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Sustainable Work and Employment in Social Care: New Challenges, New Priorities

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ABSTRACT

Human Resource Management (HRM) research focused on social care is sparse. This gap is surprising given the scale of the social care workforce in many countries, its vital role in meeting the increasingly complex needs of vulnerable community groups, and the persistent challenges in recruiting and retaining staff. Framing the special issue of articles on HRM in social care, we suggest the relative neglect stems from difficulties: defining the boundaries of the social care sector; scoping its workforce; capturing the diverse range of organizational service providers; and in a crowded research space, clarifying how HRM researchers might make a distinctive scholarly and practical contribution to the literature. The six articles comprising the special issue, together with literature from HRM and related fields, are explored through the organizational, systems, and stakeholder perspectives that underpinned the original call for articles. We develop a substantive characterization of HRM in social care comprising various parts. First, systemic features of the sector, including service fragmentation and light touch state regulation, are presented as pushing social care organizations towards opportunistic, low-cost workforce management approaches that stakeholders—particularly employees and less directly service users—often experience negatively. Second, providers, nonetheless, retain some discretion to pursue alternative management strategies, with recent policy shifts towards networked care delivery models creating opportunities for more strategic, developmental HRM approaches. Third, leadership behavior and intrinsic employee satisfaction with care work can moderate the often-degraded employment experience, albeit within limits, suggested by the sector's ongoing recruitment and retention difficulties. Synthesizing these insights through the systems, organizational, and stakeholder themes, we present a multi-level analytical framework for the study of HRM issues in social care. Accompanying research questions aim to support the exploration of workforce issues by policymakers, practitioners, and HRM scholars.

1 | Introduction

Most national social care systems are under increasing pressure as the support needs of aging and other vulnerable communities grow in scale and complexity, while the capacity and resources to meet them tighten (OECD 2025). This pressure is reflected in, and exacerbated by, challenges in sourcing and managing the social care workforce. Despite rising global demand for social care workers, labor markets continue to discount their value, apparent in the often-degraded nature of terms and conditions of employment (Pavolini and Marlie 2024; ReWage 2024). With social care delivery typically centered on direct worker-client interaction, sectoral labor market failure, manifested in difficulties recruiting and retaining staff, raises questions about the future accessibility and quality of social care provision. Our call for special issue articles on Human Resource Management (HRM) in social care (Kessler et al. 2022) was informed by an interest in whether and how the field was exploring these sector

workforce challenges. It was also designed to prompt a research agenda examining the scope to establish a more sustainable sector workforce, that is, one with the capability and capacity to cope in an assured and inclusive way with the rising tide of social care needs.

A review of the mainstream HRM literature highlights the continued neglect of social care, certainly relative to healthcare (Cooke and Bartram 2015) and even more so relative to other sectors of the economy (Baluch and Ridder 2021). A search of the principal HRM journals, including *Human Resource Management*, reveals a limited number of articles on the sector. At first sight, this is puzzling. Social care is a major employer in most developed countries. In 2023, the European Union's (EU) social care sector employed approximately 3.1 million workers, representing circa 1.5% of the region's total workforce (European Commission 2024). In England, there are currently around 1.6 million workers in adult social care (ASC), close to 5% of the paid workforce (Skills for Care 2024), while in the USA, care in home and community settings employs 4.3 million workers, alongside 3.3 million in residential and nursing homes (Dorinda Allard 2024). In the EU, social care is the fastest-rising item of social expenditure, projected to increase from 1.7% to 2.5% of GDP between 2019 and 2050 (European Commission 2024). The scale of social care expenditure, in large part accounted for by labor costs, highlights the importance of incorporating the sector's workforce and service context into HRM research.

In this editorial, we explore reasons for the neglect of social care in the HRM literature, and use this as a point of departure not only to reflect on the six articles comprising the special issue and how they relate to the themes raised in our initial call, but to pursue several other objectives. First the editorial seeks to map features of the social care workforce, and in doing so to scope areas for further study. Second, in reviewing evidence from HRM, and a range of other academic fields, on this workforce, the editorial attempts to develop a substantive argument. This suggests residual discretion amongst social care provider organizations in how they manage their staff, but systemic features of the sector, including service fragmentation and light touch state regulation of the workforce, which drive many towards the shared adoption of a hard, cost minimization approach, degrading the work experience of staff, and potentially the care experience of service users. Third, this argument is framed by a layered analytical model designed to encourage an interest in whether and how systems, organizations and stakeholders, including the state, service commissioners, employers and workers, interact to shape and administer HRM in social care. The model generates a plethora of research questions for scholars in HRM, and is presented as a tool for policy makers and practitioners in navigating their way through a sector characterized by considerable structural, organizational and managerial complexity.

2 | Explaining Neglect: Scoping the Sector and Its Workforce

Four challenges explain the relative neglect of social care by HRM scholars (see Table 1). The first is the difficulty in *scoping the sector*. While healthcare addresses formally classified clinical conditions, social care is more loosely framed, dealing with an amorphous set of needs. Even the term used for such care varies, with the USA and many EU countries referring to social care as long-term care (a term we use interchangeably with social care throughout our editorial). Notwithstanding different labels, social care services essentially involve the provision of personal assistance with the activities of daily living to support the recipient's pursuit of a meaningful life. A distinction can be made between ASC and children and families social care, reflecting differences in the nature, procedures and regulation of service delivery. In the call for articles, we principally focused on ASC, defined in a recent UK government document as including:

> Any form of personal care or other practical assistance provided for individuals aged 18 or over who, by reason of age, illness, disability, pregnancy, childbirth, dependence on alcohol or drugs, or any other similar circumstances, are in need of such care or other assistance. (House of Commons 2024)

The open-ended nature of this definition, referring to "any form of personal care", is striking, with scope for interpretation by policy makers, practitioners and indeed scholars on the character assumed by such care. It also a reminder that while older people represent the principal source of demand for social care, such services respond to the needs of client groups varying by age, condition and care context.

Adding to the difficulties of delineating social care is the sector's close relationship with healthcare. The efficient and effective functioning of healthcare is closely connected to the workings of social care. Increasingly short stays in acute hospitals generate the need for ongoing social care in a domestic setting to facilitate recovery. Moreover, aging populations, often with chronic clinical conditions such as dementia and diabetes, typically require healthcare in the community to complement social care. Empirically, it remains important to consider how health and social care interact to affect the structure and organization of work and employment. However, distinguishing the contribution of the respective sectors for analytical purposes is not always straightforward.

The second reason for the neglect of social care in the HRM literature lies in the difficulty faced in *scoping the sector's workforce*. An uncertain service terrain makes tying down the sector's workforce challenging. Yet even with clear service parameters the social care workforce needs careful unpacking. It is a segmented workforce characterized by different working arrangements. These segments, to be examined in turn, include waged employees, personal assistants, volunteers, and family carers.

At the core of the social care workforce is the *waged employee* working for a social care provider organization. This segment can sometimes be lost within a wider, generic category of employees undertaking paid "care work". Duffy (2011, 6), for example, suggests a category of "nurturant" paid care workers whose labor is inherently relational and embraces "nurses, childcare workers, physicians, teachers and social workers". A broadly conceived interest in care work is also to the fore in the literature on emotional labor (Hochschild 1984). Examining how and with what personal and organizational consequences

TABLE 1 | Social care scoping challenges for HRM scholars.

Difficulty in…	Dimensions	Indicative HRM tensions/ implications for HRM
Scoping the sector	*Social care needs* – Diverse, amorphous and linked to different subsectors – Overlap with healthcare needs – Influenced by demography	– Whether and how social work interfaces and overlaps with healthcare work – The relationship between social and health care workers – The alignment and tensions between workforce management practice within social care and between social and health care
Scoping the workforce	*Workforce structure* – Occupationally undifferentiated – Conflated with care work in various settings, the distinctive social care qualities being lost – Segmented: core wages labor, personal assistant; volunteer family carer.	– The scope and nature of career development in a non-hierarchical workforce – Institutional features of social sector and their influence on workforce management – Difference in workforce management between segments
Scoping provider organizations	*Multiple provider types* – For-profit private – Not-for-profit/voluntary – Public sector provider *Within type differences* – Small, family-owned – Large corporate chains – Private equity	– The relationship between organizational governance and workforce management. – The state and nature of the HR function in different types of social care providers (e.g., small and medium enterprises [SMEs]) – The scale and character of the sector's HR infrastructure
Scoping HRM's contribution	*Crowded, fragmented research space* – Multiple fields – Specialist professional/practitioner communities.	– The interface between broader policy issues and workforce management in social care – Understanding and addressing neglect in HRM – Incorporating multi-disciplinary insights

employee feelings are regulated as part of employment, this literature embraces waged labor within, but not limited to, social care (Bolton 2004a, 2004b). The shared features of paid care work across diverse services, with a predominance of women often holding low-paid and low-status jobs, fully justifies such work being treated as a distinctive analytical construct. However, it also runs the risks of obscuring the distinctive institutional and substantive qualities of such work in a social care context.

In general, the waged ASC workforce is found in a limited range of settings: nursing homes, residential homes, individual client homes and day centers. In terms of structure and composition, it is a relatively under-professionalized, and occupationally undifferentiated workforce, dominated by care assistants, variously labeled. In the USA, for example, close to three quarters (70.7%) of workers in home care are "aides", with barely a tenth (12.3%) registered nurses. In US residential care home "aides" constitute well over half of the workforce (59.3%) (Bates et al. 2018, 11). Similarly in England, 1.3 million of the 1.6 million ASC workers are classified as direct care workers: unregistered assistants providing face-to-face care. They work alongside just 123,00 managers and 84,000 registered professionals, principally nurses, occupational therapists and social workers (Skills for Care 2024).

In healthcare, the wide variety of waged job roles, performed in diverse clinical contexts, has attracted the interests of researchers keen to examine the creation and maintenance of work boundaries (Abbott 1988; Lunkka et al. 2022). Occupationally less differentiated and found in a narrower range of care settings, the social care workforce has proved less enticing as a research domain for scholars. It is a domain, however, which rewards more detailed examination, with intriguing workforce nuances. Generic job titles, such as aide, direct care worker or care assistant, obscure subtle but important distinctions in the nature of paid frontline care roles—for example, between care assistants, senior assistants, or team leaders—and in the work experiences of social care workers interacting with different client groups: younger as well as older adults, those with physical and mental disabilities. Indeed, the diversity of work roles in social care should not be understated, with ancillary workers in cleaning, catering and administration invariably complementing direct care employees and forming part of the skill mix (Luijnenburg et al. 2024).

The second segment of the social care workforce, *the personal assistant* (PA), is also a paid employee, but has a very different employment relationship to that underpinning core wage labor. The PA has an unmediated relationship with the individual service user, who typically pays and therefore employs

them directly. The PA role has roots in an informal secondary labor market for paid domestic labor, found in many developed countries (Jokela 2015), and often drawing on workers from less developed countries (Ehrenreich and Hochschild 2004). In certain national contexts policy developments have heightened and formalized the PA role in a social care context. In late 1990s England, for example, the role was enabled by the government through individual social care budgets, to be spent on a discretionary basis by the service user as the fund holder, including on employing a personal assistant. With 123,000 posts currently established, the PA is now a significant part of the English social care workforce (Woolham et al. 2019). The PA model finds echoes in France and Belgium, which, in the early 2000s, introduced voucher-based arrangements—respectively the *Cheque emploi service universel* (CESU) and *titre services—to* facilitate at scale the employment of domestic assistance for the elderly, those with disabilities and other support needs (Pulignano et al. 2023).

The final two segments—*volunteers and family carers*—share an unpaid status and represent a sizeable component of the social care workforce and indeed the broader community (Pulignano and Domecka 2025). In the UK, 2021 census data indicated 5.8 million unpaid carers, constituting 9% of the general population (Carers UK 2024). It remains important, however, to distinguish between volunteers and family members. Volunteers arguably have greater agency in their engagement with care work than family carers, who may experience a normative kinship obligation to provide care. The volunteer might also be expected to be less intensely and physically engaged with the care recipient than the family carer, likely influencing the nature of the care process. Volunteers might well have an organizational affiliation, delivering their services through an independent or third sector body (Baines et al. 2017), although such bodies are often staffed by paid employees as well as by volunteers.

This latter point raises a third possible reason for the challenges faced by HRM scholars in engaging in social care research: *the complex patchwork of provider organizations* comprising the sector. Social care is delivered by a combination of for-profit private, not-for-profit or voluntary, and public sector organizations. The configuration of these provider types varies by national context, reflecting different funding and regulatory models. However, sensitivity to the distinctive features of the provider types is analytically important, with differences in founding principles and governance arrangements possibly impacting approaches to workforce management. Even within categories, there is variation in organizational design, geographical scope and service practice, with potential workforce implications. For example, non-profit organizations (NPOs) are active in diverse service areas—health, education and culture- (Baluch and Ridder 2021, 599)—making it difficult to pull out their particular engagement with social care. Moreover, for-profit social care providers, perhaps most likely to attract the interest of HRM scholars, range from small family-owned single-establishment providers to corporate, nationwide chains.

A final reason for the relative neglect of the social care sector by HRM scholars relates to *the crowded nature of the research terrain*. The gendered character of care work has attracted interest from a wide range of scholarly fields, including feminism, women's studies, and the wider sociology of work community (Duffy 2005; Stacey 2011). Moreover, it is difficult to examine and debate the policy and practice of social care without confronting issues of workforce management and organization, attracting interest from scholars in diverse streams of social and public policy. This still begs questions as to why HRM has not jostled more determinedly for its place in this space. As management scholars, it might well derive from a reluctance to grapple with the technical, sometimes clinical, nuances of service delivery in the sector. Indeed, as social care professions such as social work, nursing and occupational therapy assume graduate status, academic communities proliferate to deliver university programs and then generate their own research agendas, journals and literatures from what might be seen as the privileged position of "insider" or practitioner with specialist clinical knowledge and expertise.

Given the challenges faced in scoping social care as a field of study, summarized in Table 1, along with various indicative substantive themes, HRM is confronted with the task of establishing its distinctive contribution to understanding workforce management in the sector. Informed by calls for HRM to better embrace context (Cooke 2018) and "real world" phenomena (Lumineau et al. 2025), together with the need to engage the "full spectrum of worker experiences and roles, especially those deemed essential by society that have been hitherto silenced or underrepresented in our scholarship" (Harney and Collings 2021, 8), we next consider the HRM literature on social care, including the six articles published in response to our call (Kessler et al. 2022).

3 | The HRM Literature on Social Care

In the call for articles to explore HRM in social care, we proposed a number of prospective topics with themes coalescing around organization-, system-, and stakeholder-centered analysis. Of the six published articles, three are largely stakeholder-centered, considering the management and experience of one key actor—the waged social care worker. They highlight the intense pressure on the physical and mental wellbeing of social care workers, while acknowledging the moderation of these pressures by organizational policies and practices. Zettna et al. (2025) examine the relationship between role clarity for social care workers and their well-being, as influenced by organizational leaders. Mostafa et al. (2025) explore the resilience of social care workers confronted with client "incivility", also tempered by organizational leadership. Cavanagh et al. (2025) are concerned with the client-driven violence faced by workers, with its management presented as indicative of organizational ethics.

The other three articles are organization-centered, albeit with an analytical interest in the broader social care system as a contextual influence. Currie et al. (2025) explore the organizational application of high-performance work practices to social workers, framed by their use in facilitating the introduction of a system-driven "strength-based" approach to social work. Baluch et al. (2025) provide a case study of a non-profit social care provider, examining the establishment of a distinctive in-house approach to recruitment, designed to secure care workers able to deliver a national "person-centered" care agenda. Hughes and

Dundon (2025) consider the sustainability of different organizational HR policies, particularly related to career development and employee voice, as influenced by features of the broader social care system.

In this editorial, we build on these articles and examine the respective treatment of the organization-, system-, and stakeholder-centered themes, as they relate to social care, in the mainstream HRM literature, and where useful in other fields of study.

3.1 | Organization-Centered Literature

The Strategic HRM (SHRM) literature has largely centered on the organization as the main unit of analysis, with its focus on whether and how universal or more bespoke HRM policies and practices, individually or collectively, shape a standard set of measurable worker attitudes and behaviors, and with what consequences for variously defined corporate outcomes. This meta-analytical model has been applied in a patchy way to social care, with varying degrees of sensitivity to the structure and nature of organizational forms in the sector and their approaches to workforce management.

A relatively well-developed literature has emerged on workforce management in care services delivered by NPOs, framed by models of SHRM (Baluch and Ridder 2021). Much of this stream has been focused on a values-based model, closely related to the ethical and "common good" strand of HRM (Cooke 2025), which seeks to develop and support a workforce able to address broad societal and community interests: in the NPO case the care needs of the frail and vulnerable (Kellner et al. 2017). However, more noteworthy is empirical evidence, which, notwithstanding the rhetoric of ethics and "common good", finds a "hard", non-strategic approach to workforce management in NPOs. Thus, Baluch and Ridder's (2021, 611) review of the relevant literature highlights "a large group of studies dealing with single HR practices and their effects...confirming the overall diagnosis that the HR function in NPOs is more or less ad hoc and reactive".

While caution is needed in extending these NPO findings to the social care sector as a whole, this hard, opportunistic approach to workforce management appears evident in other social care provider types and indeed in various country contexts (Pavolini and Marlie 2024; ReWage 2024). It is, for example, illustrated in Eaton's (2011) study of HRM practices and care quality in 20 US private nursing homes, which found only a quarter adopting a supportive developmental employment regime, the remainder committed to a "traditional" low service quality model founded on coercive Taylorist working practices.

Organizational convergence on hard, opportunistic HRM across different national contexts can be interpreted in several ways. On the one hand, systemic features of the social care sector may drive organizations towards cost minimization and ad hoc workforce management, an issue examined in the next section. On the other, the sector may attract organizational forms that, for various (or possibly similar) reasons, are predisposed to adopt this approach to HRM. For example, the increasing involvement of private equity firms, often via leveraged buyouts, in social care provision across Europe (Hildebrandt and Moutinho 2024) has arguably contributed to the sector's degraded terms and conditions of employment. Some caution is needed in assuming leveraged buyouts necessarily undermine working conditions (Hoque et al. 2023). However, in England, for instance, private equity firms own one in eight care home beds, with the suggestion that the funds required to service debt "leave little for staff and front-line services" (Hansard 2022).

The predominance of SMEs (Harney and Alkhalaf 2021), in the provision of ASC might also account for the low cost, ad hoc character of HRM in the sector. In the UK, the fragmented nature of social care provision is reflected in some 18,500 social care providers, 85% employing fewer than 50 workers (Skills for Care 2024), while in the USA, there are over 66,500 long-term care facilities (Schmidt 2024). Typically, smaller organizations lack the funds to resource a dedicated HR function, and, with limited scope to draw on economies of scale, are unlikely to have the capacity to develop the internal infrastructure required to nurture their employees.

A pattern of low-cost and ad hoc workforce management should not detract from research highlighting variation in HR policy and practice among social care employers, with consequences for worker attitudes and behaviors, and in turn organizational performance. These relationships have largely been explored by scholars from outside the field of HRM, and therefore rarely framed by mainstream HRM debates. These scholars have, however, displayed a marked sensitivity to the social care context, not least reflected in the HR policies and practices selected for consideration. In a recent study exploring staffing practices in over 5500 UK care homes, alongside a basic pay measure (average hourly wage rate) for care workers, Towers et al. (2021) included bespoke sector training measures: the proportion of staff who received training in person-centered care and dementia care. Other studies have selected HR policies and practices centered on work organization, implicitly acknowledging their close relationship with care outcomes. For example, the workforce practices selected by Spilsbury et al.'s (2024) UK care home survey included: the proportion of workers on full-time and permanent contracts, skill mix ratios (the balance between professional and non-professional staff) and staff-to-bed ratios. The weight placed on work arrangements is also evident in a US review, principally of nursing studies, exploring the relationship between staffing levels in care homes and organizational performance (Bostick et al. 2006).

Attention to, and alignment with, the social care context is further reflected in the choice of organizational outcomes. In contrast to the quantifiable, often financial and economic, measures used in the mainstream SHRM literature, the performance of social care providers remains difficult to assess. Nonetheless, it can and has been considered according to various care quality outcomes. Towers et al. (2021), Spilsbury et al. (2024), and, in the special issue, Hughes and Dundon (2025), use quality ratings awarded by the body inspecting the performance of social care providers in England, the Care Quality Commission (CQC), and find relationships with workforce management policy and practice. Towers et al. reveal pay level and dementia training as positively related to such ratings, while Spilsbury et al. note an association between higher staff-to-bed ratios and high CQC inspection scores. Hughes and Dundon also find a relationship

between care workers on high pay and secure contracts, and care rated as "outstanding". Such findings have to be treated with a degree of caution. The CQC inspections do cover workforce management (amongst a range of other factors), suggesting the need to avoid "double-counting". Perhaps more compelling evidence can be found in attempts to relate HR policy and practice to more specific client safety and clinical outcomes. Spilsbury et al. (2024), for example, find a richer skill mix related to fewer client falls, infections, and medical errors.

Overall, there is evidence to suggest a positive relationship between the introduction of more developmental and supportive HRM policies and practices, particularly those centered on work organization, security of employment, pay and bespoke forms of training, and organizational social care outcomes (Towers et al. 2021; Spilsbury et al. 2024). Equally clear is the relative dearth of such policies and practices in the sector (Dubois et al. 2020). These patterns encourage an interest in system-centered studies to explain varying patterns of workforce management, but more particularly the sector's convergence on a hard and ad hoc approach based on minimizing labor costs through low pay, precarious jobs and limited staff development opportunities.

3.2 | System-Centered Literature

The HRM literature has long appreciated the effect of external context on organizational approaches to workforce management. The seminal Harvard HRM model (Beer et al. 1985) drew attention to situational factors, including business and labor market conditions, informing the adoption and nature of firm-level HRM practices. More generally, there has been debate on the nature and dynamics of the socio-economic space beyond the firm as an influence on work and employment (Cooke 2018). Notwithstanding this interest, Farndale and Paauwe (2018, 202) still note the "disappointing progress (made by HRM scholars) in capturing contextual issues."

Analytically and theoretically, context has often been viewed in systemic terms in the HRM literature, that is, configured as a series of purposeful, interlocking institutions, typically animated by a set of socio-economic and political principles and values, which regulate the employment relationship in substantive and procedural terms. At the level of the economy, systems analysis in HRM has been reflected in the "varieties of capitalism" literature, distinguishing between co-ordinated and liberal market economies founded upon and sustained by distinctive employment relations institutions (Hall and Soskice 2001). A more disaggregated approach has been sensitive to country differences within these models of capitalism, impacting workforce management (Mayrhofer et al. 2024). Other HRM scholars have focused on *sectors* of the economy as systems, examining whether and how patterns of workforce management are linked to industry features such as technology and product market structure (see for example, Gittell and Bamber 2010). Such competing systemic perspectives have encouraged an empirical interest in the relative institutional influence of sector and country: whether there are shared sector patterns in workforce management which cut across countries, or whether in-country sector patterns emerge with distinctive national characteristics.

These competing perspectives play out in the social care context. There are important institutional differences between national social care systems, for example, in terms of funding, provider arrangements, citizen access and governance (Ariaans et al. 2021). However, given convergence across countries on the use of "hard", low-cost HRM policies and practices (Dubois et al. 2020; Pavolini and Marlie 2024), it is pertinent to ask whether the social sector has structural features, or perhaps faces common challenges, which override national context to produce this pattern. In examining this question, there is value in venturing upstream to policy decisions made by the state, a territory rarely explored by mainstream HRM scholars (Martínez Lucio and MacKenzie 2017), but which might lead to shared national choices on models of public service, with consequences for workforce management in social care.

Providing support for society's most frail and vulnerable, the underlying principles of social care delivery have long been set by state decision makers (Cylus et al. 2018). Post-1945, social care models in developed countries varied in the weight they placed on state, market and family contributions to such care. However, in general, social care provision was nested in relatively well-funded national welfare regimes articulated by state bureaucracies (Esping-Andersen 1990), with demonstrable implications for workforce management. This is illustrated in the case of England where the direct provision of social care by municipalities saw the emergence of a large state-employed social care workforce. A "model employer" approach, where the state set an example to the rest of the economy in its approach to workforce management (Fredman and Morris 1989), was evident in a collectively bargained sector agreement ensuring standard, annually uprated pay rates, and secure terms and conditions of employment.

From the 1980s, cumulative socio-economic pressures and ideological volatility in many European countries prompted generic shifts in state policy on and practice in social care (Colfer et al. 2023). This saw moves from the direct provision of social care by state bureaucracies, to competitive market provision (Johnson and Pulignano 2021), underpinned by a neo-liberal New Public Management normative rhetoric (Pollitt and Bouckaert 2011). National markets for social care were variously constructed, but often required state actors to tender for, and then commission, ASC services from external providers. This hollowed out municipal ASC workforces, leaving a small residual core to meet ongoing statutory duties. More generally, it opened social care delivery to the array of provider types previously discussed, including those who, in seeking to secure social care contracts at a competitive price, often sought to minimize labor costs, and undermine national pay agreements (Cunningham et al. 2014). As commissioners of social care, state actors often retained discretion to encourage "fair" treatment of staff through labor standards embedded in the service contract, referred to as contract compliance. However, in countries such as England, the application of this discretion has been patchy (Kessler et al. 2020).

In many developed countries, the institutional imprint of the New Public Management model, in the form of a competitive and fragmented market for social care, remains the engine of a hard, low-cost approach to workforce management. However,

more recently states have moved towards more joined-up or networked approaches to public service provision. This has been driven by a policy concern to moderate what has often proved to be the resource-intensive, disjointed, and inefficient nature of market provision (Brown et al. 2006), problems assuming particular significance as the demand for and costs associated with public services have increased. This new networked approach acknowledges, and seeks to strengthen, links between health and social care commissioners and providers in a cohesive local system, with downstream, workforce consequences.

Over recent years, these inter-organizational, place-based, relational networks (Gittell et al. 2008) or systems embracing both social care and healthcare have emerged in various countries, including the Netherlands (Mur-Veeman et al. 2003), Germany (Groene and Hildebrandt 2021) and Sweden (Ahgren and Axelsson 2011). In England, the model is manifest in Integrated Care Systems (ICS) bringing together health and social care in localities covering populations of between 500,000 and 3 million. In seeking a more holistic approach to care delivery, such systems have created new possibilities for managing the social (and health) care workforce (NHSE 2023). In England, for example, these include scope to design a more ordered and connected workforce planning process, notionally enabled by economies of scale as care organizations across the system are able to pool resources and expertise. As organizational boundaries loosen within the system, so opportunities emerge to create a more integrated labor market between health and social care, as well as between different parts of social care. This is illustrated by the creation of "skills passports" in certain ICSs providing mutual employer recognition of employee skills and competences, facilitating employee mobility between system employers. In Belgium, the FutureCare project enhances innovation and collaboration through regulatory leeway across employment sectors within social care (Department of Care 2025).

Whether such workforce initiatives, suggesting the possibility of a more planned, perhaps developmental, approach to workforce management in social care (and health), have emerged on a broader scale remains an empirical issue. There are, however, grounds for suggesting continuing difficulties in taking this path. Within any given locality-based system, social care providers remain small, numerous and scattered, making it difficult for them to aggregate and articulate their collective workforce and broader service interests, particularly relative to large, monolithic healthcare providers with whom they now interact more closely. This influences the balance of power within any network and the politics of service configuration, particularly given that care funding is typically a "zero-sum game". Thus, with fixed budgets, a service commissioned from social care, and its associated workforce, is likely to take funding from healthcare, generating conflict and resistance.

3.3 | Stakeholder-Centered Literature

Research centered on the social care system and its influence on workforce management in social care runs the risk of overlooking the more granular experiences of key stakeholders in the sector. Certainly, the worker has been pivotal to SHRM analysis, but often as a reactive, atomized figure whose responses to workforce practices in the form of readily measured and "neatly" constructed attitudinal and behavioral outcomes assume importance principally as predictors of organizational performance (Godard 2014). Notwithstanding important HRM streams of research, for example, on equality, diversity and inclusion, the personal and collective values held by workers, their socio-economic characteristics and identities are often overlooked. At best, they are controlled, in typically statistical analyses which rarely acknowledge the "real-world" situated instability and uncertainty of workplace attitudes and behaviors. The volatility of the employees' workplace experience is marked in social care, creating the need for a deeper and more textured understanding of working life. This involves a sharper focus on the service user, especially important as an influence on the employment relationship in care. Indeed, we present the dyadic worker-client relationship as a central feature of social care employment, a key driver of workplace dynamics in the sector.

3.3.1 | The Social Care Worker

At the outset, we highlighted the segmented nature of the social care workforce, comprising waged employees, personal assistants, volunteers and family carers. In this section, we continue to concentrate on the waged employee as the core component of the sector's workforce. It is a component with a distinctive demographic profile, comprising a high proportion of women, people with black and minority ethnic backgrounds and those with migrant status. On average across EU countries, women make up 87% of the long-term care workforce (Pavolini and Marlie 2024), with a similar figure evidenced in the USA (Dorinda Allard 2024). In the UK, those with a non-white ethnic background comprise 13% of the population but make up 30% of the social care workforce. In the US, 40% of the long-term care workforce has a black/African and Latino ethnic background, compared to just over one in eight (13.5%) of the population (Bates et al. 2018). In the UK, one in four social care staff comes from overseas. This is a relatively high figure, although in 2019 a not insignificant proportion of the EU's long-term care workforce, 7.9%, comprised overseas non-EU workers (Dubois et al. 2020).

The most distinctive feature of employment in social care is the nature of the employee's workplace, which is typically the service user's home. This is literally the case with domiciliary workers who visit the client in their private homes or provide live-in support. Other social care workplaces are constructed and function as homes, whether residential or nursing, designed as places where the client permanently lives, their full physical and affective needs being met by staff "round the clock".

Differences in the organization and regulation of the home-as-workplace impact the intimacy and character of the client-employee relationship. For example, in a study of 20 Flemish care homes, Vermeerbergen et al. (2021) found the dynamic between care home worker and resident was influenced by work design: the scope of employee practice and the structure of work teams. This complements Lopez's (2006) research, which relates the nature of the worker-client dynamic to variation in the care home rules of engagement, ranging from the hard, coercive to the softer, empathetic.

Notwithstanding these contingent influences, the workplace-as-home has consequences for how employment is experienced and enacted by care workers. It often leads to an intense personal relationship between the worker and the client, captured by Rodriquez's ethnographic study suggesting that "nursing home staff often relate to residents as 'fictive kin' or 'like family'", with all the associated stresses and strains (Rodriguez 2014, 15). More specifically, it might well affect how clients engage with the care worker, perhaps accounting for the high level of workplace violence and aggression experienced by social care workers. This negative experience is highlighted in several of the articles in our collection (Cavanagh et al. 2025; Mostafa et al. 2025). It is further manifest in the EU European Working Conditions Survey (Dubois et al. 2020, 47), revealing one in three long-term care workers (33%) reporting exposure to some type of adverse social behavior at work, twice as high as the prevalence in the overall workforce (16%). In caring for clients often with chronic mental health conditions, an element of such challenging behavior is to be expected. But given the unusually high incidence amongst social care employees, it is worth speculating on whether this reflects clients emboldened to act in unacceptably aggressive ways towards workers they feel transgress their domestic boundaries and norms.

Alongside this workplace aggression, we have also stressed convergence, particularly at the organizational level, on the application of hard, low-cost HR practices to employees in the sector. This is partly manifest in tightly controlled and insecure working patterns. In England, close to one in five employers directly employing care home staff work under zero-hour contracts, rising to one in three in domiciliary care (Skills for Care 2024). Across EU countries two in five (42%) social care employees work part-time, double the rate for the entire workforce (19%), with many doing so, "because they cannot find full-time work" (Dubois et al. 2020, 1). Indeed, in domiciliary care these contractual arrangements are underpinned by peripatetic forms of employment involving workers traveling, sometimes unpaid, between households and clients, to deliver short episodes of care, tightly monitored by the employer (Rubery et al. 2015). More indicative of the degraded nature of employment is the low pay, and by implication, low status, endured by social care workers. It has long been established that care work attracts a wage penalty in the USA (England et al. 2002) and UK (Barron and West 2013) of between 5% and 10%. More specifically, evidence suggests social care is a low pay sector, with the average hourly earnings of social care workers in most EU countries (24 of 27) 10% or more below the national average rate (Dubois et al. 2020, 29).

The causes of the degraded treatment of many workers in the sector have been touched upon previously. However, it is worth reframing and elaborating on these causes by relating them to the "contextual elements of vulnerability" (Restubog et al. 2023, 2200), and considering them from the employee perspective, rather than the organizational or system, perspective. Several sets of causes can be distinguished. The first is *structural causes*, already presented as shaped by the design and governance features of provider organizations and the nature of the social care system. Social care is a fragmented, competitively driven, and financially constrained system accessible to various organizational forms, often lacking the willingness, ability or capacity to support and develop the workforce.

A second set of causes centers on the *regulation* of employment in the sector. Regulation varies by national context (Dubois et al. 2020; Pavolini and Marlie 2024) but is often diffuse, disordered and weakly administered. This is illustrated in the case of social care in England where beyond the "safety net" of an economy-wide statutory minimum wage, loosely enforced (Pyper 2018), worker treatment in the sector relies on a disconnected set of largely "soft" regulatory mechanisms. A national agreement collectively bargained by trade unions and employers continues, but now encompasses only a small rump of municipal care workers. No longer covered by such an agreement, there is limited evidence on how terms and conditions of employment are determined for the majority of care workers now employed in the private and independent sectors, but it is likely through unilateral management decision-making (Skills for Care 2024). In several European countries sector collective agreements continue, sometimes covering both health and social care workers—as is the case in Ireland, Belgium and Sweden (Dubois et al. 2020, 38). Eleven EU countries have collective agreements covering between 80% and 100% of the social care workforce, including Denmark, France Spain and Italy (Pavolini and Marlie 2024), although, as noted, the pay set typically remains below the national average.

Other regulatory mechanisms also influence workers' terms and conditions of employment. A small but significant presence in the social care workforce, professionals are covered by regulatory bodies, playing a part in mandating aspects of their work as the basis for securing and maintaining registered status. The Nursing and Midwifery Council in the UK, for example, establishes educational and training standards, and the nursing profession's scope of practice. In addition, state bodies with a broader interest in regulating service management and quality in social care usually include workforce issues within their remit. This is the case for the CQC in England. It inspects social care providers using regulations that include a broadly framed requirement that, "Staff receive the support, training, professional development, supervision and appraisals as necessary" (CQC 2025), although how the CQC assesses compliance with this requirement remains opaque.

The third set of causes for the sector's degraded pattern of employment relates to the *nature of care work*, entwined with the characteristics of those performing it. Traditionally, most aspects of social care work have been perceived as low-skilled and therefore low value. In part, this derives from the minimal formal entry requirements to perform care jobs, particularly the care assistant role. More fundamentally, it reflects the presentation of care work as "women's work" involving the use of tacit skills "naturally" developed and applied in a domestic context, "simply" transferred to paid employment (Payne 2009). This view of caring as low-skilled has been contested, for example, by Bolton (Bolton 2004a, 2004b), who views the emotion management work central to care as invariably complex and skilled. Certainly, the COVID-19 crisis encouraged a challenge to the low value placed on care work, given the intensity of the care workers' experience during the pandemic, along with the selflessness displayed by them (Harney and Collings 2021; Fotaki

et al. 2023). However, in many countries, this challenge has not to date led to any tangible policy shift in the treatment of such workers.

A *weak labor market position*, reflecting the workforce intersectionality of gender, ethnicity and migrant status, has created negative worker experiences and treatment in social care, while also undermining the capacity to resist. Blake et al.'s (2024) survey of the largely female social care workforce, found that those employees with black and minority ethnic and non-British backgrounds were more likely to witness and experience violence from managers or colleagues than those with other backgrounds. Limited labor market power also derives from the underdeveloped nature of collective employee voice in social care, highlighted by Hughes and Dundon (2025) in our collection. A systematic review of 19 studies on unionization amongst US care workers in long-term care found trade union presence was associated with higher wages (Abraham-Aggarwala et al. 2024). However, in most countries, including the US, trade union organization in social care remains limited, particularly amongst workers in small independent private sector providers where unions are likely to be seen by employers as "unnecessary" and "unwanted". The muted collective response amongst social care workers to their low-value treatment during and post the pandemic was indicative of this limited organizing capacity, and in stark contrast to the significant scale of industrial unrest displayed by healthcare workforces better able and willing to mobilize (Vandaele 2021).

In general, joining a union and raising collective, as well as individual, concerns continues to prove difficult for social care workers. This is especially so for migrant care workers, often adopting a second language and adapting to a new cultural context, typically on a conditional work visa. In the UK, independent trade unions such as the Independent Workers' Union of Great Britain, formed in 2012 by Latin American cleaners, have emerged, perhaps more sensitive to the needs and circumstances of ethnic minority and migrant care workers than the traditional general unions (Holgate 2005). However, these remain small-scale organizations, with as yet limited collective power (Weghmann 2023).

The consequences of the degraded employment terms and conditions of many social care workers, in terms of their impact on employees' attitudes and behaviors remain nuanced, and perhaps counterintuitive. The harshness of employment in the sector is revealed in the recent Blake et al. (2024) attitudinal survey of social care workers in England, which registers concerns regarding pay and financial well-being. Over two-thirds of social care workers report an absence of financial security, a significant proportion linking this to low pay. It is also glimpsed in the limited personal development opportunities: just over one-third (39%) felt they currently had an opportunity to advance their careers. However, the same survey suggests social care workers are still positively disposed towards their job; thus, over two-thirds (69%) feel that they make a "difference to peoples" lives. This resonates with a research stream suggesting that social care workers often rise above their poor economic treatment to garner considerable intrinsic satisfaction from their work, a function of their capacity to support those in need (Cominetti et al. 2023; Hebson et al. 2015; Vermeerbergen et al. 2021).

The presentation of social care employees as deriving intrinsic satisfaction and a sense of self-worth from their work, possibly tempering the impact of harsh employment conditions, does need qualification. Deep emotional engagement can be a double-edged sword, with the worker satisfaction derived from the close and continuous care of a client having an emotional cost, including as the client's health inevitably deteriorates. In this sense, social care can be a stressful workplace, with the risk of emotional burnout. This is apparent in a recent Swedish study which found that stress and burnout were much higher amongst workers in care homes, engaging intensively with clients, than amongst domiciliary care workers having much more episodic contact with service users (Åhlin et al. 2022). COVID-19 deepened such stress and burnout (Pulignano et al. 2024) and in a survey of just over 600 UK care workers Fotaki et al. (2023) found 82% of respondents working extra hours during this period, and 95% increasing their workload.

Moreover, despite the widely encountered intrinsic satisfaction, staff turnover and vacancy rates in the sector remain high. A US study (Gandhi et al. 2021) found a mean turnover rate amongst staff in over 15,000 nursing home facilities of 128%, albeit with considerable variation between homes. In England, the 2022–2023 *vacancy rate* for social care was close to 10%, well above the national rate of 3.4%. In the same year, *employee turnover* in social care was also high at over 28% (King's Fund 2024). Indeed, there is a considerable fragility to employee organizational commitment. Blake et al.'s (2024, 41–42) survey found half of the respondents "often thought about leaving their employer", with over a third (34%) intending to leave "as soon as they found a new job". Mostafa et al. (2025) in our collection highlight work meaningfulness as a buffer against the less positive features of employment. However, this protective quality is not limitless. As client incivility increases, the study finds such meaningfulness reduces and employee workplace resilience declines.

3.3.2 | The Service User

The services user, variously conceptualized as the client, customer, and end-user, has figured in an uneven and patchy way as a proactive, autonomous and influential stakeholder in the mainstream HRM literature. Heery (1993) explored the impact of service users on the three traditional stakeholders in employment relations—the state, employees, employers and their representatives—but from the perspective of these respective stakeholders rather than the users themselves. Others have conceived the service user as a more proactive actor in public services employment relations, with their own volition and agenda. In the context of Canadian public transport, Bellemare (2000) for example developed a framework differentiating end-user involvement in employment relations by its scope and purpose, teasing out three substantive forms namely the co-production, -supervision and -design of workforce management.

Policy developments over recent decades have provided strong grounds for including service users as a key stakeholder in the study of social care employment relations. The emphasis placed on "person-centered" care is founded on an increased sensitivity to service user perceptions of their own needs and their capacity to articulate and pursue them. This has inevitably

brought service users to the fore in managing their social care, something already illustrated in the case of the directly employed personal assistant. It can also be seen in the context of a government-sponsored programme in Britain to develop new work roles in social care, where end-user contributions ranged from helping to develop job descriptions and recruit, to actually performing the roles themselves on the grounds that they were better able to relate to their peers than the paid employee (Kessler and Bach 2011).

In a more general sense, end-user engagement in workforce management has been manifested in multiple ways in social care. The first is in the emergence of new organizational forms, for instance, related to the concept of collaborative communities (Adler and Heckscher 2006), where citizens take a lead in establishing and managing service delivery organizations (OECD 2011). In Belgium examples include organizations where citizens with disabilities pool resources and live together with support from workers, and care communities in local neighborhoods. New technology and digitalization are crucial for the success of these organizations, facilitating interactions amongst a diverse set of actors (Resch and Rozas 2024).

The second manifestation of end-user engagement is in campaigns on broadly framed social care issues which directly or indirectly touch on workforce matters. For example, in England, a recently drafted national workforce strategy for ASC was overseen by an executive group including representatives from user organizations, Age UK and the Alzheimer's Society. Moreover, Citizens UK, a coalition of community-based groups, has campaigned for the introduction of the living wage for social care workers, with a higher minimum wage implicitly being seen to attract more capable workers and therefore improve the quality of care received by users.

The third manifestation of direct user involvement is co-production. Originally defined by Alford (1998, 128) as "the involvement of citizens, clients, consumers, volunteers and/or community organizations in *producing* public services as well as consuming or otherwise benefiting from them", co-production has increasingly informed public policy as a means of empowering users to develop services more informed by their needs. Cutting across different public services, the approach has informed emerging policy and practice in social care often with a statutory underpinning designed to ensure such user engagement (Hunter and Ritchie 2007). There is an extensive public management literature on co-production: the different forms it takes in social care; the rationale for its introduction and its application in practice (for an overview, see Masterson et al. 2022). In the main, however, co-production has not figured in the HRM literature, surprising given its likely impact on working arrangements and the employee's work experience.

4 | Integrative Summary: Towards an Analytical Framework for the Study of HRM in Social Care

The paucity of research on HRM in the social care sector was a key factor in motivating this special issue. The neglect was seen as puzzling given the considerable size of the sector's workforce, and its significant cost and essential contribution to delivering services essential to community wellbeing and social cohesion both now and in the future. We attributed the sparse coverage to a number of factors. Most striking were difficulties in scoping a sector workforce designed to address a broad and loosely defined set of care needs, not easily distinguishable from, but crucially interfacing with those addressed by the healthcare sector. Indeed, social care was presented as often lost in a wider research literature on care work which diminished the distinctiveness of the institutional social care setting. Locating the social workforce was further complicated by the range of organizational types operating in the sector. These were drawn from the private, public and voluntary sectors, displaying different governance and funding arrangements with possible consequences for the character of workforce management. More generally the paucity of studies was related to the crowded nature of the social care research space. This was filled by disciplines beyond HRM, and suggested a need for HRM research to connect to a broader policy audience, and to adopt or foster an interdisciplinary approach to understanding workforce management in the sector (Harney and Collings 2021).

Building on our call, we suggested a research agenda for HRM in social care informed by three perspectives centered on: the system, the organization and the constituent stakeholders. These perspectives were used in several ways in our editorial. First, they framed our commentary on the six articles published in the special issue. In part, these articles centered on workforce management in care provider organizations (Baluch et al. 2025; Currie et al. 2025; Hughes and Dundon 2025), typically framed by a sensitivity to the systemic features of the social care sector. They also concentrated on the work experience and management of a key stakeholder, the employee, and in particular their direct and challenging interactions with another stakeholder, the service user (Cavanagh et al. 2025; Mostafa et al. 2025; Zettna et al. 2025). Second, the perspectives structured our narrative review of the research literature on workforce management in social care, in the main concentrating on the work of HRM scholars, but also on studies from other fields of study. Figure 1 provides a summary of the main points to emerge from this review. Third, the perspectives, again as presented in Figure 1, more ambitiously provided the basis for an analytical framework for the study of HRM in social care. They were seen as levels of analysis, interacting to shape the sector's workforce management in iterative and connected ways. As such, this framework aligns with a well-established stream of social science research examining how and why socio-economic and political developments manifest themselves as they cascade through macro, meso and micro societal levels (c.f. Archer 1995). Used in this way, we have been able to develop a substantive argument on the nature of workforce management in social care. The framework also allows us to highlight important areas of future research and associated research questions mapped onto the Figure as Q1–10.

Unpacking Figure 1, particularly as an analytical framework, in greater detail, social care organizations (Level 2), often the key unit of analysis for HRM scholars, are presented as nested in a sector system (Level 1), comprising structural and institutional features—for example, a fragmented service market, diverse types of provider and tight profit margins—likely to shape their approaches to workforce management. Indeed, evidence

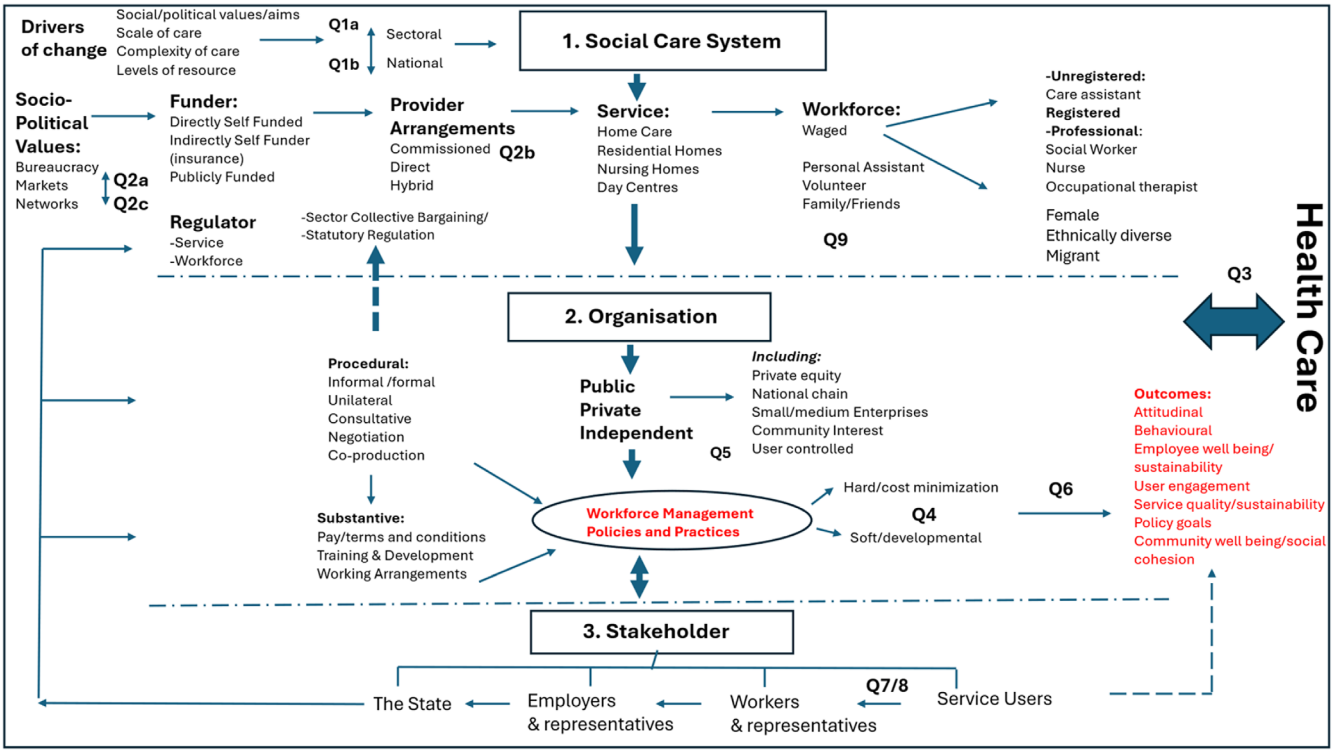

FIGURE 1 | An analytical framework for the study of HRM in the social care sector.

presented suggested convergence amongst social care employers across developed countries on the adoption of "hard", opportunistic approaches to workforce management, founded on cost minimization and degraded terms and conditions of employment. There is scope for research to further assess the potency of these systemic sector features including the nature of the common pressures, and to what degree they continue to generate a cross-national convergence in workforce management (Q1a). At the same time, we have noted important institutional differences between national social care systems, for example in terms of funding, access and regulation encouraging a more granular exploration of whether and how they are connected to workforce management. Are there different national models of HRM in social care, perhaps reflecting different welfare regimes, and if so, what substantive form do they take (Q1b)?

The framework also connects organizational workforce management to socio-political values and aims underpinning the provision of social care at the system level (Q2a). In the face of shared demand and supply-side pressures driving social care delivery, we noted generic shifts over time in many developed countries, from the provision of services through bureaucracies to markets and most recently to networks. Given political and ideological cycles, these shifts are not irreversible and might well overlap as they unfold, generating hybrid models that variously combine features of the different service delivery models. For example, the state commissioning of social care services, previously a means of nurturing competition under a market approach, endures in many national networked systems. This raises questions on the role and influence of the state as service commissioner on workforce management in the sector, particularly through the design, administration and enforcement of the contracting process (Q2c).

More broadly, the contemporary policy emphasis on networked service models encourages a research interest in how the range of actors involved, interact in the delivery of social and health care, perhaps through forms of relational co-ordination (Gittell et al. 2008). In a sector characterized by provider fragmentation and an underdeveloped HR function and infrastructure, we noted cases of networked models facilitating the pooling of employer expertise and resources, and creating the potential for a more planned, perhaps developmental approach to workforce management. There remains considerable scope to further explore the impact of emergent networks on HRM in social care (Q2c). To what extent do such networks allow new, more connected procedural and substantive HRM approaches to emerge between social care (and health) providers and, indeed, commissioners? What factors facilitate or hinder the development of such approaches?

More specifically, the framework highlights the interface between social care and healthcare (Q3). In many countries, these remain distinctive systems, with their own funding, regulatory and governance regimes differentially impacting workforce management and employees' experience. However, with the sectors being driven together by the growing and deepening connection between clinical care and personal support, this interface becomes a pivotal site for research and encourages a breakdown of siloed interests in one sector or another To what extent do social and health care tasks and responsibilities overlap, and, if so, how are they distributed between workers at the frontline? Where does accountability lie for their performance? How is the interaction, and the possible tension between health and social care professionals and other workers, manifested and managed?

The framework is predicated on systemic features constraining but not determining organizational approaches to workforce

management in social care. Despite a convergence in the sector on a "hard" approach to HRM, different organizational patterns of workforce management, including "softer" developmental approaches, were still noted. We saw how a "softer" bundle of HR practices in care might include those often associated with "high commitment" HRM approaches (Beer et al. 1985), such as higher, fairer pay, greater job security, and person-centered care training. Given the labor-intensive nature of care work, the use of "high performance" practices, more typically centered on work organization, including high staff–patient ratios, and a rich skill mix, was also noted. The capacity of outlier social care employers to adopt such approaches begs various questions (Q4), for example: Why and how are such employers able to defy system constraints in managing their workforces in "softer" ways? What are the effects of doing so on workforce management, care processes and outcomes? What is the impact of leadership behaviors even in constrained contexts? Close attention to employer approaches to HRM also prompts a research interest in the range of organizational types delivering social care—private equity firms, SMEs, large national chains, state-run or municipal agencies, and independent, often small, not-for-profit providers (Q5): To what extent does organizational form, in particular differences in governance and funding arrangements, in the scale, scope and nature of their service provision, impact the management of the social care workforce?

The framework presents the organizational outcomes associated with workforce policies and practices in social care as differing in character from those typically examined in the mainstream HRM literature. Readily measurable financial and economic outcomes remain important in a sector that continues to attract employers pursuing profit and shareholder returns. However, in a sector often heavily funded by the state, and seeking to protect and further the well-being of the most frail and vulnerable, care quality and the capacity of the workforce to deliver it assume importance. Care quality is less easily measured and tested, in large part resting on meeting the perceived needs and preferences of individual service users, and with the process of care delivery arguably assuming as much, if not greater, importance than more narrowly conceived outcomes. Indeed organizational outcomes in social care might be examined in a broader value-added way as contributing to community well-being and social cohesion. As we argue above, this encourages an interest in whether social care employers are able to develop a "common good" approach to HRM, an approach able to capture and nurture sustainable worker capabilities with the capacity to contribute to the community in supporting its most frail and vulnerable members (Q6).

At Level 3, the framework highlights the role and interaction of different actors with a stake in the management of the social care workforce and suggests a variety of related research questions. The service user emerges as an important actor, in part a consequence of the emphasis placed by policy makers on co-production as the basis for care design and delivery. This process has been extensively examined in the public management literature, less commonly in HRM (Q7). To what extent are service users involved in the administration of HR practices in social care, such as recruitment, performance appraisal and even pay determination? Does co-production challenge the expertise of social care workers, and if so how do workers manage this dynamic? The significance of the service user as an HR actor also derives from the intimacy of the care worker-client relationship, almost invariably framed by a domestic setting. The emotional intensity of this relationship has been extensively explored in various fields of study, but again more unevenly in HRM, where the predominant quantitative research methods might well be less suited to examining the textured and volatile nature of the interaction and its consequences for the respective parties (Q8).

Finally, the social care worker as a key stakeholder was presented at the outset of the editorial as assuming different forms: the waged employee, the personal assistant, the volunteer, family member and friend. We concentrated on the waged employee as the core of the care workforce, but the working conditions and experiences of other segments are worthy of in-depth study (Q9). These are likely to be diverse and influenced by contrasting workers' personal and socio-economic circumstances and the needs of the client group being supported: younger and older, those with dementia and other conditions, and those with physical or mental disability.

In addressing this wide range of questions, there is a need to balance and seek complementarities between research based on different phenomenological assumptions, seeking data from survey overviews and more intensive qualitative considerations, and from different national contexts. Multi-method and phenomena-driven approaches will inevitably advance contextually sensitive understanding, highlighting interactions and engagements between the levels and stakeholders outlined in Figure 1. Equally, the discussion points to the importance of a range of outcomes, related to immediate social care worker–client interaction through to sector-relevant measures of quality and care. It is also important to consider temporal dimensions, for example longitudinal research on the emergence and development of networks. Finally, despite a wide-ranging call for papers, we acknowledge that the papers received and published are limited in their global coverage.

5 | Practical Implications

In turning to the practicalities, we have stressed the pressing need for a sustainable social care workforce, securely equipped with the skills, knowledge and capabilities to provide ongoing support to aging national populations with chronic and increasingly complex conditions. The evidence base covered in our editorial, together with our special issue articles, has cast light on the significant scale of the task faced by policymakers and practitioners to meet this need. The social care workforce is gendered and ethnically diverse, with a limited voice, often weakly valued in terms of pay, constrained in terms of career opportunities and facing precarious, often physically and mentally challenging working conditions. Perhaps paradoxically, this workforce remains remarkably committed to and motivated by employment in the sector but this should not distract from the fragility of workforce capacity, resilience and stability, with possible consequences for the future security of care delivery and quality. In seeking practical solutions, the published articles, and our editorial point to policy makers and practitioners at the systems level as key to overcoming structural barriers to

organizational workforce sustainability and development. We have also stressed the discretion individual social care providers retain to ensure more ordered and supportive approaches to workforce management, whilst not understating the level of resource and expertise needed to do so.

In a sector responsible for the care of a community's most vulnerable members and where such care could and perhaps should be seen as a public good, the state remains a key actor both as a sector regulator and a funder, but with possible tensions between these respective roles. In a labor-intensive sector, care quality is dependent on the regulation of terms and conditions of employment that ensure the adequate supply of care workers, their retention in the sector, as well as their workplace motivation and dignity. In many developed countries, the fragmented nature of social care provision inhibits voluntary collective employer and worker attempts to forge meaningful sector-wide substantive and procedural rules of employment. In such circumstances, the state and related bodies assume importance in developing and enforcing such rules. Less directly, there is also scope for the commissioners of social care services, at the national or municipal level, to secure regulatory compliance with employment standards through provider licensing and contractual requirements.

Substantively, this regulation might include: statutory minimum employment standards, for example, a sector's "living wage" or protection against the misuse of zero hours contracts; mandatory entry and training requirements; and the inclusion of workforce management as an essential and much more transparent part of broader regimes of care inspection. Procedurally, the state might broker collective bargaining arrangements in social care where they are not already in place, a move underway in Britain, where a new statutory negotiating body is being established (Sisson 2024). Such collectively bargained agreements already exist in certain EU countries, raising questions for policy makers about their breadth of coverage and the level of enforcement. In some countries, agreements cover both health and social care sectors, creating a "level playing field" for the treatment of staff. In others, separate and divergent sector agreements exist, with the potential to generate a more fragmented labor market and dysfunctional worker mobility between sectors.

However, employment regulation by national and municipal policymakers will likely increase labor costs for social care providers. Any tightening of regulations raises funding issues, including increased public expenditure with monetary and fiscal implications. If public funding fails to adequately cover these regulatory costs, providers face limited options: reduce expenses at the risk of compromising care quality, increase charges for self-paying clients, or raise insurance premiums. These latter responses, in particular, risk deepening or creating community divisions over who should bear the cost of social care.

At the organizational level, practitioners, particularly employers, need to confront the balance between constraint and choice. In a sector where profit margins are often low, corporate debt and shareholder interests need to be serviced, and small and medium-sized care providers predominate, there are structural limits on the scope for investment in the workforce and on the establishment of a specialist HR function and infrastructure to enable this. The opportunistic, low-cost approach to workforce management in social care has been presented as indicative of and perhaps driven by these limits. At the same time, the determinism of systemic structures should not be overstated. The adoption of a low-cost approach to workforce management as a strategic organizational choice cannot be discounted. The choice to adopt developmental, high-commitment workforce practices, however, remains, clearly taken by some social care providers and empirically found to be associated with better care outcomes. Equally, research points to the impact of leaders and supervisors as key intermediaries mitigating some of the severe contextual factors, providing greater scope for local consultation, feedback and engagement and improvement in work organization and design.

6 | Conclusion

Our special issue, and its accompanying editorial, have sought to bring to the fore workforce management in social care as a domain worthy of more extensive and detailed research within the field of HRM. In any developed country, social care is a large, labor-intensive sector delivering services increasingly important to community members, but facing deep-seated challenges in recruiting, retaining and motivating staff. It is a rich research domain comprising different and interacting institutional levels, and characterized by distinctive employment features, not least the home-as-workplace, unleashing an emotionally charged working environment. Our analytical framework, relevant to scholars, policymakers and practitioners, is presented as a means of navigating this intriguing but complex and neglected employment landscape.

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Conflicts of Interest

The authors declare no conflicts of interest.

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