Care work and status subjugation: an exploration of the relationship between care work organisation and training, and the recruitment crisis in adult long-term care

Abstract

Using data from interviews, workshops and focus groups with 149 care workers across five European countries, we show how a combination of organisational structures and social constructs impact recruitment and retention in the adult social care sector. Our study focusses on the lived experience of residential and domiciliary care workers, identifying low status, role stigma and organisational structures as key barriers to personal and professional development leading to role dissatisfaction. Our research explores specific constraints faced by care workers and proposes processes, which could increase the status of care workers and improve recruitment and retention within the sector.

Keywords

Adult social care, care workers/providers, care worker recruitment/retention/training, role stigma

Introduction

European Union (EU) data suggests that there are common challenges and structural weaknesses across the care work sector (Social Protection Committee, 2021).[1] Challenges faced by the sector include organisation fragmentation, significant recruitment problems and high staff turnover, exacerbated by perceptions of care work as a low-skill, low-status add-on to health care, lacking 'parity of esteem' with medical services (Quilter-Pinner and Hochlaf, 2019). This crisis is predicted to worsen as population demographics change over the next 30 years, with the number of people aged 65 or over in the EU-27 set to rise by 41% and more than 7 million more people needing long-term care by 2050 (European Commission, 2022, p. 12).

To explore this issue and propose solutions, we use data from interviews, workshops and focus groups with 149 care workers across five European countries to examine how organisational structures and social constructs impact recruitment and retention. For the purpose of this article, we define care work as the 'work of looking after the physical, psychological, emotional and developmental needs of one or more other people' (European Institute for Gender Equality, 2023). While it is widely recognised that much care work is unpaid (Duffy et al, 2013; Folbre, 2006), we focus on care workers employed in residential and domiciliary care settings by social services (local and state authorities), small and medium enterprises (SMEs) and charities.

Our empirical findings support a model of *status subjugation*, which shows how stigma, public devaluation of care roles and fragmented organisational structures interact to suppress the development of recognised professional identity and limit opportunities for advancement. This model illustrates how care workers' self-perceptions and experiences are shaped by the interplay of social devaluation and systemic neglect, reinforcing the perception of care work

as unskilled and morally driven rather than being an externally valued and professionally significant career option.

We contribute to existing literature by demonstrating how social perceptions of care work, institutional stigma, and the fragmented, often small-scale organisational structures of the sector combine to restrict access to the development opportunities required for professionalisation. Since provision is dispersed across numerous SMEs, charities, and quasi-familial organisations, care settings often lack the managerial capacity, support protocols, and coordinated training systems that more integrated health services can provide. This fragmentation undermines recruitment and retention and ultimately affects the quality of care and outcomes for service users. By capturing the lived experiences of care workers across diverse European contexts, we shift the debate from improving individual skills to challenging the structural and cultural conditions that can render those skills invisible.

Care work and society

The notion that women are functionally suited to more expressive, caring roles and men to more instrumental roles are stereotypes that remain deeply embedded in the care sector, where over 80% of care workers in all countries where there is data are women (World Health Organization, 2024). There is consensus in the literature that care work is viewed by society as the 'natural sphere' for women (Cuban, 2013; Folbre, 1994, 2006, 2008a; Gray, 2010; Olasunkanmi-Alimi et al., 2022; Stacey, 2005). In turn, this encourages employers to promote the positive benefits of a naturally caring (female) workforce to care recipients and their families who are the customers of this largely for-profit sector (Folbre, 1994). These same social constructs enable employers to give credence to notions there is limited need or demand for training or role progression from care workers, who are widely seen as working for secondary wages or fulfilling a caring vocation (Palmer and Eveline, 2012). This process

further devalues care work, undermining the essential role care must play in contemporary society (Folbre, 1994).[2]

The financial imperatives driving adult social care policy are implicit in the widespread deskilling of care work in public and policy discourse, for a skilled workforce is more expensive. Paradoxically, though, care work is a multifaceted occupation, demanding and requiring specific high-level skills (Cameron and Moss, 2007; Pavlidis et al., 2020). In fact, while viewed as 'unskilled' and correspondingly being low paid, care work in community and residential settings involves high levels of expertise across clinical, emotional, and coordination domains. Care workers routinely manage diverse needs such as dementia, stroke, end-of-life care, and complex nutrition plans during a single shift (Murphy and Turner, 2017). They also engage in emotional labour requiring rapid judgement and significant moral discernment (Bailey et al., 2015; Johnson, 2015). Home-care staff draw on detailed knowledge of client needs, legislation, and care plans to deliver safe and dignified care (Lloyd et al., 2024), while collaborative models for care in dementia show how care workers operate at the interface of health, social, and technical knowledge (Murphy and Turner, 2017). Such competencies go beyond routine task-based activities and require both technical knowledge and emotional intelligence, challenging the perception of care work as 'low skilled' and highlighting the need to reframe it as a skilled, professional role deserving of recognition and support.

The pay and benefit gaps experienced by care workers have far-reaching implications. For example, many employers do not offer paid sick leave (Community Integrated Care, 2022), which leads to presenteeism, increasing health risks for both workers and care recipients. Limited or non-existent pension accruals exacerbate long-term financial insecurity,

particularly for women, who dominate the sector (Community Integrated Care, 2022). Recent EU initiatives, including the European Care Strategy, emphasise the need for fair working conditions and social protection in long-term care. Enforcement, however, remains uneven and progress towards equitable pay and benefits within adult social care remains slow. Without robust access to benefits, care work continues to be undervalued, contributing to high turnover, workforce shortages, and declining job attractiveness (Folbre 1994; 2014; Folbre et al, 2023). A proportion of care workers do undoubtedly find the work fulfilling, despite low pay, low status, and heavy demands (Hebson et al., 2015), but this should not detract from the central issue of every developed country in the world currently experiencing a recruitment and retention crisis in adult social care (UNI, 2025).

Care work and stigma

Goffman (1963/2009) conceptualises stigma as a means of explaining how social categorisations are used to justify the 'othering' of individuals or groups in society. Stigma enables discrimination, which in turn affects how the stigmatised individual or group can participate in wider society. Discrimination amounts in all cases to a reduction in life chances, and what Goffman terms a 'spoiled identity,' which the stigmatised person may respond to by adopting strategies which could improve their status in the eyes of those making social judgements. Indeed, it may lead workers to conceal the truth of their experiences in order to maintain their work role and reduce or manage work-related stigma (Goffman, 1963/2009).

The role of social information in constructing stigma is highlighted by Goffman and noted in the social construction of care. Since the early 2000s some sociological perspectives have focussed on care as 'dirty work' (Duffy, 2007; Ostaszkiewicz et al., 2016; Stacey, 2005, 2011; Simpson et al., 2012; Simpson and Simpson, 2018), which may be linked to role stigma. These authors highlight the social and moral jeopardy of occupations that are outside

the mainstream by dealing with things perceived as being 'dirty' – such as human bodies in this case. This in turn stigmatises these groups of workers and spoils their identity (Dick, 2005; Goffman, 1963/2009). The need to repair a spoiled identity leads workers to employ normalisation strategies (Ashforth and Kreiner, 1999), which may be used to highlight the high moral status of care work (Stacey, 2005). However, Stacey (2005, 2011) notes how internal strategies developed by care workers to restore their dignity then act to reduce the visibility of the severe inequalities faced by this workforce who are rarely unionised and experience persistent low-pay and low status.

Following Goffman, stigma scholarship in health and care settings has been further developed by Link and Phelan (2001, 2006); Link et al. (2004); Phelan et al. (2010) and Hatzenbuehler et al. (2013), who significantly broaden the scope of analysis. Goffman (1963) provided the foundational language for understanding stigma as an interpersonal phenomenon marking and discrediting identity. Building on this, Link and Phelan (2001) introduced a multi-component framework foregrounding the role of power relationships in the stigmatisation process. They identified key mechanisms – labelling, stereotyping, separation, status loss, and discrimination – and set out a process of stigmatisation, arguing stigma is only enacted when power differentials allow these processes to occur. Their later work operationalised this model for empirical research and directly linked stigma to tangible life outcomes, such as employment, housing, and access to services (Link and Phelan, 2006). Phelan et al. (2010) extended the theory by asking not only how stigma operates but why it persists. They argue stigma serves a social function, with a role in justifying inequality, reinforcing existing hierarchies and limiting access to power and resources. Hatzenbuehler et al. (2013) contributed the concept of 'structural stigma,' which moves beyond the individual and

institutional levels to consider how laws, policies, and cultural norms embed stigma within society.

Meanwhile, Tyler and Slater (2018), in a special issue journal devoted to stigma, reposition it as a political and economic instrument. Within this collection, Paton (2018) argues stigma can be economically productive in a neoliberal labour market, which is particularly pertinent to our examination of the adult social care sector. Her analysis of stigmatised places demonstrates how negative social value can be leveraged to suppress wages and resist professionalisation. In this sense, stigma is not merely an outcome of inequality, it is a tool used by the (relatively) powerful to sustain it. As she notes, 'stigmatisation is a key form of exploitation integral to capital accumulation' (Paton, 2018, p. 921).

The contradictions identified in this literature are also reflected in analyses of care work before and during the COVID-19 pandemic. Stacey's (2005, 2011) insights into dignity repair and moral positioning, together with critiques of symbolic recognition (Wood and Skeggs, 2020) and 'bitter recognition' (Manthorpe et al., 2022), underscore the persistent structural inequality within the sector, and how public appreciation is very often only fleeting. These accounts reinforce the need to conceptualise stigma not only as an interpersonal process, but as embedded in organisational, cultural and political-economic arrangements.

Taken together, these works shift the conceptualisation of stigma from a mark upon individual identity to a multi-level social process with the power to reinforce and embed structural inequality. Each contribution–Goffman's identity focus, Link and Phelan's power-based framework, Phelan et al.'s functionalist analysis, Hatzenbuehler's structural public health model, and Paton's political economy lens–serve as building blocks helping us understand how care workers become and remain devalued. These theoretical developments directly

inform our analysis, which explores stigma as a socially embedded force undermining social care workers status and preventing them from gaining a professional identity.

As such, we pose the following research questions: 1) What are the lived experiences of care workers with respect to stigma and the social perceptions of care work? 2) How do these factors act as barriers to recruitment and retention? 3) To what extent can training and development be used as a means to address the above issues?

Methodology

Our underlying methodology was Participatory Action Research (PAR). This was appropriate because it centres the voices of those with lived experience and supports collaborative knowledge production aimed at social change. Given the marginalisation often experienced by care workers, PAR provided a framework in which participants could help shape the research direction, validate emerging findings, and co-develop policy and practice recommendations. Our approach combined quantitative data collection (see Pavlidis et al., 2020), semi-structured interviews, interactive workshops using the Ketso method,[3] and facilitated discussion sessions enabling care workers to reflect critically on their experiences and influence the analytic process. Participants also contributed to an advisory panel, ensuring their insights informed both data interpretation and dissemination. Our democratic and iterative process is well aligned with the principles of PAR, which emphasises empowerment, reflexivity, and action (Wicks et al., 2008).

Methods

The research reported here was undertaken as part of two funded EU projects covering the UK, Poland, Greece, Italy and Bulgaria, the first running 2015–2018 and the second 2020–2023, with the only partner change being in geographic focus within our Greek partnership, where data collection moved from Thessaloniki to Athens. This choice of countries was the result of long-term cooperation between partner organisations, previous joint projects on care,

and trusted access to the desired target groups. Over the course of the two projects, we recruited 699 people involved in the provision of care in a range of settings such as care workers, care managers, care recipients, care commissioners and directors of social services. The project team collected quantitative and qualitative data using a survey, semi-structured interviews and workshops (see Table 1). The research plan was submitted for ethics approval at Lancaster University, coordinating the projects and completed in line with ethical guidelines.

Sample

Our five partner countries represent the broad experience of long-term care provision, namely, in-home care (live-in or domiciliary), day care centres, care homes and nursing homes. All five countries maintain some limited state and charitable (not-for-profit) care provision, while the for-profit sector provides an increasing amount (Poland, Bulgaria) or even the majority of long-term adult care (UK, Italy, Greece). While broadly the same types of provision are available in each country, the balance of provision differs in each case. For example, Italy has a tradition of employed (often immigrant) carers living in the family home, whereas in the UK, domiciliary care is the dominant provision. While paid-for care is the focus of this article, each country also relies heavily on unpaid care from family and friends. Of the 124 interviews reported here, two from each country were with unpaid, informal carers, though this data is not included.

[Table 1 HERE: Types of data collected]

In this article, we focus on the qualitative data from our funded projects, collected via semi-structured interviews and workshops. We also make a brief reference to our quantitative data where relevant (see Pavlidis et al., 2020 for a detailed analysis). Qualitative data collection included 149 participants, of whom 124 took part in semi-structured interviews and 25 in Ketso-based workshops.[3]

We used a convenience sampling strategy because employment data from all participating countries showed the care workforce structure to be broadly uniform (European Commission, 2018; Hirst, 2019; Skills for Care, 2025; WHO, 2015) but ensured our sample included care workers from each of the different types of care provision (e.g., public/private sector, day care, live-in care workers, care homes and domiciliary care). We employed research coordinators within professional networks in each country to help us recruit participants. In each participating country, we collected first-wave data from care workers as follows: 19 care workers in Poland (all Polish born), 20 care workers in the UK (including two migrant care workers, four minority ethnic care workers and two male care workers), 20 in Bulgaria (all female and all Bulgarian born), 20 in Greece (including one migrant care worker and four male care workers), and 20 in Italy (all female care workers, two of whom were migrant care workers), giving 99 first-wave interviews. In addition, 25 care workers, five from each country, took part in Ketso-based workshops, providing additional data. Second-wave data included here comes from 25 interviews conducted between 2021–22 with care managers. Across all data collection points the topics covered were skills needed for care, training needs, barriers to training, perceptions of care work (both by staff and society), reasons for working in the care sector, and experiences of interactions with care recipients and managers. We also conducted workshops with 5 care workers from each participating country to explore in greater detail issues raised in the quantitative part of the study and the interviews. A summary of our sample characteristics can be found in Table 2.

[Table 2 HERE: Summary of characteristics of care worker interview sample]

After translation and back translation of transcripts from interviews and workshops (Brislin and Freimanis, 2001), data was verified for consistency, reliability, and quality by open

coding, using preliminary open/deductive codes established by the lead researcher in each partner country. Initial open/deductive codes were broad, drawn from our literature reviews and discussions with our project advisory panel. Examples of codes included in the initial process were: motivations for taking employment in care work, stressors in the workplace, training needs, opportunities for career progression, social perceptions of care, personal self-esteem, and wellbeing.

The authors of this study narrowed down initial open codes to axial codes, which were refined through collaborative selective coding across the five countries to build a narrative. For example, the axial code of self-confidence grouped together open/deductive codes of stressors in the workplace, self-esteem, wellbeing, and social perceptions of care. We focussed on quotes including vocabulary around trust, dependence, reliance, assertiveness, shyness, nervousness, anxiety, avoiding social situations, comparing self negatively to friends/family/community, tending to avoid new experiences and procrastination, as well as any explicit mentions of confidence. The coding process supported the description of data content and facilitated a combined analysis of all interviews and the development of a narrative account.

This process led to the development of themes, enabling the research team to identify depth and details. Triangulation with data from our quantitative study and workshops allowed exploration of the research problem from several viewpoints to confirm the credibility, validity, and generalisability of the conclusions (Bryman et al., 1996; Gilbert, 2000; Miles and Huberman, 1994; Olsen et al., 2004).

Results

The following sections address the key themes derived from our data. Theme 1 examines social devaluation, focusing on external social, cultural, and institutional narratives framing care work as low-skill, feminised and morally driven labour. Theme 2 shifts attention to the lived experience of stigma, analysing how workers internalise, negotiate, or resist these external narratives. Theme 3 explores access to training and opportunities for progression, considering how the structural and organisational barriers identified in Themes 1 and 2 shape workers' ability to acquire skills, exercise autonomy, and develop a recognised professional identity within an undervalued sector.

Social devaluation

Our findings reveal evidence that social perceptions of care work significantly impact recruitment and retention. Many participants see care work as an unattractive career option, a 'last resort' (UK14), 'my duty' (UK10, IT12) or 'all that is available at the current time' (GR2). Despite most respondents enjoying the work, these perceptions push staff to leave the care sector as: 'I want a better job, better pay' (IT3). The director of an organisation employing 800+ care workers told us: 'I dread Aldi or Lidl opening a new store near any [of our] homes because every time four to five staff leave.'

While many care workers understood their role(s) required high levels of skill, they believed the wider public, employers and families of people receiving care did not recognise this element of their job.

> The devaluation of this profession by those around them [care workers] is evident. On the one hand, out of ignorance of what is really care work, on the other hand, due to the inadequate training of staff resulting in the impression we are unskilled. (GR2)

Social perceptions of care work as 'dirty work,' undertaken by a low-skilled workforce (c.f. Clarke and Ravenswood, 2019; Hughes, 1951; Ostaskiewicz et al., 2016; Stacey, 2005), were deeply embedded among the people we interviewed. Our participants felt stressed, undervalued, and even shamed by their job – 'Unfortunately, this profession is seen as necessary but disreputable' (BG3) – while a UK carer said she rarely told people she was a care worker because they might look down on her. Many care workers felt they were second-class workers, with some reporting being abused and unhappy at work and often feeling poorly supported by management, care commissioners and relatives of people receiving care.

Many of the negative social perceptions we uncovered in our research appeared to be rooted in cultural assumptions that caregiving is a 'natural' extension of women's roles and therefore undeserving of professional recognition or adequate pay. As Folbre (2006, 2008b) argues, care is often devalued precisely because it is feminised, unpaid in the home, and associated with mothering – another role widely perceived as instinctive and low-status. If care is 'natural,' the logic follows that it requires no special training or expertise. Our data supports this account, indicating that while public discourse assumes 'anyone' (by which we really mean, any *woman*) can do care work, the actual labour involves complex decision-making, emotional intelligence, and high levels of technical competence.

The paradox, then, is that society entrusts care workers with its most vulnerable members – children, older adults, and people with disabilities – while simultaneously denying the value and skill of that work. This broader cultural framing provides the backdrop against which the personal, gendered and emotional experiences explored in Theme 2 unfold.

Structural stigma

While Theme 1 outlines how external cultural and social narratives often construct care work as low-status and feminised labour, Theme 2 explores how workers experience, negotiate, and sometimes internalise these narratives.

Socio-culturally embedded notions of moral and/or social obligation often shaped the decision to undertake or continue care work, with comments about the vocational nature of the role common. These participants accepted low pay and low status in the minds of others because they internalised an almost religious motivation for their work: 'This is the job of my life because I feel that as a vocation' (IT20). These factors seemed to uniquely impact the female respondents in our study. Only one male respondent reported feeling a moral obligation to care. The research data revealed many women experience this obligation, perhaps as the result of embedded gender roles (Folbre, 2008b), or to repair a stigmatised identity (Goffman, 1963/2009).

However, respondents who felt a vocation did not see this as a negative issue. One interviewee described her experience in the workplace as a reflection of a traditional gender role in the family:

> The feeling of doing something good for humanity, when you are working with vulnerable people, it is not about the money that you get, we get completely nothing. It is the feeling you get by doing something good for people. That's the one positive thing, in care, the way they come to rely on you, the service users, even if they don't talk, they look to you like a mother. (UK4)

These motivations appeared to reflect an almost spiritual belief among some participants that they had a particular calling for this type of work that was stronger than low pay, lack of training or lack of respect from wider society; and this belief motivated some care workers to remain in the sector. This illustrates how vocational identity can both shield individuals from

and reinforce structural stigma, making it emotionally sustaining while simultaneously limiting resistance to poor conditions.

This moral obligation was also reinforced in some contexts by traditional gender roles, especially in southern and Eastern Europe, where, until recently, a family would be considered shamed if it did not provide care for a relative. This intersected with the preponderance of small and medium enterprises providing residential and domiciliary care, mimicking traditional family structures, as well as the domination of home-based self-employment (often informal and in the grey economy) across the care sector in Bulgaria, Italy and Poland.

In Italy, where many care workers are migrants working in the homes of the people they are caring for, workers faced both stigma and significant precarity, including risks of modern slavery, lack of legal protection, and invisibility within the host country. Similar patterns appeared in Poland, where informal work in the grey economy was common and legal protections were limited.

> I would probably not do it if I had a choice. It is not paid well. This job requires physical and mental strength. Young people do not want to do this job because of lack of prestige and poor money. (PL9)

These experiences were common across all partner countries and reveal the presence of multiple levels of institutionalised stigma. Structurally, workers are often excluded from labour protections or formal employment systems. Organisationally, they are frequently not given professional recognition, development, or voice in decision-making. Interpersonally, they face disrespect and shame from others in the wider community and in public discourse. Together, these accounts show how external stigma (Theme 1) becomes internalised, embodied and lived (Theme 2), shaping identity, wellbeing and the emotional experience of care work.

Organisational constraints

Our study found significant evidence that care workers do not have established routes to explore work practices or training needs with managers. This lack of opportunity for dialogue reflects structural and interactional constraints: hierarchical decision-making, time pressures, fragmented leadership, and fear of being seen as problematic all contribute to a climate in which learning is not prioritised. We found care workers are often placed in situations where they feel they have inadequate levels of knowledge to manage effectively, and this causes them stress and anxiety.

> Sometimes the work of the carer is also very unsafe especially when they are using the hoist, sometimes no proper hoist, no proper sling you know… unsafe work is normal, […] you cannot complain and they don't want to pay for training and pay to cover your shift while you're off training. (UK8)

This type of experience was common in all countries, showing how unsafe working conditions are normalised and often linked explicitly to employers' unwillingness to invest in both the cost of training and the time to attend it. This can be seen as the consequence of institutional neglect coupled with unequal power relations between care workers and managers.

This is evidenced in the fact that many participants reported a general lack of management engagement in the daily routines of care, which leads to managers failing to recognise the types of training needed. Care workers generally found it easy to identify their own training needs, including the need for practical, hands-on training in stoma care, stroke care, dementia care, effective communication with patients and their families, and end-of-life care (Pavlidis et al., 2020). However, the most common types of training provided were instead: completing paperwork and following regulations (Bulgaria); completing paperwork, regulations, ethics, lifting and handling (Poland); repeating the Care Certificate each time they changed employer

(UK); fire safety, mental capacity or ethics, regulations, and lifting and handling (Greece, UK, Poland and Italy) (Pavlidis et al., 2020). In total, care workers identified more than 400 unmet training needs and reported either not being able to access training beyond that routinely provided, or that the training they needed did not exist (Pavlidis et al., 2020). This mismatch between what is provided and what workers need reflects a form of symbolic compliance: employers meet external obligations while failing to support internal development.

Care workers often explicitly linked training opportunities to progression but were not optimistic that access to training would enable career advancement.

> You know you can move up if you get an NVQ [level 3 qualification] but the management's quite a small cluster you know, there's not many, so there's not a lot of scope, well if somebody leaves, yeah if somebody leaves then you can move up. (UK9)

Some care workers also noted that they needed to be seen as compliant with existing management practices in order to progress: ‘I see a career progression in this sector only if I learn not to express my opinions, even if they are truthful.’ (IT15)

This highlights the interactional dimension of stigma and control, where progression within the profession depends not only on training but on acceptance of institutional norms, and maintaining silence in the face of poor or even dangerous practice.

Indeed, we found care workers regularly developed strategies to negotiate around managers in all partner countries. One carer even described how her suggestions were routinely adopted only when attributed to management:

> The organisation sometimes doesn’t want to show that the opinion you’ve put across is important…, they’ll play it down. But sometimes, down the line, you’ll find the opinion that you’ve put across is implemented, they act like it’s their brain-child. (UK4)

Others described highly hierarchical relationships that positioned managers as unquestionable authority figures:

> Our work is not valued by the centre manager, our opinion is not taken… everything, even on the matter where we're the expert. Everything must be done the way he sets out, like the olden-days Papa, he is always right, we are always wrong. (BG6)

In several cases, workers took unilateral steps to maintain professional standards or protect those they cared for, even when this meant acting without managerial approval. For example, going online to learn more about stoma care (UK), taking first aid courses at their own expense (Italy), and hiding stocks of PPE from management to ensure they were available to use (UK).

Several carers also described actively unsafe or professionally compromised situations in which raising concerns was discouraged or punished. For example, one UK respondent recounted being told not to use protective equipment:

> So the organisation buys this protective equipment…, yet when they find some people who are very careful and want to use these things all of the time, through the gossip from other staff members who do it [the task] without any [protective clothing], then the managers say you must not wear masks and throw them away. And you are scared to lose your job… you can't voice anything in case you lose your job, even if you know it's not safe. (UK14)

Across countries, respondents noted that many managers had been in that post for long periods, often without qualifications in leadership or staff development. Workers reported that managerial resistance, lack of understanding about training needs, and limited opportunities for dialogue left them with little scope to influence decisions or improve their working environment. In some cases, poor training led to direct safety risks: 'Sometimes the work of the carer is also very unsafe… sometimes working without a hoist because they think that they can manage… unsafe work is normal […]' (UK8).

One of the most commonly identified training needs was, therefore, leadership training for managers rather than frontline staff. Workers emphasised that without competent leadership, organisational learning, workplace safety and staff development were all compromised.

> I see much need for training and for managers to listen. They do not ask our opinion on how to work the program better or when we say our opinion on certain things [it] is rarely taken seriously, that is we do not see much zeal in that direction so now I don't bother to speak out. (GR19)

The management structures often left care workers with no system through which to complain or negotiate in situations where managers behaved unfairly or disregarded professional standards. Power relationships were deeply unequal, reflecting what Folbre (1994) terms "structures of constraint." Even where the workplace appeared to have a flat structure, the often familial or quasi-familial organisation of care homes created hierarchies that legitimised inequality and placed care workers firmly at the bottom.

Fragmentation and lack of professional identity

The fragmented, often peripatetic nature of care work means that there are limited opportunities for staff to compare their experience with other organisations so staff are not aware of alternative approaches to the management and delivery of care. The opportunities afforded by the larger organisations are a stark contrast to those working for smaller, less well-managed operations. One interviewee who worked for a large UK charity commented:

> I retired from teaching but got bored being home... I got several days of training in Liverpool, and I get to choose courses now, that fit with my skills. It all feels very professional. My teaching experience is respected, I feel like I contribute to a team. So, now we plan activities with proper outcomes for our residents, rather than just trying things out. (UK7)

This comment illustrates the potential for training to empower staff and improve retention. However, this experience was unique among our interviewees; most did not feel they had a

professional persona. One respondent reported that she experienced significant distress at being unable to access training, equipment or to be respected as a skilled carer.

> I did the Care Certificate [UK Government mandated training] when I started, fire safety, lifting and handling, food and meds safety, mainly short, online courses. Each year there's a training day, just our manager discussing new activities for residents, or a refresher on dispensing meds, nothing to develop skills… I want to move into management but no training, no opportunities, you know your employer doesn't value you when they won't train staff up. (UK14)

These accounts highlight the issue of dual stigma within the workplace: the devaluation of the role and the implicit message from employers that care workers are not worth investing in. The predominance of online, repetitive, compliance-focused training, often delivered in workers' own time and without pay, signals to care workers that their work is viewed as task-based and routine rather than relational and skilled. This contrasts sharply with the actual demands of care work, which involve high levels of emotional labour, ethical judgment, and personal resilience. The apparent invisibility of these skills reinforces stigma.

Barriers to progression

Just over 26% of our care worker participants saw care work as a route to other roles, aiming to progress to healthcare assistant (a comparable role but within a hospital), nursing, social work, physiotherapy, speech therapy, or occupational therapist training within five years. For these respondents, care work was a stepping-stone, but they described being stuck in roles that offered little preparation for more skilled responsibilities.

> It's difficult to work out if I don't get opportunity because I'm a woman, or a migrant or it's just down to how care's organised. Everyone on the floor can see the need for specialists in care, for support and training to improve things, for access to basic equipment and so on, but there's no real change, and I don't see it coming. (UK14)

The desire to attain a more professional status appears to be one of the reasons for very high rates of turnover. In England, the turnover rate was 23.1% in 2024/25, and there were over 111,000 care sector vacancies in July 2025 (Skills for Care, 2025). Turnover data is not

collected in all European Union countries, but where it is we see similar figures. For example, in Austria 75% of care workers are considering leaving the sector within three years; in Portugal, staff turnover is around 36% (Eurofound, 2020, p.13) while the European Union considers it highly likely that true vacancy rates are much higher as there are high levels of undeclared work in the sector (Cedefop, 2023).

Building motivation and job satisfaction

More positively, many care workers reported feeling a strong sense of satisfaction, affection for clients, pleasure, and pride at succeeding with complex tasks, often with inadequate equipment or knowledge, a strong camaraderie with colleagues, and most felt they did person-centred work to a high standard even under difficult circumstances.

> This job satisfies me emotionally in terms of what I see in some people I care about. I see the gratitude in their eyes. That satisfies me more than the whole part of my job that I feel like I am helping a man in need. (GR19)

These positive factors could be expected to support retention. However, for many care workers there are insufficient pull factors when set against role stigma, poor pay, and lack of support via from managers to enable them to cope with the many complexities and stresses of their role.

One of the major problems is the restrictive nature of organisational structures that are difficult to change. Challenging role norms and expectations is daunting, especially for care workers whose role places them at the bottom of a hierarchical organisation.

> The carers don't see any way for professional development. Sometimes I meet carers for 15 years who have good skills and knowledge who were never pushed up. […] Still a simple care assistant. (UK6; moved on to nursing since being interviewed)

A care worker trained as a senior midwife in Poland told us she was unable to get a job in the NHS, so took a care role in the UK. She found the lack of training ‘incomprehensible’ and

later returned to Poland, setting up a domiciliary care business, which at that time was a new concept in the country. She highlighted poor communication from managers a significant barrier within the organisation: ‘Sometimes the management forget about additional training, they don't speak with the staff. They are only interested in making sure the rota is OK.’ (UK8; now running her own care business overseas)

This comment draws attention to another key organisational constraint: a focus on the short-term, rather than developing a long-term strategy that may benefit the organisation and its staff in the long run. For example, even in larger organisations with existing training programmes, there was little flexibility and no option for personalisation. The training was often brought in without consulting staff about what might be useful, with staff seeing this as a 'tick-box' exercise to show inspectors, patients, and families that training had taken place. A member of staff at a UK care home reported taking part in the same or very similar training session each of the five years she was with one employer, but as many staff were new to the organisation each year the employer saw no need for change. So, while management may have technically ‘provided’ training to staff, the lack of strategic thinking meant that experienced staff were not supported, felt devalued in their roles, and were more inclined to leave.

Discussion

It is clear from our data that a large portion of the care work force is demoralised. The participants in this research clearly identify and resent their low social status while recognising the potential for training and professionalisation to improve their status and equip them with skills to deliver better care to clients. However, professionalisation is only one part of a much wider necessary solution.

Our findings highlight the significance of the two inter-linked ideas of status and stigma, which act as both visible and invisible barriers to recruitment and retention. Understanding the relationship of status and stigma to the global recruitment crisis in care is important, and our evidence suggests the following model of our findings (see Figure 1):

[Figure 1 HERE]

The two-way relationships in our model are between stigma and low status, a relationship which was not an unexpected finding, as previous work has drawn similar conclusions (Aronson and Neysmith, 1996; Folbre, 1994; Nishikawa and Tanaka, 2007; Razavi and Staab, 2010; Stevens et al., 2012). However, we also identify two-way relationships between the fragmented care sector, profit maximisation, the profit-driven market in care and the low status endured by care workers. As Paton (2018) suggests, where there is stigma there is a need to establish who is profiting from maintenance of the stigmatised status quo, and in care work and we propose that a process of status subjugation is deeply embedded in the current organisational structure of care. These structural imperatives ensure the maximisation of profits from care, but at the same time fuel the global recruitment crisis which ultimately will threaten profits and is already leading to the collapse of care provision as private equity firms and organisations pull out of the sector, often with little warning and with damaging consequences that the current crisis in fuel prices and food inflation will only exacerbate.

Low role status, deeply entrenched power differentials, and relative powerlessness of care workers all act to demoralise and demotivate staff. Changes that would serve to professionalise the sector, such as comprehensive programmes of staff training, recognition of the high levels of skill required in care work, and professional registration, will undoubtedly increase wages and therefore costs to providers. The structural imperatives that drive profit

maximisation serve to maintain status subjugation of care staff and so restrict wider initiatives to improve staff retention and recruitment.

Reframing stigma as systemic

Our findings contribute to and extend contemporary stigma theory by illustrating how care work stigma is institutionalized across social, legal, and organizational domains. Drawing on and expanding Goffman's foundational insights, our data shows that stigma in care work is not merely about individual prejudice but about systemic patterns of misrecognition, of the labour, the person performing it, and the conditions under which it is done. The occupational identity of care workers is devalued through a combination of cultural stereotypes, regulatory neglect, and institutional disempowerment, particularly in the case of migrant workers. As stigma shapes not only how care workers are seen by employers, regulators and wider society, but how they are governed, supported, abandoned (when promised policy changes do not materialise) and even how they view themselves.

Pathways for advancement

Our interviews suggest high staff turnover is driven not only by poor pay or difficult working conditions (although these are viewed as very important by staff), but by the failure of employers to foster personal growth, to create meaningful advancement pathways, or to value care workers as skilled professionals, which feeds into public discourse of care work as a low-status and unskilled role. However, at the same time, it must be recognised that many care providing organisations are small, and they too lack route to access robust training programmes to offer career development or to learn of innovative practices. Sector fragmentation, policy stasis and the sheer complexity of the problems facing the sector intersect, and this pattern of political stasis is global. Across Europe and beyond, systemic inaction has allowed care crises to deepen. In Poland and Bulgaria, reliance on informal care

and decentralised governance has stalled professionalisation and investment (European Social Policy Network, 2023; OECD, 2021). Italy and Greece persist with family-based models and informal migrant labour, leaving care workers without legal protections or career pathways (Eurofound, 2020; Pasquinelli and Rusmini, 2022;). Even countries with formal inquiries, like Australia's 2021 Royal Commission or the U.S. federal proposals under Build Back Better, have struggled to implement substantive workforce reform. These examples reflect a broader global dynamic in which feminised, racialised, and precarious care labour is structurally devalued, reinforcing cycles of stigma and systemic neglect.

Recommendations

In care workers' experience, low status and stigma are closely related to the devaluation of their skills, which are described as being *'*natural*'* (Hatton, 2017) rather than learned and practised. While improved access to nationally recognised qualifications, professional registration, and expanded training opportunities are essential for raising the status and mobility of care workers, these measures alone are insufficient to address the entrenched structural and cultural barriers identified in our research. Our findings highlight the need for a more systemic response to the professionalisation crisis in the care sector. Drawing on our model of *status subjugation*, and consistent with feminist economic analyses such as those of Folbre (2006), we propose five interlinked areas for policy and sector development.

First, there is an urgent need to reframe care as essential, skilled labour rather than a 'natural' extension of women's roles. Governments and care providers should explicitly challenge the pervasive gendered assumptions underpinning the devaluation of care. Public campaigns and policy messaging should position care as a core component of national infrastructure, comparable to health or education. As our data show, these gendered perceptions not only

reduce the status of the role but actively discourage workers, and particularly men and young people, from entering or remaining in the sector**.**

Second, governments must move rapidly to include the true economic value of care work in national accounting and policy planning. As Folbre (2006) has argued, the failure to account for care's economic contribution renders it invisible in budgetary decisions and justifies systemic underinvestment. Developing fiscal tools to enable this form of accounting would begin to redress this neglect, bringing care work into the centre of long-term workforce and productivity planning.

Third, there is a clear need for enforceable sector-wide employment standards extending beyond minimum wage guarantees. These should include protection from zero-hours contracts, consistent access to reflective supervision, and secure time for rest and recovery. Our findings show care workers employment in fragmented, poorly regulated sectors are often subject to exploitative conditions which both damage morale and prevent skill development. Without harmonised employment standards, even the best training initiatives risk being undermined by precarity and the impacts of being part of a stigmatised workforce.

Fourth, care workers must be empowered through institutional structures promoting voice, co-design, and democratic accountability**.** As our data illustrate (Pavlidis et al., 2020) many frontline workers have both the insight and motivation to improve services but lack avenues for meaningful participation. We recommend that worker advisory panels or co-production structures be built into care commissioning, inspection frameworks, and organisational planning processes. This would challenge the organisational silencing we describe in our model and better align care provision with those who deliver it.

Fifth, governments and funders should support long-term investment in care workforce research, particularly participatory and co-produced approaches which include the perspectives of care workers themselves**.** Our analysis suggests policy responses to the care crisis are often reactive, short-term, or cyclical. In the UK, for example, the promise by Prime Minister David Cameron to reform care in 2015 has been followed by successive inquiries, the latest of which, Baroness Casey's Commission into Adult Social Care, is not due to report until 2028, encouraging policy inertia. This mirrors stagnation in other European countries such as Poland and Greece, where reforms have either failed to materialise or have lacked implementation capacity. Addressing the global nature of the crisis requires structural reform informed by ongoing data and reflective of diverse care models.

In summary, raising the status of adult social care providers requires more than enhancing individual skills or mandating training. It requires a sustained challenge to the economic, cultural, and institutional dynamics perpetuating stigma and suppressing professional identity. Only by attending to these interlocking structures can care work be recognised as the skilled, essential, and dignified labour it truly is.

Limitations and further research

Our research examined the experience of care workers across five European countries, collecting data in two waves, pre-pandemic (2015–2018) and during/post-pandemic (2020–2023). Further research might consider the impact of COVID-19 on the long-term situation of care workers, including working conditions and access to support. We would also recommend further studies looking at the situation in other parts of the world, to see how our European-focused study compares. In our research, we found the experience of care workers was very much alike, regardless of their ethnicity or immigration status. However, this may not be the case in other regions, such as the U.S.

While the research we conducted produced the outputs it was expected to from our funders, the recommendations we have made are not easy or straightforward to implement. Without funding and systemic change, the situation we have outlined in our research is not going to improve. We therefore call on governments globally to give more focus and funding to this incredibly important area of work.

Conclusion

Despite differing regulatory frameworks within which care takes place, the similarities of our findings across five countries are striking. The deeply embedded stigma and associated low status of care work is at the heart of this societal problem and is reinforced by structural imperatives driving profit seeking. The training opportunities and pay gulf between the small charitable/civic not-for-profit care sector and the majority for-profit private provision is also striking. The care problem is recognised by governments globally, however changes long promised by governments still fail to materialise. While many of the steps needed for professionalisation have long been articulated (e.g., Stone, 2000), maintaining the status quo benefits care companies in the short term, although in the medium to longer term, failure to recruit may force unplanned changes on the sector. Additionally, the people who stand to benefit from professionalisation – care workers and care recipients – often do not have a voice in the corridors of power. Furthermore, while training and development would increase the autonomy and confidence of care workers, the invisible nature of most care work will still hinder the development of a public, professional identity for care workers. If the fragmented care sector is not reformed through cooperation or integration, changes which will have to be government-led, care workers will continue to find progression in the sector difficult or impossible.

Endnotes

1. Within the confines of this paper adult social care refers to care provided by paid employees to older or disabled adults within the family home (domiciliary) or in a residential care home and does not cover any form of professional nursing care.

2. We recognise other identities also interact with the care system in many complex ways and can be represented to different degrees depending on the country. In this case, our research focuses on the experiences of care workers in five European countries: Poland, Greece, Italy, Bulgaria, and the United Kingdom. Based on our sample and the data gathered, we focus on the role of women generally, as opposed to, for instance, women of colour or care workers from other minority groups.

3. Ketso is a tool for delivering effective workshops and enables equal participation by all attendees. See www.ketso.com for more information. An edited video of one of the five workshops held is available here: https://helpcare-project.org/co-researcher-workshop/. All participants consented to being filmed and for the film to be made public.

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Tables

Table 1

Category of data	**Number of participants**
Quantitative data collection with care workers (first wave)	550
Interview data with care workers (first wave)	99
Workshop data from care workers and managers (first wave)	25
Interview data from care managers, users and providers (second wave)	25
Total	699

Table 1 – Data collection by category

Table 2

Characteristics of qualitative sample	**Details**
Female	89%
Male	11%
Average age	43.9
Holding professional qualification (level 3 or above)	27%
Completed basic training in social care	55%
Average hours of work in care per week	34
Domiciliary care workers	46%
Formal Paid care workers	79%
Informal paid care workers (grey economy)	2%
Unpaid care workers	19%
Migrant care workers	7%

Table 2 – Characteristics of data sample

Figures

Figure 1

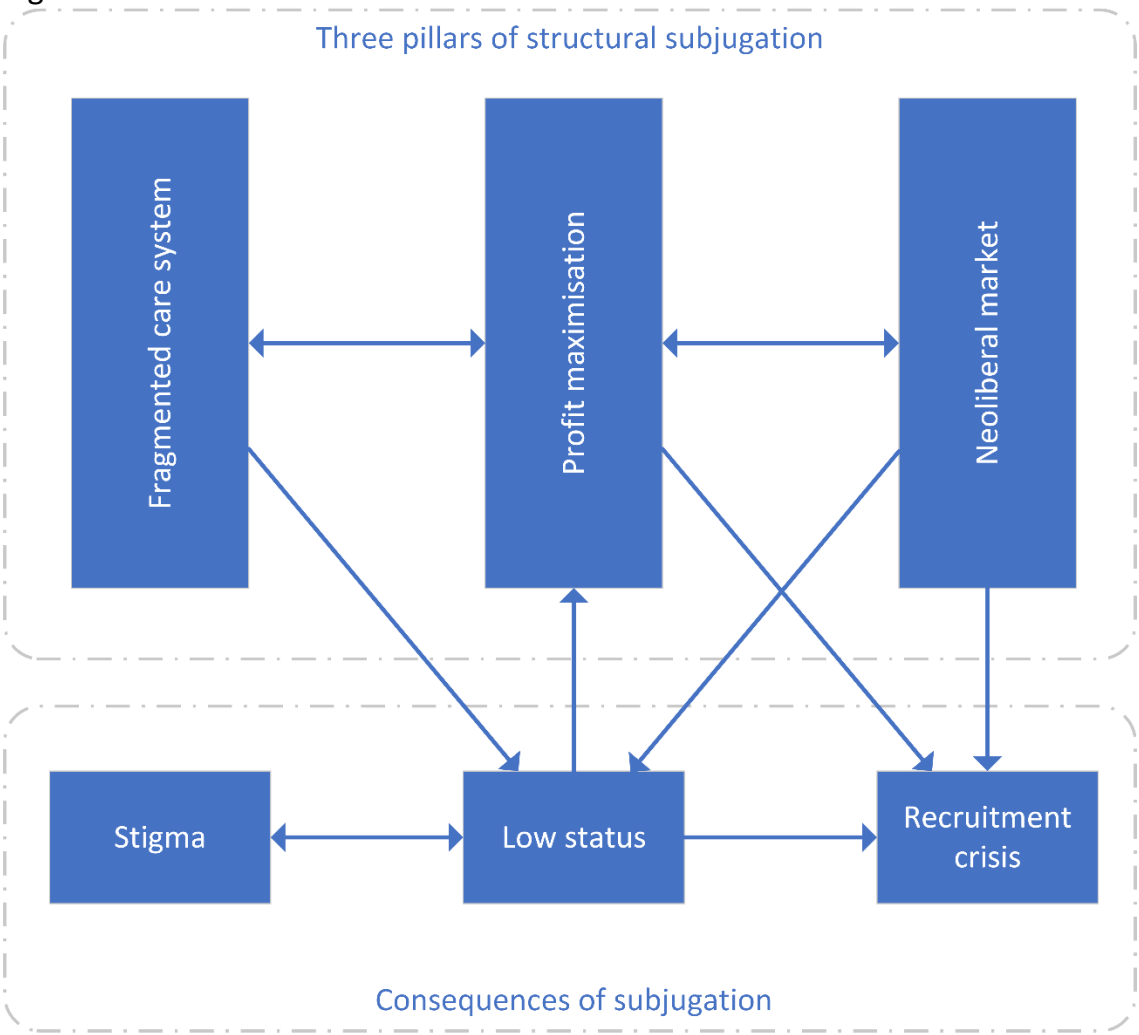

Figure 1 – Visible and invisible barriers to recruitment and retention in the care sector