement the agreement, adopt a new progression and pay framework and pay unpaid wages. Although this advance was limited to one county, other counties in Kenya were considering following the Kiambu agreement at the time of the research. In Ireland, employer objections and some trade union misgivings about reopening job-grading issues had delayed a long-standing 2015 commitment to revalue low-skilled jobs in the public sector. The employers failed to raise further objections when social care staff were upgraded during the pandemic in fulfilment of the 2015 commitment. In Scotland, a commissioned report on the state of social care was published early in 2021 (Scottish Government 2021), and its recommendations, including exploring possibilities for sector-level bargaining, were accepted by the Scottish Government. This was expected, since pre-pandemic joint action by the Scottish Government and the trade unions had already led to an agreement to use public procurement to establish the Real Living Wage as the default minimum for private providers (Baluch 2021). However, the obvious pressures in social care during the pandemic smoothed the path to social dialogue to explore options.

In the cases of the nurses in Slovakia and the social care workers in New Zealand, long-term pre-pandemic commitments to adjust the value attached to FLWs continued to be respected during the pandemic, even when other public sector workers' pay was frozen. Following mass resignations by both doctors and nurses (owing to restrictions on strikes) and high rates of emigration to elsewhere in the European Union, the Slovakian state had conceded that very low wages inherited from the communist period were no longer sustainable. Revaluing had taken place from 2010 onwards (OECD and European Union 2022), notably in 2012 and after 2015, largely through legal mechanisms as new and revitalized trade unions increasingly turned to the state in preference to collective bargaining to bring about real and consistent change (Bernaciak and Trif 2023; Kahancová and Martišková 2023). The agreed formula for setting pay was respected during the first year of the pandemic, providing a significant above 7 per cent pay rise for nurses in contrast to the 0.3 per cent imposed in Portugal. Data from the Organisation for Economic Co-operation and Development (OECD) show that Slovakian nurses' remuneration rose by over 60 per cent in real terms between 2010 and 2020 (OECD and European Union 2022) and was 30 per cent above the average wage, whereas nurses' salaries have remained around the average wage in Portugal (OECD 2023), where the state has continued to freeze or offer very low increases in public sector pay. In New Zealand, the programme of five-year pay awards for social care workers, to deliver the up to 50 per cent pay increases set out in the 2017 pay equity agreement, continued to be respected while other pay awards were frozen. This agreement was negotiated following trade unions' success in taking and winning legal cases, one on payment for travel time and another to establish that revaluing social care labour on grounds of gender equity did not require a male comparator (Charlesworth and Heap 2020; McGregor and Graham Davies 2019). The state took action owing to its concerns over both gender equity and the severe labour supply problems, which were affecting delivery of an essential service. The employers acted only as observers of the negotiations.

Although there was limited evidence of trade unions initiating new actions during the pandemic to take advantage of public concern over the value attached to FLWs, the findings do not imply a lack of interest or action from trade unions in reducing inequalities in the value of labour. Taking into account activity before as well as during the pandemic, we can identify several cases where trade unions devoted both time and energy to revaluing FLW labour, in some contexts successfully. In a smaller number of cases, trade unions showed more caution about the potential disruption to established collective bargaining arrangements. This diversity of experiences supports the argument made by Gumbrell-McCormcik and Hyman (2013) that trade unions, even when facing "hard times", are taking

multiple forms of action intended to regulate and support those in more marginalized sectors. However, where union and collective bargaining structures are well established, there may also be cases of inertia or the prioritization of protecting the status quo, in line with the "vested interests" or "insiders" side of the debate.

In six key cases, trade unions had clearly taken lead actions to improve the value of labour and secured some tangible improvements. These did not always involve traditional collective bargaining. Instead, four main types of tactics were deployed, shaped by the industrial relations context: pursuing legal cases and public campaigning on pay equity and delivery problems to bring the state to the table to seek innovative solutions beyond what was possible through bilateral bargaining (New Zealand and Scottish social care); after exhausting collective negotiation, resorting to mobilization and protest through illegal strikes or mass resignations to gain the attention of the state (Kenyan and Slovakian nurses); exerting pressure on the company through many local strikes (Chilean food retail); and a partnership approach combined with a long-term campaign for a higher minimum wage, which stopped short of industrial action (UK food retail). These tactics had varying outcomes: success in the UK food retail case more probably reflected labour shortages and a related employer desire for good publicity than union strength; in Chile, the employer was offering higher pay rises to counter opposition to more internal flexibility; and in Slovakia, the increased reliance on the state to set pay may have enabled the bypassing of social dialogue in the pandemic, though the election of a more right-wing government also played a part (Molina and Pedersini 2022). Nevertheless, a significant revaluation of nurses was achieved. In some cases, outcomes were unclear. For example, in the Kenyan nurses' case, gains depended on whether the Kiambu agreements were copied elsewhere. In Scottish social care, what mattered was whether agreement would eventually be reached on establishing sector-level bargaining.

In three further cases – retail in Canada and Hungary and nurses in Portugal – the apparent lack of initiatives to improve the value of FLWs' labour may reflect weaknesses in the collective bargaining system rather than trade unions' lack of interest in or protection of insiders. In Canada, the increasing concentration of ownership in food retail had led to more fragmented bargaining, at the store rather than company level (O'Brady 2021), and the legally binding agreements limited scope for action during the pandemic, with most agreements not due for renewal. In Hungary, the hostile political environment had led to the retail trade union losing membership and collective bargaining opportunities. The union had asked for higher basic pay but was unsurprised by the rejection of this request, since other supermarkets were not engaging in bargaining. In Portugal, the main problems lay in the strong austerity policies imposed by the European Union. This led to real public sector pay cuts, including for already low-paid nurses. Trade unions had been trying unsuccessfully to agree a new career structure for nurses since collective bargaining was allowed in 2008, the doctors having signed an agreement in 2009. These problems were reinforced during the COVID-19 pandemic by state actions to suspend some employment rights, impose an effective pay freeze in 2021 and further postpone negotiations on the career structure.

In the remaining cases – Norwegian social care and Irish healthcare and social care – there are grounds for regarding some of the trade unions as having more limited interest in raising the value of FLW labour, owing to concerns about the impact of doing so on the future stability of current collective bargaining arrangements. These are thus cases in which vested interests possibly held more sway than sword-of-justice objectives, but interpretation is complicated by the very different contexts. In each case, the main unions' core concerns were not to disturb existing collective bargaining arrangements. In Norway, collective bargaining arrangements were relatively robust, covered the small private sector and had long-established low wage inequalities within and between sectors. In contrast, the Irish trade unions were in a position of weakness in several senses; the tripartite bargaining system had collapsed during the financial crisis and, although industry-wide collective bargaining for the public sector had been restored, it remained fragile (Maccarrone, Erne

and Regan 2019). Ireland had a large outsourced private domiciliary care sector that was almost entirely unorganized and unregulated except by legal minimum wages.

Although the Norwegian trade unions had a good track record of protecting the lower-skilled through high pay rates and extensive collective bargaining coverage, the absence of any apparent debate on revaluing FLWs was striking. In our probing of this issue with regard to social care workers, it emerged that job grading in both public and private sector agreements was based only on required qualifications, not on full job evaluation. The priority was to ensure that wage increases in the public and private sectors remained in parallel and that differentials should not change. Hence, when the nurses' union successfully negotiated a higher increase for nurses in the social care private sector, the other unions ensured that this increase was extended to all social care staff, front-line and others. This benefited the social care staff but did not address the issue of the right relative pay for nurses, even though nurses in Norway earn about the average wage, whereas in 25 out of 35 OECD countries, nurses receive higher relative pay (OECD 2023).

The Irish trade unions' clear priority was to retain the national bargaining system and therefore avoid any changes in pay differentials within the public sector agreement that could undermine the agreement in the future. This concern was long-standing; the nurses' union reported that it had taken 20 years (until just before the pandemic) to resolve their demand that nurses' pay be upgraded to reflect their higher skills and education and provide parity with paramedics. This objective had been resisted by other trade unions as well as employers on grounds that it would destabilize the collective bargaining agreement. Following a strike by the nurses, a solution was found that involved moving most nurses into a little-used existing job grade, thereby avoiding a full-scale regrading exercise. Similarly, the delay in fulfilling the 2015 promise to evaluate lower-skilled public sector workers' jobs reflected both opposition from employers and trade union qualms over disturbance to differentials. Perhaps most surprising was the apparent lack of any sustained trade union campaign to address the pay gap between the public sector and the mainly minimum-wage-paying private social care sector. The unions had been engaged in largely unsuccessful campaigns to limit insecure contracts (Murphy and O'Sullivan 2021), but there had been no significant action on wage levels. The unions appeared fatalistic and considered that an idea mooted during the COVID-19 pandemic to set up a Joint Industrial Council to set pay and conditions in social care was already a lost cause owing to employer opposition.

These findings support and extend the increasing evidence that trade unions have been taking a wide variety of actions to improve conditions in more marginalized sectors, albeit with mixed success. Most actions predate the pandemic, but the increased awareness of FLWs' societal roles during the pandemic may have protected the implementation of some pre-pandemic agreements to improve pay or smoothed the fulfilment of much-delayed promises. That said, there is also evidence that, where collective bargaining and trade unions were weak and fragmented or had been damaged by austerity policies, hostile new labour laws or debt-ridden public finances, trade unions were unable to pursue significant positive actions to improve the lot of FLWs. Moreover, in some institutionalized bargaining systems there was a reluctance – at least in two countries considered here (Ireland and Norway) – to countenance changing internal pay differentials between front-line and other groups. Three of the healthcare cases also revealed divisions among trade unions in addressing the undervaluation of nursing work and skills: in Slovakia, new trade unions were behind the mass resignations that finally led to revaluation; in Ireland, the nurses' union attributed the two-decade delay in revaluation to other trade unions as much as to the state; and in Kenya, the nurses' union left the federation of trade unions because it felt the nurses' case had not been properly supported. This suggests that fully addressing the inequalities perceived to be suffered by FLWs requires more than action to extend coverage and improve value for those considered outsiders; it also requires the willingness to question long-established internal wage structures – something some unions may be reluctant to do.

What also stands out from this cross-country and cross-sectoral analysis of trade union responses to the position of FLWs is the critical role played by the state. In Kenya, the ongoing strikes and labour shortages that were exacerbating the health pandemic proved difficult to resolve because of the twin problems of state debt and the division of responsibilities between national and county-level government. In Hungary, the state's political stance was to discourage any union-led improvements. In other cases, support from the state, particularly for FLWs delivering public services, was critical to making progress in ways that bipartite collective bargaining alone was unable to deliver. This does not mean that trade unions were fully subservient to the state's agenda: in the New Zealand and Scottish social care cases and the Kenyan and Slovakian nurses' cases, the trade unions played a vital role in bringing the need for improvements on to the state's agenda. However, progress could not be achieved without positive state support and intervention, albeit only at subnational level in the Kenyan and Scottish cases. The state had to be persuaded of the importance of the argument for improved conditions, whether for reasons of equity or the sustainability of the service, or both. Furthermore, reliance on the state to improve conditions runs the risk of weakening collective bargaining in the longer term, as researchers (Bernaciak and Trif 2023; Kahancová and Martišková 2023) warn in the case of Slovakia. This raises the long-standing debate as to whether state interventions, such as minimum wages, can be complements to or replacements for collective bargaining.

4. Discussion and conclusions

The analysis of these 12 case studies covering FLWs in 3 sectors across 10 countries fills an important gap in knowledge about the role played by collective bargaining and social dialogue in managing the pandemic in these sectors and in improving conditions for FLWs. In doing so, it also contributes to two important employment relations debates.

Firstly, it confirms, in line with findings for the industrial relations system as a whole (Behrens and Pekarek 2023; Eurofound 2022b; Meardi and Tassinari 2022), that both established and emergent collective bargaining and social dialogue institutions did provide important forums for employee voice, for raising new topics outside the pre-existing scope of bargaining or dialogue and for substantive agreements on how to manage the pandemic. They thereby passed the stress test of what collective bargaining is actually for and confirmed these institutions' capacity to repurpose themselves to address new crisis-related issues. The pandemic opened up new dialogue opportunities – for example, fostering tripartite relations in Scotland or overcoming constraints on cross-union collective bargaining in the Chilean food retail case. In all cases, the unions showed interest and initiative in either negotiating or campaigning (when this was the only option) on non-traditional topics such as health and safety, sick pay, PPE and new or temporary employment or working-time arrangements. This flexibility was found in both bipartite and tripartite forums. Owing to trust relations and mutual benefits, the agreed measures were not always formalized in an agreement but were immediately implemented by management. This demonstrates the importance of these institutions in a crisis and collective actors' ability to build on their established relations to address new topics. Nevertheless, it is also clear that opportunities to engage in constructive dialogue in a crisis are strongly dependent on state actions, as indicated by the bypassing of dialogue in the Portuguese and Slovakian cases.

The study also contributes in three respects to the wider debate on the tensions between the trade unions' dual role as promotors of social justice, on the one hand, and protectors of vested interests, on the other. First, it adds to the mounting evidence in employment relations literature that it is not valid to characterize trade unions and collective bargaining institutions as focused only on insiders; unions were widely engaged in pursuing inclusionary agendas to protect those in more precarious and low-paid jobs and used multiple tactics, from legal cases to formal campaigns and new forms of social dialogue to mass protests. These findings

fit the vision outlined by Gumbrell-McCormick and Hyman (2013) of eclectic responses by trade unions and other actors to the increasing challenge of precarious employment, requiring both path-specific and context-specific actions to construct more inclusive labour markets. In most cases, the trade unions had taken initiatives to protect or improve conditions for FLWs even if few new initiatives were identified as direct responses to the rising public awareness of FLWs and their working conditions during the pandemic. In part, this lack of new initiatives resulted from employers' and the state's strategies to take issues off the bargaining table by providing pandemic-related temporary improvements in both sick pay and earnings. The findings also reflect in some cases the weakness of the trade unions and the wider national or sector institutional context, whether this was the dysfunctional state and governance system in Kenya; the authoritarian, hostile state in Hungary; the legacies of neoliberalism and the fragmentation of bargaining structures, particularly in Chile but also in the United Kingdom; the fragmenting strategies of increasingly dominant multinationals in Canada; or the legacies of strong austerity policies in Ireland and Portugal. Only Norway had a strong autonomous collective bargaining system. In other cases, the weakness of bipartite collective bargaining led to strategies to engage the state to take measures that could not be achieved through bipartite negotiations alone.

This confirmation of multiple tactics and efforts to seek to extend protections to the more marginalized sits alongside evidence from Ireland and Norway that institutionalized collective bargaining systems may act as a constraint on actions to revalue the labour of FLWs already integrated in the collective bargaining wage structure. This was manifest in overriding concerns not to threaten the bargaining arrangements by changing occupational wage differentials. Thus the study's second contribution to the insider–outsider debates is to suggest that not all insiders may be treated fairly or equally relative to the value of their work and that the creation of more inclusive employment systems for FLWs may require greater willingness of trade unions to critically reassess the fairness of existing wage structures, even if negotiated, alongside the extending of protections to outsiders.

The third contribution is to highlight the need for debates on trade unions' role in promoting more inclusive labour markets in order to pay more attention to the interactions between trade union initiatives and the critical role of the state in shaping opportunities for significant change. It was the state that the trade unions relied upon to bring about marked change in the value attached to FLWs' labour in the social care cases in New Zealand and Scotland and in the nurses' case in Slovakia. In all three cases, the state took action because the state was not simply a promoter of neoliberal policies but also had final responsibility for the delivery of some front-line services. Moreover, there may be context-specific opportunities to engage the state as a supporter or promoter of the trade unions' sword-of-justice objectives. The state has to be engaged in revaluation where it is a funder and/or employer of FLWs. Innovative social dialogue and non-standard collective agreements such as the New Zealand pay equity agreement represent important new ways of seeking to improve conditions for some groups of FLWs. State-backed initiatives or legal interventions may risk displacing collective actions, but there has been widespread recognition in the debate on legal minimum wages that the former are a necessary complement to collective bargaining and that action is needed to promote such complementarity (Grimshaw 2013). A similar focus needs to be developed with respect to solutions for those FLWs who provide publicly funded services but are not direct employees.

Acknowledgements

The article draws on an internal report funded by the ILO on the role of collective bargaining in protecting front-line workers during the COVID-19 pandemic. Two of the case studies draw on doctoral research: Abbie Winton was funded by the Alliance Manchester Business School, University of Manchester; and Alejandro Castillo by the National Agency for Research and Development (ANID) of the Government of Chile (project code NCS2024_021).

Competing interests

The authors declare that they have no competing interests.

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