Healthcare workers' survival in times of COVID-19: The need for social dialogue

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Abstract. *Healthcare workers were more than essential during the COVID-19 pandemic, a fact that is recognized by societies the world over. However, in many countries, healthcare workers are not satisfied with their working conditions, which has resulted in frequent protests and strikes. One such country is Spain. How can the theory of social dialogue contribute to explaining and improving healthcare workers' conditions during a healthcare crisis such as this one? In this paper, we aim to explore what it is really like for healthcare professionals working under these challenging*

circumstances, and link their experience to the theory of social dialogue in order to engage in a double process of contribution: from practice to theory and vice versa. In order to do so, we first explore the real-world problems encountered by professionals, focusing particularly on cases in Spain, before reviewing theoretical approaches to the study of social dialogue in organizations, an area that has received very little attention in the revised academic literature. Finally, we show how constructive social dialogue can be an effective tool for improving working conditions for healthcare workers.

Keywords: *Healthcare workers; COVID-19; Collective Labor Conflict; Social Dialogue.*

Sobrevivir como personal sanitario en tiempos de COVID: La necesidad de diálogo social

Resumen. *Durante la pandemia COVID-19 la sociedad, a nivel global, se ha dado cuenta de la importancia clave del personal sanitario. Sin embargo, en bastantes partes del mundo se puede apreciar que el personal sanitario no está satisfecho con sus condiciones laborales, y esto se ha reflejado en las abundantes y diversas protestas y huelgas. Esta también es la situación actual a la que se enfrenta España. La cuestión es: ¿de qué manera puede contribuir la teoría sobre el diálogo social a explicar y mejorar la situación del personal sanitario en una crisis sanitaria como la actual? Este artículo pretende explorar la realidad del personal sanitario en estas circunstancias tan cambiantes y retadoras, y enlazarlo con la teoría sobre diálogo social, con el fin de establecer un doble proceso de contribución: desde la práctica a la teoría, y viceversa. Para ello, en primer lugar, se exploran dichos problemas actuales, con un especial foco en el caso de España, y a continuación se revisan los enfoques teóricos aplicables sobre el estudio del diálogo social en las organizaciones, un área que ha recibido muy poca atención en la literatura científica revisada. El estudio muestra cómo el diálogo social constructivo puede ser una herramienta efectiva para la mejora de las condiciones laborales del personal sanitario.*

Palabras clave: *Personal sanitario; COVID-19; Conflicto laboral colectivo; Diálogo social.*

1. Introduction

During the COVID-19 pandemic, healthcare workers were lauded as heroes and honored with public applauses, songs and praise. But away from the public eye, these professionals faced grim and dark working conditions. In the midst of the COVID-19 crisis, on 13th October 2020, while a new wave of the pandemic was on the rise, hundreds of primary care doctors in Catalonia (Spain) went on strike in the name of better working conditions. In Spain, public primary care centers were the first line of defense against the virus and handled the testing and tracing of potential cases, as well as treating infected patients. As reported in various international media, physicians claimed that these centers were overwhelmed. "We're asking for help because we cannot give people the resources they need to be treated during this COVID-19 pandemic", said one doctor at a protest in Barcelona on the first of a four-day strike. They demanded pay rises and more staff to compensate for the impact of budget cuts over the last decade, as well as other improvements to better distribute the workforce and deal with the crisis (Reuters, 2020).

Following on from this outcry, on 20th October, young doctors in Barcelona highlighted their claims about low salaries and a lack of rest and supervision by protesting in their underwear. This received substantial global media attention (Euronews, 2020). The protest came at a time when hospitals in this region were struggling amid a surge in coronavirus cases. The doctors tried to symbolize the lack of protection they felt in their jobs. Doctors in Spain typically complete a three- to five-year residency in different hospitals in order to specialize in a particular area of medicine, but the pandemic forced many of them to put their training on hold and join the front line, assuming responsibilities for which many felt they were unprepared. Then, on 27th October came a national strike of physicians, the first in Spain for 25 years. About 85% of Spain's 267,000 doctors took part in the walkout. According to the State Confederation of Medical Unions (CESM), which called the 24-hour action, most of the doctors only walked out symbolically and in reality, continued to see their patients. While officially declaring themselves on strike, they went to work to ensure they maintained a minimum service and that patients were not left alone, as reported in several media (The Local, 2020).

These actions by healthcare workers in Spain in response to the impact of the pandemic are representative of the situation almost worldwide, where healthcare workers are on the front line, often facing high-pressure and high-risk environments. The situation caused by the pandemic in 2020 continued into 2021 with important implications for these employees. In February 2021,

the newspaper *El País* reported that healthcare professionals in Spain were warning of excessive hours and a lack of resources, meaning they were unable to assume their current workload. Doctors and nurses announced that they were "exhausted" and "discouraged", admitting that workplace pressure was affecting their mental health (Mouzo, 2021). Conditions for nurses in Spain were poor and the impact of the pandemic was heavy (Martin-Rodriguez, *et al.*, 2022; Pérez-Raya, *et al.*, 2021).

In May 2020, a global initiative to report problems and initiatives by healthcare workers revealed that in many countries, there was a dangerous lack of personal protective equipment (PPE), whether due to shortages or poor distribution. By way of example, in a hospital in South Africa, nurses were only given one mask per week and were expected to wash their own PPE at home, despite the potential risk to their family. Healthcare workers across the USA also expressed concern over a lack of supplies, or over being asked by hospitals to re-use PPE or use PPE that has been "sanitized" for re-use. Several employees who refused to follow these instructions, or voiced their concerns, were fired or faced retaliation. In this regard, healthcare workers faced threats not only from the virus, but also from hospital administrations. Moreover, in November 2020, over 1,000 nurses at the non-profit McLaren Flint Hospital in Michigan (USA) were preparing to go on strike after the nurses' union and hospital management failed to reach a settlement for their job contracts for a month. The conditions at the hospital seemed to be very poor, with nurses demanding that the hospital addressed the severe shortage of nursing and ancillary staff (Johnson, 2020).

Another key problem healthcare workers faced was disrespect and aggression. From the very beginning of this pandemic, headlines captured stories of healthcare personnel being attacked as they travelled to and from healthcare facilities. Nurses and doctors were pelted with eggs and physically assaulted in Mexico. In the Philippines, a nurse was reportedly attacked by men who poured bleach on his face, damaging his vision. Across India, reports described healthcare workers being beaten, stoned, spat on, threatened and even evicted from their homes (McKay, *et al.*, 2020). In the Netherlands, a COVID-19 test center was bombed[1]. As reported by McKay and colleagues (2020), in some countries, it was also not unusual for neighbors to "invite" healthcare workers to leave their homes for fear of contagion.

In many countries, even healthcare workers' right to express their interests and grievances in public is still not that evident; note the risk of being fired, for example, in the USA. Raising one's voice might even lead to violence. In Iran,

1 <https://www.reuters.com/article/us-health-coronavirus-netherlands-blast-idUSKCN2AV0O4>

Malaysia, Pakistan, and Zimbabwe for example, doctors and nurses who engaged in peaceful protests in order to achieve a minimum income and adequate supplies from their employers were assaulted by police. Doctors in Nigeria went on strike following continued harassment by police for violating lockdown rules in order to treat patients. These types of conditions evidently contrast with conditions for a constructive social dialogue, as promoted by the ILO and OECD (International Labor Organization, 2020c).

This list of actions and problems could easily be extended by often dramatic stories from healthcare workers from around the globe. According to the World Health Organization (WHO), "COVID-19 has exposed healthcare workers and their families to unprecedented levels of risk. Although not representative, data from many countries across WHO regions (WHO, 2020) indicate that COVID-19 infections among healthcare workers are far greater than those in the general population". For this reason, the WHO makes a strong appeal to governments, employers, and healthcare management to ensure healthcare workers' safety.

This appeal by the WHO reflects concerns worldwide, as it seems healthcare workers need to negotiate and ensure decent working conditions. Several groups of healthcare workers, such as nurses and midwives do not have stable positions (Llop-Gironés *et al.*, 2021) and working conditions have worsened over the course of the pandemic. Furthermore, the effects of long-covid among healthcare workers in the aftermath, in addition to poor working conditions, is of great concern for many.

Why is it apparently so hard to get results out of these negotiations? And how can theories on collective negotiation and mediation contribute to improving healthcare professionals' working conditions in crises such as this one?

During the pandemic, we saw an unprecedented number of social initiatives by healthcare workers in defence of their rights. This is unique, as it normally takes a lot before healthcare workers will act and speak out. The obvious reason is that they feel a great deal of responsibility to provide care, and the consequences of their actions might impact their patients. This is evidenced by the doctors' walkout in Spain, who took action whilst continuing to care for their patients. The current pandemic however, shows that in many cases these workers know that their voices have not been heard and that their interests have not been taken into consideration, leaving them little alternative other than to take social action, including strikes, as seen in Spain and the USA, as well as many in other countries around the globe. All are a reflection of failing negotiations and a lack of social dialogue. Or even worse, the repression of healthcare workers' rights

to peaceful social action in many countries, as reported by the Accountability Research Centre (2021).

In this paper, we explore the theory of social dialogue with the aim of integrating knowledge and contributing to the improvement of working conditions for healthcare workers. First, we explore the theoretical framework, focusing on conflict management and social dialogue as key tools for collective negotiation. Second, we present the challenges shared by the parties regarding the system of social dialogue and elaborate on the main conclusions of an international study on the topic, linking it to the case of healthcare workers. Third, we elaborate on how an effective system of social dialogue could contribute to improving working conditions for healthcare workers.

2. Theoretical framework for social dialogue

The pandemic has not only had direct repercussions on public health, it has also heavily impacted healthcare workers, the organization of their daily working lives, their working conditions and contracts. Even today, the impact continues, with an increased shortage of workers and high rates of sick leave (Martin-Rodriguez, et.al., 2022). The result is a rise in collective labor conflicts, which can escalate to dramatic levels, as we have seen. Conflicts between employers and employees have received extensive attention in academic literature and are the basis of what is called 'industrial relations' or 'labor relations' (Katz, Kochan, & Colvin, 2015; Kochan, Katz, & McKersie, 1994; Roche, Teague, & Colvin, 2014). The recognition of different interests between employers and employees has been a cornerstone of the development of these labor relations, materializing in collective agreements that regulate most employees' working conditions and wages worldwide. Unions have played a key role in uniting and representing employees. Governments also play a crucial role, as they set the legal and regulatory frameworks for these negotiations and conflict management. This is also seen in regulations and institutions –often at national, regional and sectoral levels– that facilitate and support the management of these collective conflicts. Such third-party assistance can be provided by mediators, conciliators or arbitrators (Euwema *et al.*, 2019). Mediation and conciliation appear to be effective tools for preventing and regulating these collective conflicts, and reduce the billions of working hours that would be lost to strikes. In many countries however, they are underused (Elgoibar *et al.*, 2019). In this section, we elaborate on the idea of social dialogue and its application to the health system, after explaining the notion of organizational conflict.

Organizational conflict

Organizational conflict refers to clashes of interests and results in disputes of varying intensity between the workforce and management (European Commission, 2012). Such conflicts are as natural to organizational life as waves are to the sea (Coleman *et al.*, 2013). Conflict can take different forms, from social dialogue disagreements and peaceful conflict resolution to strikes that can involve violence and impact members of broader society, such as customers, or patients, as is the case here. Managers' and employees' interactions are interdependent, with some interests being compatible and others incompatible, inevitably resulting in organizational conflict (Bacon & Blyton, 2007; Walton, Cutcher Gerstenfeld, & McKersie, 1994; Walton & McKersie, 1994).

In the current (post-)pandemic, management and employees alike are often faced with pressures of all kinds related to technology, finance, health, and safety, among others. To cope with this optimally, all parties involved must be highly engaged and motivated. Participation in decision-making is an important driver for such engagement, as it is in healthcare (Bhatti, Hussain, & Al Doghan, 2018; Elgoibar, Medina, Munduate, & Euwema, 2021). However, as seen in the scenarios presented above, employees often feel they are not, and certainly not sufficiently, involved in decision-making processes, and that their interests are not fully considered, driving them to protest and strike.

Social dialogue

Management and employees negotiate at many different tables in modern labor relations in order to prevent and solve conflicts. One table is at the organizational level, where senior management meets with elected employee representatives (ERs). This is framed as social dialogue, our current subject of interest.

In a recent report, the ILO and OECD strongly advocate the use of social dialogue to overcome the consequences of the COVID-19 pandemic as regards workplace conditions worldwide (ILO, 2020c). They state that social dialogue between employers, employees, and government can play a central role in managing the impact of the COVID-19 crisis in the workplace, and that it has great potential for ensuring that the livelihoods and opportunities of those hardest hit are protected (Global Deal Flagship report, 2020). Social dialogue can be applied and becomes relevant at national, sectorial, and organizational levels (Euwema *et al.*, 2015). At the organizational level in particular, employees might be reluctant to raise their voices as their positions may not be wholly stable. Many 'frontline' healthcare workers are on low wages and poor contracts. According to this same report, social dialogue provides a forum to understand employees'

concerns and negotiate balanced approaches. This contributes to better living standards and perceived fairness and equity. Social dialogue is also an important vehicle at all levels (national, sectoral and organizational) to promote lifelong learning and the development of skills. Involving employees in decision-making can facilitate the effective adoption of skill development programs.

Social dialogue is described by the ILO as all types of negotiation and consultation, or simply an exchange of information between or among representatives of governments, employers and workers, on issues of common interest relating to economic and social policy (ILO, 2020). The main goal of social dialogue is to promote consensus and democratic involvement among the main stakeholders in the place of work. It is a process by which "relevant parties seek to resolve employment-related differences via an information exchange" (Bryson, Forth, and George, 2012, p. 5). In the European Union, social dialogue has been promoted for many years by the Commission and many national governments. Within organizations, this is reflected in legislation by which employees have the right to constitute a council, the members of which are co-workers elected to represent all employees. These ERs, therefore, serve as a bridge between senior management and the workforce, and are key mediators in social dialogue. Within the EU, these works councils have legal rights pertaining to information, consultation and co-determination. This means that management must inform and consult employees, and that they even need the approval of the works council on many issues, otherwise decisions may be blocked (Müller & Stegmaier, 2017; Mohrenweiser, Jirjahn, & Smith, 2020; Pender, Elgoibar, Munduate, García, & Euwema, 2018). In hospitals, such works councils also can have a great impact on decision-making, particularly when relationships with management are constructive (Van den Berg, Grift, & Van Witteloostuijn, 2009).

In the context of social dialogue, the influence of ERs is understood as their ability to impact the decision-making process (García et al, 2017). However, ERs are losing influence due to changes throughout the working world, including globalization, neo-liberal politics, an increase of flexible work and a decrease in union memberships (Koukiadaki *et al.*, 2016; Molina & Miguelez, 2013). In this study we discuss the key challenges workers are facing and how social dialogue can be improved, thereby increasing employee participation in the decision-making process.

Social dialogue in the context of health care

In healthcare organizations, particularly when facing the stress and turbulence of a pandemic, high levels of trust among the different parties are essential to

achieve positive results in social dialogue (Van Barneveld *et al.*, 2020; Berwick, 2003). Important factors that contribute to this are the perceived competence of ERs, a unified voice, role clarity, and ERs acting as a strong and cooperative counterpart at the table (Elgoibar *et al.*, 2016; Van den Berg et al, 2009). So, what are the strengths and weaknesses of ER healthcare workers in terms of their role as negotiators?

The main strength is that healthcare workers represent a strategic sector in society for public good. For this reason, a strike in the healthcare sector is not sustainable and cannot be supported by political representatives. This relative power increases the chance of an agreement and usually works in their favor.

However, this same argument could paradoxically also be used against them as a relative weakness, as striking is considered unethical for them as essential service employees (Loewy, 2020). At the same time, high levels of commitment to their job and caring for patients is a weakness in terms of their negotiation power (Dave *et al.*, 2011; Dolea & Adams, 2005). For this reason, healthcare workers are typically hesitant to initiate social action that could put patients in harm's way. This was the main reason why healthcare workers in Spain were so reluctant to take social action during the pandemic.

An interesting consideration is whether healthcare workers have the right to use collective pressure measures such as strikes in their collective bargaining processes. The right to strike is a civil right recognized at a constitutional level in many countries, and by the ILO. However, the right to strike is not a complete right, as it could be limited due to conflicts with other fundamental rights, such as health and life. ILO regulations recognize that the right to strike is limited when it would result in an "acute national crisis endangering the normal living conditions of the population" (Le Roux & Cohen, 2016, p.5). Some countries regulate this right by introducing the demand to guarantee minimum services in the case of strikes in healthcare services. In some cases, these minimum services guarantee almost 100% fulfilment of daily activity, leaving healthcare workers with no option to strike.

When it comes to labor relations, such negotiations within organizations have traditionally been the domain of unions. The agreements reached by unions usually affect the group of employees they represent, whether that is only the union members or the complete workforce. This means that in some countries, due to their regulations, a single negotiation can influence millions of workers (i.e., nurses) in both public and private organizations. However, in the 21st century, we can see a decline in union memberships around the world and some laws that reduce their influence. Therefore, more negotiations take place through

different forms of participative decision-making at the organizational level, often through ERs, elected within the organization.

Healthcare systems are complex and layered, which results in different levels of social dialogue. At the ground level, implementing collective agreements and daily management requires a dialogue between unit management and employees. Many day-to-day arrangements such as work schedules, tasks and safety measures are agreed upon, and often representatives of the different employee groups play an important role in this dialogue. However, other issues such as salary, working hours, or holidays are decided upon by the organization in question, or at a regional or sectorial level (for example agreements for nurses as a collective professional group). This dialogue typically takes place within national frameworks, such as laws and government regulations, expressed in collective agreements (Greer, Schulten, & Böhlke, 2013). In many countries, there is a structure for negotiating such general agreements (regional or national). Within such general agreements, there remain issues of implementation and more specific arrangements that need to be made by the organization.

In the previously presented case of the hospital in Michigan, negotiations took place between nurses and the local hospital, while in Spain, many issues are regulated at the regional level (i.e., by the Government of Catalonia). These negotiations were 'nested', ground-level problems are often passed on to top-level arrangements, for example, negotiations with insurers or with national health boards. These negotiations set the budget for the hospital, and within that budget, specific arrangements can be made. The supply of personal protective equipment (PPE) in many countries was regulated by governments. In some cases, healthcare institution management did not take further action, while in other cases, management was creative and used hospital budgets to provide sufficient PPE, instead of continuing to focus on efficiency, or claiming this should be provided by the government (Greene, 2020).

As well as this vertical form of dependency regarding negotiations in healthcare, there are also horizontal levels of interdependence. By this we mean the interdisciplinary nature of healthcare by which doctors, nurses and many other professionals must cooperate, whilst inevitably often competing over limited resources, from staff and working hours, to access to safety equipment, working conditions and financial compensation.

EU regulations provide that in all these organizations a works council is the body through which dialogue between management and ERs must take place. One major challenge here is that typically, these works councils consist of representatives of medical specialists, nurses, paramedics, as well as other staff

working in these facilities such as cleaning and catering teams. They are also often members of different unions, with different and even conflicting ideologies and interests. Improved working conditions for nurses might come at the expense of better facilities for others, or investments in new equipment. These dynamics might indeed weaken the position of groups with relatively low status and power who work within the organization.

The structure of social dialogue, with vertical and horizontal interdependences, means that negotiations occur at many different levels and between multiple groups, with asymmetric interests. Given the diversity of perspectives and interests, conflicts of interest are prevalent, and trust and distrust typically coexist. Lewicki et al (2016) refer to this system as a "tree of trust", where both trust and distrust can be present at different levels of dialogue. To be effective, these levels must be aligned, both vertically (at the unit, hospital and higher levels), as well as horizontally (between different employee groups). Arrangements made for doctors that do not take the interests of nurses and other professionals into account will result in distrust and ineffective dialogue. Competent ERs are therefore key at all levels (García *et al.*, 2017).

3. Investigating perceptions of social dialogue and representatives

ERs negotiate at different levels. At the organizational level, Ers typically take on this role part-time in combination with their contractual responsibilities. They need to be trained in other competences, such as representation and negotiations on issues varying from the provision of PPE and all other aspects of health and safety, to working conditions, working schedules and restructuring. Furthermore, this dialogue is related to conflicts of interest, as well as conflicts of rights, the latter referring to the organization's respect of workers' collective rights, for example the right to PPE, the right to refuse overtime and the right to be paid.

Social dialogue requires structures and competent healthcare worker representatives, who are trained to act as such. This is not at all evident, as is shown in a series of studies conducted over the past ten years. These studies (Euwema *et al.*, 2015; Euwema et al, 2019; Munduate *et al.*, 2012) collected data from Ers on their experiences and the challenges they face, as well as from management on the expectations and practices of their ERs.

The outcomes of these studies correspond with the recent views of healthcare workers and their representatives. A first important notion is that problems of representation are heard in almost all societies (see Table 1). However, there are

substantial differences in social dialogue within and particularly between countries when it comes to legal rights, as well as cultural traditions. The structures and practices for third-party support in collective conflicts also differ greatly. In this regard, the common denominator is that these provisions are underused and are in need of further development (Euwema et al, 2019).

We will now elaborate on these issues, starting with a typical example of (the lack of) social dialogue in a hospital during the COVID-19 pandemic. One representative of nurses stated that "during the first wave in March 2020, new COVID-19 units had to be staffed. Hospital management acted in a crisis-climate, in a very directive manner, and ordered nurses and doctors to these units. Though understandable, this was not the most effective strategy and created high levels of stress among staff. We expected management to consult us and we strongly suggested that first of all management make an inventory of volunteers to work on COVID-19 wards. We knew many members of staff would be happy to do so. These staff members were overlooked, whereas others, who had high-risk families at home, were sent to work on COVID-19 units, which created a feeling of insecurity. Again, during the second wave, management started to respond as if they were managing a crisis. The mood in the hospital was low, and we did not feel trusted. We felt we were not taken seriously as members of the works council in the hospital, as partners in a dialogue to find proper solutions to the huge challenges we faced. We feel conflicts are increasing and wonder who can assist us in this process".

4. Promoting social dialogue in healthcare in (post) Covid times

Previous research on social dialogue within the EU concluded that some of the key challenges shared by the parties included participation in decision-making, trust, competencies, constructive conflict management and third-party assistance (Eurofound, 2022; García *et al.*, 2017; Pender *et al.*, 2018). Constructive social dialogue for healthcare workers could be promoted through the following actions.

1. *Participation in the decision-making process*. Participation and dialogue are important means for ERs to become "strategic business partners" within the organization (Martínez Lucio *et al.*, 2012). The results from our studies show that the ERs' roles change in the context of partnership from caretaker and negotiator to communicator and developer. For a meaningful social dialogue to take place, management must recognize the value of ERs in the decision-making process. As García *et al.* (2017)

point out, employee participation in decision-making is key in order to promote this integration of perspectives, quality of decision-making and support for organizational decisions.

2. *Trust*. Trust is essential for building relationships, cooperation and integrative negotiation (Elgoibar *et al.*, 2016). Trust is central in industrial relationships (Lewicki *et al.*, 2016) as managers and ERs invest in each other and share confidential information with some inherent risk that the investment will not be repaid. As such, when ERs see that management is investing in their role, trust building is initiated and ERs react with a more cooperative approach. Sharing information and interests can contribute to creating value in the agreement (Brett, 2014; Elgoibar *et al.*, 2021). In this case, a trusting relationship between ERs and management would facilitate open communication, which would contribute to improving, for example, the assignment of tasks to workers in a more efficient way.
3. *Competences*. Both parties share the need to attract competent and motivated employees who can negotiate efficiently (Euwema *et al.*, 2015; Martínez Lucio, 2016; Sen & Lee, 2015 Visser, 2010). Empowering ERs with core competencies are required to navigate the new working environment. We argue that despite the formal and legal position of ERs in European organizations, strong competencies make a difference in decision-making at the organizational table. Managers perceive ERs as competent if they see that they are knowledgeable and have the appropriate skills and adequate attitudes to perform their role (Soares & Passos, 2012).
4. *Constructive conflict management*. Constructively managing conflict in organizations is a key issue for ERs as well as for management. Improving the quality of conflict management in organizations is an important goal for social dialogue (Bryson, Forth, & George, 2012; Euwema *et al.*, 2015). In support of this theory, previous research concluded that a cooperative-constructive process of conflict resolution leads to positive outcomes, such as mutual benefits and satisfaction, which strengthens relationships between managers and employees and leads to positive psychological effects for both parties, among others (Fells & Prowse, 2016; Nauta, Van de Ven, & Strating, 2016). On the other hand, a competitive-destructive process leads to material losses and dissatisfaction, worsening relationships between parties and negative psychological effects for at least one party, namely the loser of a win-lose outcome (Deutsch, 2014; Benítez, Medina & Munduate,

2011). In relation to the previous concepts, when management sees ERs as competent and cooperative, they increase their participation in organizational decision-making (Pender *et al.*, 2018).

5. *Third-party assistance*. When conflicts arise and dialogue is difficult, ERs or employers may be overcome with a sense of distrust and conflict may escalate. As it does so, third parties may be called in to assist. In the initial stages, this may involve the facilitation of dialogue. If the conflict escalates further, formal mediation or even arbitration may a be more suitable option in order to bring parties together and end the confrontation. Third parties can also often help to rebuild trust following a conflict. Previous research on mediation has shown that primary parties are highly reluctant to bring in third parties at any stage, despite the potential and demonstrated effectiveness (Euwema *et al.*, 2019; Martínez-Pecino *et al.*, 2008).

Table 1: Challenges regarding social dialogue and representative negotiations

Systemic challenges

- Legal frameworks promoting structural social dialogue at different levels.
- Sectoral and organizational cultures promoting social dialogue.
- Investment by organizations in strong employee representation at different levels.

Representation challenges

- Finding and recruiting competent and motivated ERs.
- Creating facilities for ERs to do their job as representatives effectively.
- Motivating ERs to continue in these roles (given the high demands and related stress).
- Providing vocational training for ERs both as individuals and team members (works councils).
- Lack of evidence-based models for representative negotiations.

Interaction challenges

- Lack of unity among representatives in organizations.
- Lack of trust between management and ERs.
- Lack of information sharing and consultation by management.
- Competitive interactions between management and ERs.
- Low impact organizational decision-making by ERs.
- Lack of evidence-based methods for trust development and constructive dialogue.

Third-Party intervention challenges due to low trust and high conflict

- A reluctancy to ask for assistance from internal or external third parties.
- Low level of organization and professionalism by (potential) third parties.
- Lack of evidence-based methods for third-party interventions.

5. Conclusion

Healthcare employees confronted with the worldwide pandemic also faced difficult working conditions and often a weak negotiation position. However, as highlighted above, the role of constructive social dialogue could be used to promote fair and sustainable agreements. The conditions for this social dialogue can and should be created. In many organizations, information sharing, consultation and co-determination as part of social dialogue are hampered. Structural organization, trust and ER competencies, as well as support from third parties at different stages of the conflict, all contribute to constructive social dialogue.

These conclusions fit with the ILO's perspective (ILO, 2020a), which states that social dialogue plays a crucial role in designing policies to promote social justice, decent work and sustainable organizations when it comes to addressing the consequences of the COVID-19 pandemic that have affected a significant proportion of "front-line" workers, especially in the health and social care sectors. "Above all, social dialogue can contribute to reconciling competing interests, and build trust in, commitment to and ownership of such policies" (p.3). Since the initial phase of the COVID-19 pandemic, the ILO's policy framework (2020b) has promoted social dialogue as a means to fight the crisis, by a) strengthening the capacity and resilience of employers' and employees' organizations; b) strengthening collective negotiation and labor relations at different structural levels –such as the sectoral or organizational level–; and c) monitoring the roles these levels can play –signaling a need for better articulation among the different levels of social dialogue (national, federal, regional, sectoral and organizational). The ILO's response policy framework was quick to identify the priorities following COVID-19's impact on the world of work, reiterating the need to build confidence through trust and social dialogue to make policy measures effective (Walter, 2020).

Academic work on these conditions, the process of social dialogue and the outcomes for healthcare workers is currently very limited, particularly studies focusing on the 'soft' side of this dialogue, which are necessary. This paper aims to be a first step towards integrating the theory and practice of social dialogue in the healthcare system and promoting constructive social dialogue for the benefit of management, employees and society.

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