Care4Skills

Care 4 Skills
– FUTURE SCENARIOS FOR LONG-TERM CARE

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Care4Skills – Future scenarios for long-term care

SCENARIOS FOR CARE4SKILLS - LONG-TERM CARE SECTORAL COOPERATION ON SKILLS • PROJECT 101140263

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FOREWORD

The future is not predetermined- ahead of us lie many alternative futures. We often perceive the future in black-and-white terms, as either-or scenarios. This report, developed within the Care4Skills project, presents four alternative scenarios for long-term care and describes the foresight process through which the scenarios were created. The aim of the report is to open perspectives on different possible futures and to support decision-making today. In the context of Care4Skills, the scenarios highlight how choices related to skills development, workforce policies and service models made in the present can shape different futures for long-term care across Europe.

This report was produced in 2025, at a time when major forces and disruptions are reshaping our operating environment in Europe and beyond. The foundations of the economy are under pressure, geopolitical tensions are creating uncertainty, planetary boundaries are being tested, populations are aging and challenges to well-being are growing. At the same time, societies are undergoing a profound technological transformation, the direction and impacts of which remain open. These developments call not only for adaptation, but also for deliberate action to strengthen the resilience and sustainability of long-term care systems.

The scenarios presented in this report should not be interpreted as forecasts. The future may contain elements from each scenario. While the scenarios aim to consider key drivers of change relevant to long-term care and skills development, they cannot account for every possible development. Moreover, the operating environment continues to evolve, underlining the importance of continuously reflecting on current practices and adjusting strategies accordingly. While significant change lies ahead, some foundations endure. In the context of future skills, empathy, interaction, collaboration and problem-solving remain essential and can be actively fostered through education, leadership and everyday practice.

There are also non-linear and potentially disruptive developments worth observing, such as advances in artificial intelligence and robotics, some of which may materialise rapidly. These developments make it increasingly important to consider multiple time horizons, including short-, medium- and long-term perspectives, when making decisions about skills investments, training systems and the organisation of long-term care.

Above all, these scenarios serve as a tool to broaden thinking and to support dialogue and informed action about the future of long-term care in Europe. The direction does not emerge by chance. It is shaped by the priorities set today, the skills that are developed, and the choices made by policymakers, organisations, professionals and people who use care and support services across the system.

Dear reader, we wish you inspiring moments exploring these scenarios. As you read, reflect on what kind of future you hope for and what actions today could help bring it about.

Minna Koskelo, Yksitoista Helsinki Oy and **Heidi Hautala**, Tukena sr

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FOUNDATIONS FOR THE FUTURE SCENARIOS

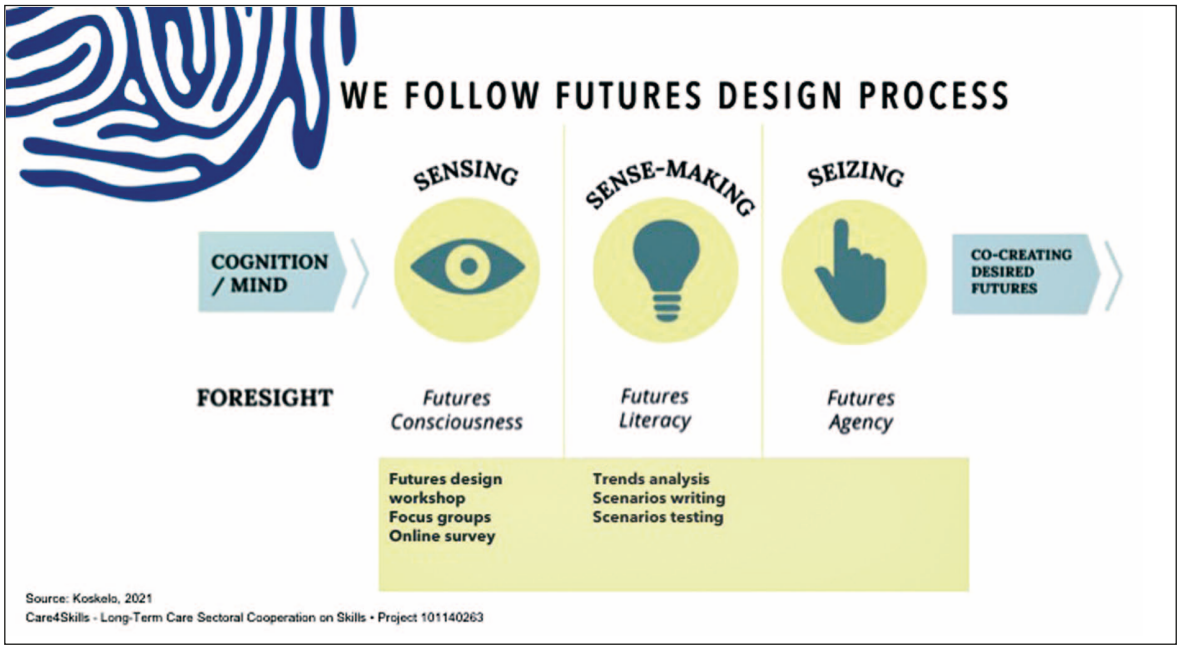
Care4Skills is a European cooperation project that aims to strengthen the long-term care sector by anticipating future skills needs and supporting the development of a shared skills strategy across countries. The project brings together partners from ten European countries, representing care providers, training organisations, research actors and other key stakeholders in the long-term care ecosystem. The scenarios presented in this document support the work of Work Package 4 in the Care4Skills project. Work Package 4 focuses on building future-oriented skills intelligence for the long-term care sector and contributing to the development of a European sectoral skills strategy. The four alternative scenarios are used as a strategic tool to explore how different future pathways may shape competence needs, professional roles and learning priorities.

FUTURES DESIGN PROCESS FOR CARE4SKILLS

In the Care4Skills project, futures design process was utilized and followed in order to create the scenarios.

Scenarios refer to descriptions of alternative futures and the coherent pathways that lead towards them. They are built from key drivers of change and grounded in systematically collected and analysed data and knowledge, using established methods and tools from futures studies.

Futures Design (Koskelo, 2021) is a 3-phase process combining futures thinking and design thinking. The phases are sensing, sense-making and seizing. (Picture 1)



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In the sensing phase, foresight is utilized for futures awareness. Different kinds of methods are used for gathering signals of change. In the sensing phase those signals are interpreted into trends, scenarios and impacts. Futures design emphasizes co-creation.

In the Care4Skills project, sensing the signals of change was carried out by partners in ten European countries. The partners were equipped with shared tools and methods through a focus group workshop held in March 2025, where the process and methodologies were introduced. Following this, participants organised national and regional workshops with their stakeholders to collect signals of change and develop initial drafts of desired futures. In addition, an online survey was conducted at the European level to broaden the evidence base.

The scenario work is grounded in the multidisciplinary expertise of the Care4Skills project consortium and its wider stakeholder network. Participants included long-term care and support professionals, education and training actors, policymakers and public authorities, service providers, labour market and skills experts, as well as people with lived experience of long-term care and support, family members, advocates and other relevant stakeholders. This diverse knowledge base combines system-level insight, professional practice, policy perspectives and lived experience, enabling the scenarios to reflect everyday realities, ethical dimensions and human impacts alongside structural and strategic considerations, and strengthening their credibility, relevance and applicability across different contexts and levels of decision-making.

The data received from the focus group and the online survey were analyzed in the sense-making phase using a scenario method called the Futures Table and four alternative images of the future were created. Here we refer to them as scenarios. They will be introduced later in this report.

The initial scenario drafts were then sent to the partners to review in the beginning of September. During September 35 partners reviewed the scenarios and gave feedback.

QUESTIONS ASKED INCLUDED FOLLOWING:

Content Completeness
– Are key elements present? What's missing?

Diversity & Enrichment
– Does the scenario reflect different viewpoints, stakeholders, or knowledge sources?

Boldness & Innovativeness
– Does it explore new, unexpected, or unconventional directions?

Practical Usefulness
– Is this scenario helpful for planning, strategy, or decision-making?

Timeframe & Pace
– Is the scenario development over time realistic or plausible? Too slow? Too fast?
Values & Ethics
– Are values and ethical issues considered? What kinds of values are visible or missing?

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The plentiful feedback received was then reviewed by 11Helsinki and Tukena and the final scenarios were formed. The feedback was thoroughly incorporated into the scenario descriptions.

Futures design differs from many traditional foresight processes through its strong emphasis on co-creation. While foresight and futures design experts facilitate the process, the future insights and outcomes – in this case, the scenarios – are not shaped by experts alone but by the participants themselves.

Dozens of long-term care professionals have acted as trends researchers in the project, enabling comprehensive signal collection across different countries.

The process is therefore deeply rooted in collaboration and collective creation.

The scenarios are not an end result, but the conclusion of one phase. Their true value and benefit lie in how they are used and interpreted.

THE FUTURES TABLE METHOD

The Futures Table method – also known as the *Tulevaisuustaulukko* (Seppälä 2013), *Morphological Analysis* (Zwicky, in Ritchey 2009), or *Field Anomaly Relaxation* (Rhyne, in Ritchey 2009) – is a structured foresight methodology used to explore alternative futures and support strategic decision-making. It enables systematic mapping of how different variables such as trends, signals, and drivers of change may develop over time (Ritchey 2009; Seppälä 2013).

The method typically includes four main steps: detecting drivers of change; defining key elements of the focal topic; outlining possible future states for each element; and finally forming future images and scenario narratives by combining these states into coherent pathways. Because of its systematic nature, the Futures Table is commonly used as a foundation for building alternative future scenarios.

Scenarios are understood as *"paths based on consecutive steps and ending in a future situation, including actors, processes, decisions, and consequences"* (Rubin 2003). The Futures Table therefore provides a logical basis for scenario development by revealing how different and contrasting futures could emerge depending on how change unfolds.

DATA COLLECTION AND INITIAL ANALYSIS

The data for the scenarios were collected from partners in ten European countries: France, Belgium, The Netherlands, Greece, Bulgaria, Czechia, Finland, Hungary, Italy, and Spain. The primary data collection approach was based on focus group workshops organised in the participating countries, while additional expert views were also included in the analysis.

The focus group workshops were mainly conducted live, after which the materials produced were digitised and uploaded to Howspace, a platform designed for digital co-creation and training.

All data provided by the partners was then transferred from Howspace into the Miro platform, where it was organised as distinct post-it notes. Miro is another digital platform. It can be

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described as an endless, highly visual white board.

Miro allowed a structured process of grouping, comparing, and further refining the data. The analysis began by identifying major themes that represented signals of change. Initially, the themes were divided into two broad categories:

(1) **external forces** impacting long-term care from the outside, such as EU influence and legislation, housing and care spaces, demographics and workforce availability, economic conditions and funding structures, changing societal values, environmental considerations, community-based care and deinstitutionalisation, digitalisation and AI, geographic limitations, the role of informal and family caregiving, and the societal appreciation of care professions; and

(2) **internal variables** emerging from within long-term care service systems, including care models and practices, roles of caregivers, safety considerations, technology integration, customer-centred service development, everyday working methods, training and competence development, leadership and management culture, expectations related to personalised care, human rights, changing health needs among clients, and cultural factors influencing care.

By structuring the data into these two categories, it became possible to identify recurring themes, strong similarities as well as topics that were frequently emphasised in the data. These findings laid the foundation for further refinement of drivers of change and the later construction of future states for the Futures Table.

DRIVERS OF CHANGE AND DEVELOPMENT OF FUTURE STATES

Following several iterative rounds of analysis, the initially broad thematic structure was gradually refined into a more focused set of key variables that would form the basis of the Futures Table. In this process, the research team prioritised variables that were both 1) highly **significant** for the future of long-term care and 2) sufficiently **uncertain** in their direction of development, ensuring that the method would highlight areas with the strongest potential to influence change.

The final classification of variables included 1) **external drivers**: such as the design and organisation of the care system, the shift in societal values, EU-level regulation and legislation; and 2) **internal drivers**: the overarching philosophy guiding care delivery, leadership practices, the evolving needs and active role of clients.

HERE IS THE COMPLETE LIST OF THE VARIABLES:

External variables
- Care system
- Changing societal values
- EU regulation and legislation
- Digitalisation
- Funding
- Workforce availability

Internal variables
- Care philosophy
- Leadership
- Customer needs and roles
- Technology integration
- Appreciation of care professions
- Training and competence
- Care facilities

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Once these variables had been clearly established, the next analytical task involved revisiting all identified signals of change and grouping them by similarity, difference, and anticipated influence. Each group of signals was then translated into four distinct future states. The outcome of this phase was a set of clearly defined alternative futures for each variable, forming the structure of the Futures Table and enabling systematic combination into different types of future images. Picture 2.

EXTERNAL FORCES LONG-TERM CARE

Picture 2: Futures table

	SCENARIO REBELLIOUS CARE	SCENARIO SHARED CARE	SCENARIO INSTITUTIONALIZED CARE	SCENARIO TECHNOCRATIC CARE
CARE SYSTEM	**Cross-sectoral and responsive system** Cross-sectoral cooperation is successfully working and meets holistically the specialized needs of customers.	**Family and community-driven system** Community, family and volunteers are managing the LTC. Care happens mostly home-based or in community facilities.	**Institutionalized system** Care is heavily institutionalised. There is a lack of personalised care services.	**Privatized and fragmented system** Care is fragmented and private sector companies compete over services. The cost of care is high and increasingly unequal.
CHANGE OF SOCIETAL VALUES	**Inclusion, equality and life-centered** Main values are equality, inclusion and humanity. Empowering individuals, and meeting the emotional and social needs aligned with physical needs. Everyone has the right for full life.	**Solidarity and compassion** Main values are collaboration and solidarity guided by ecosocial ethos. Care is everyone's business.	**Welfare state and power structures** Care is defined through the values of welfare state, and managed by those who hold the power in society.	**Hard economic and market oritented values** LTC is managed through the economic values and people's rights are decided externally. Medical needs are taken care, but not social or emotional needs.
EU REGULATION & LEGISLATION	**EU's strong involvement supporting** Regulation enables better resources, services, innovation and care development.	**Legislation or regulation do not influence** There is no strong role of legislation or regulation, care givers and the individuals make the decisions based on expertise and best practices.	**National and local regulation** National / local regulation maintain institutionalised care and LTC remains highly regulated.	**EU's strong involvement hinders** Political guidance increases administration work and hinders innovation and development.
DIGITALIZATION	**Slow and selective** Geopolitical tensions hinder the global development of technology. Slow global innovation, but creative local adaptation.	**Reverse development** Technology development is reverse due to high regulation and ethics.	**Incremental and bureaucratic** Tech evolves to manage data and control systems, not to support personal care.	**Exponential development** Integrated smart systems dominate.
FUNDING	**Hybrid funding** Care is equally co-funded by different sectors public budgets are complemented by social investment funds, philanthropic capital, and private impact investors.	**Self-paid, one's own responsibility** Care is funded through individuals themselves, family, community or charity.	**Public funding** Care is funded through the public state and EU funds. Care is a public cost, not an investment.	**Private, project-based funding** Care is funded mainly through private sector and is project-based, short-term and uncertain.
WORKFORCE AVAILABILITY	**Sufficient workforce** Care work is an appealing field, and there is no shortage of workers.	**Informal and volunteer workforce** Family members, the community, and unpaid volunteers largely make up the workforce.	**Insufficient workforce** There is a severe understaffing: the workforce is exhausted and the sector struggles to attract new workers.	**Digitalized workforce** Care is mainly managed through technological solutions, such as robots and remote care which have replaced the need for human workforce.

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CARE PROVIDERS FORCES

Picture 2: Futures table

	Rebellious care	*Shared care*	*Institutionalized care*	*Technocratic care*
CARE PHILOSOPHY	**Life-centred** Long-term care is life-centred and build a broader context the person's whole life in mind.	**Person-centred** Long-term care is person-centred and built around individual needs.	**Disability-centred** Services are tailored to specific functional limitations or diagnoses. Needs are addressed through a clinical or compensatory lens, often narrowly defined by disability categories.	**One size fits all** Dictated by rigid systems. Standardized, protocol-driven care. Individuals are expected to adapt to systems. Efficiency and consistency are prioritized over personalization.
LEADERSHIP	**Self-directed care** Individuals and their family members with the support of professionals take responsibility for planning and managing care.	**Community managed care** Care is provided by interdisciplinary teams formed around customers including volunteers, family members and professionals in the community. They organize their work independently following communal guidelines.	**Hierarchical care** Care is organized through top-down leadership and strict roles. Decision-making is centralized, and staff follow clearly defined protocols.	**Satellite care (network-based provision)** Care is coordinated through decentralized networks or platforms. Multiple providers and actors form loosely connected hubs around the person in need of care.
CUSTOMER NEEDS & ROLE	**Emergent, evolving and expanded needs** Care adapts to shifting societal, cultural and existential contexts. Services are co-developed to meet not-yet-defined human experiences. Customers have active and co-creative role.	**Personalized needs** Care is tailored to customer's personal life needs as broadly as possible. Customers are active in defining what they need together with their care network.	**Basic needs and safety-focused** Care targets survival, hygiene, and risk prevention. Services are designed to meet essential physical needs with minimal personalization.	**Predictable and standardized needs** Needs are seen as known and stable. Care delivery is structured around predefined categories and routines to ensure efficiency and comparability. Customers are passive recipients.
TECH INTEGRATION	**Flexible tech** Tech is used adaptively based on context, ethics, and human need.	**Minimal use of technology** Care relies on human interaction with supporting digital tools.	**Imposed tech** Technology used top-down for compliance, monitoring, and efficiency; customers have little control.	**All tech** Fully automated, AI-driven, human contact minimal.
APPRECIATION OF CARE AS A PROFESSION	**Care as a profession is highly valued** New roles are emerging, and the entire professional field is redefining itself toward a more attractive and respected status.	**Appreciation of care has grown** People take pride in and find purpose through long-term care, showing deep pride and commitment to their work.	**Appreciation of care work remains unchanged** The field continues to be dominated by a low-paid, predominantly female workforce, and labour shortages persist.	**Appreciation of care work has declined** Long-term care is increasingly viewed as a last resort or a forced career choice.
TRAINING	**Flexible, continuous workplace-driven learning** Multiple types of training are accepted. Most learning takes place in real-life care environments, with recognition for experiential and on-the-job learning.	**Informal and diverse knowledge pathways** A wide range of backgrounds and lived experiences are accepted as valid. Community knowledge, intergenerational skills and peer learning are respected alongside formal education.	**Mandatory, state-enforced training (care obligation)** Formal training is compulsory for all care providers, including informal carers. Certification is required to legally provide care. Care is seen as a regulated societal duty.	**Standardized formal education** Education is formal, role-specific, and data- and operations-oriented.
CARE FACILITIES	**Location-independent, high quality care** Adaptive technological development enables location independent care, based on individual needs. Care is either remote or can easily be transferred between places.	**Location dependent, high quality care** Innovative supported housing, and community service hubs enable high-quality care on-site.	**Location dependent, low-quality care** Care has been centralised in large institutions, where services are primarily provided on-site.	**Location independent, low quality care** Care is mainly managed remotely without no social interaction.

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COMBINING FUTURE STATES INTO FUTURE IMAGES

The Futures Table was next used as a structured tool for composing future images by selecting one future state from each variable row. Multiple combinations were created and iteratively refined to ensure internal consistency and strong differentiation between outcomes.

The selection criteria originated from logical reasoning and were influenced by Jim Dator's well-known scenario archetypes (Dator 2009), which distinguish between continuity scenarios, preferred transformative developments, radical disruptions and undesirable collapses. Applying these criteria ensured that the scenarios illustrated a wide and policy-relevant range of possible futures.

Following validation, four distinct future images were identified, each telling a different story of how the future of long-term care could unfold. Each future image is based on a different value orientation.

- **Rebellious care** – representing surprising and radical transformation.
  This future image is grounded in **life-centred values**, emphasising individual agency, autonomy and personalised care solutions.

- **Shared care** – reflecting a preferred and transformational development path.
  This future image is grounded in **community-centred values**, highlighting collective responsibility, co-production of care and strong support networks.

- **Institutionalised care** – portraying a continuation of the current system.
  This future image is grounded in **institution-centred values**, maintaining hierarchical structures, regulated environments and traditional care practices.

- **Technocratic care** – describing an undesirable or collapsing trajectory.
  This future image is grounded in **technocratic values**, prioritising standardisation, efficiency and technological control at the expense of humane aspects of care.

Together, these futures illustrate a wide and contrasting range of developments, from transformative and collaborative change to stagnation and systemic rigidity.

These future images together form the conceptual basis for the scenario narratives that can be further developed to support discussion and decision-making.

The combination process also acknowledges that alternative experimental variations, such as "wild cards", could be generated through intentional inclusion of unexpected or low-probability states to explore vulnerabilities and opportunities within the system, further strengthening the foresight applicability of the results.

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UTILIZING SCENARIOS

As stated already, the scenarios are not an end result, and they are not predictions but describe alternative futures. Their true value and benefit lie in how they are used and interpreted.
A central principle of the scenario method is that alternative futures do not emerge in a vacuum; they are built on assumed developments, choices, and external drivers of change.

Scenarios work best when their underlying drivers, uncertainties, turning points, and weak signals are made visible.

Constructing the pathways that lead to each scenario helps illuminate system interdependencies, the consequences of decisions, and the mechanisms that steer development toward different futures.

For this reason, the recommended use of scenarios is not merely to compare alternative end states, but above all to analyse the pathways: What would need to happen for a given scenario to materialise? Which choices would strengthen or weaken a particular trajectory? Which early signals merit attention, and which decisions could alter the direction of the path?

This approach helps identify both opportunities and risks, and – most importantly – it guides the conversation toward what we can do today to make a desirable future more likely, or to avoid an undesirable one.

ADDITIONAL WAYS SCENARIOS CAN BE USED INCLUDE:

- Visioning – What is desired and how to get there
- Building shared understanding and alignment – helping diverse stakeholders develop a common language about change and uncertainty.
- Exploring ethical dimensions and societal implications – reflecting on values, equity, and the human impact of different futures.
- Supporting policy design and prioritisation – using scenarios to stress-test and future-proof policy options or reforms.
- Enhancing resilience and adaptability – preparing for disruptions and designing flexible strategies.
- Engaging citizens and communities – using scenarios in participatory and inclusive settings to democratise futures thinking.
- Narrative and communication tools – turning complex foresight insights into compelling, relatable stories.
- Monitoring weak signals and emerging issues – using scenarios as reference frames for continuous scanning of change.

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- Experiential futures and futures design methods – making scenarios tangible through creative, human-centred, and immersive approaches that invite people to feel and imagine futures, not just read about them.

Written scenarios alone rarely reach or engage everyone. Therefore, innovative and human-centred futures design methods are increasingly used to make futures thinking accessible and meaningful to wider and more diverse audiences. This shift reflects the growing importance of futures literacy, participatory foresight, and futures democracy – where the power to imagine and shape the future is shared more broadly across society.

The questions used in the scenario evaluation process can also be applied in other contexts.

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FOUR ALTERNATIVE FUTURE SCENARIOS

Next, the four alternative scenarios for long-term-care will be presented. The drivers and the variables from the Futures Table are transformed into four different scenarios.

The following four long-term care scenarios explore how care could evolve under different social, technological, and ethical conditions. Each scenario presents a distinct logic – from grassroots experimentation to shared community networks, from institutional stability to algorithmic automation – and examines how **person-centred approaches and digitalisation** take shape in each future.

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Together, they illustrate how governance, technology, professional roles, and values might shift as societies age, customer needs change and resources, trust, and expectations transform. They present both hopeful and cautionary futures, revealing trade-offs between efficiency, empathy, autonomy, and equity.

These scenarios are not predictions but tools for reflection, dialogue, and strategic preparation for the next generation of care.

They are colour-coded as follows.

- **REBELLIOUS CARE**
- **SHARED CARE**
- **INSTITUTIONALIZED CARE**
- **TECHNOCRATIC CARE**

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SCENARIO 1: REBELLIOUS CARE

Origins of the Movement: From Resistance to Renewal

Care professionals, as well as persons with long-term care and support needs and their family members, have had enough of rules, regulations, administration, and institutions with their strict services that do not meet their needs. These outdated structures worsen people's quality of life and fail to reflect emerging values such as inclusion, equality, and life-centeredness. Early weak signals included rising burnout among staff, major demographic shifts, and publicized care scandals that eroded trust in the system.

National examples, have served as a historical inspiration for a broader cultural shift: **moving away from rigid quality standards toward a focus on what truly matters to people: their quality of life.** This approach calls for greater flexibility, more personalized solutions, and meaningful care and support tailored to each individual's lived experience, regardless of background or income.

The belief is growing that **everyone has the right to a full life** – regardless of their status, support needs or background – and that care should reflect individual emotional, social, private, and physical needs. It's no longer enough to simply provide care; now **the goal is to support clients' independence and self-determination to live and decide as independently as possible and make their own choices**.

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A vocal and determined group of care professionals shares a new understanding of **good care, support and positive health, built around the person's values, needs, and everyday realities**. This group has launched a movement against obstructive policies and formed powerful cross-sectoral alliances that include public institutions, volunteers, people with long-term care and support needs and their families, communities, non-profits, and private actors. Together, they co-create innovative solutions that address the actual needs of long-term care and support.

The transformation did not happen overnight. It was promoted through a deliberate and coordinated effort across levels of society. Early advocacy from care professionals and family alliances was amplified by civic movements and media attention on care scandals. **EU frameworks for social innovation** provided the legal and financial space to experiment. The change has been the result of a long struggle, and maintaining the rebellious system requires strong communication and marketing of its positive outcomes and effectiveness.

Building Trust and New Competences

As the movement spread across Europe, it evolved within a volatile geopolitical and economic landscape. Periodic global shocks – financial crises, supply chain disruptions, migration waves, and environmental instability – tested the capacity of local care ecosystems to remain inclusive and self-sustaining. These external pressures reinforced the importance of regional resilience, diversified funding, and social solidarity beyond national borders.

At the same time, the movement catalyzed a transformation of the **care system into one that is more adaptive, respectful, and life-focused**. The path toward this culture of trust and shared responsibility has been gradual and intentional. Early initiatives focused on building psychological safety and peer-based reflection spaces, where professionals could openly question practices without fear of sanction. Cross-sector mentoring networks emerged to strengthen mutual understanding between social, medical, and community actors. Over time, these practices evolved into a new skill architecture for care, including relational intelligence, adaptive leadership, ethical co-decision-making, and the ability to manage complexity through dialogue rather than control. These competencies are not innate – they are continuously cultivated through reflection, feedback, and co-learning. **The transformation of care has thus been as much about inner work as it has been about system design.**

Finally, these small but connected experiments reached a tipping point – transforming a fragmented system into a self-sustaining ecosystem driven by shared values and collective intelligence.

Mobilising for Change: Leadership, Roles and Alliances

By 2040, long-term care has evolved into an interconnected ecosystem where collaboration across public, private, community, and individual actors is the foundation of trust and resilience. **The old boundaries between "providers" and "recipients" have dissolved; care now functions as a living network sustained by shared purpose and transparent governance.**

Public institutions continue to guarantee fairness and universal access, but they no longer steer the system alone. Instead, they act as ethical anchors – ensuring data

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protection, equal rights, and the coherence of impact metrics that guide investments and outcomes. **Private and social enterprises bring flexibility, innovation, and long-term capital**, operating under impact-based agreements that link their success to improvements in quality of life rather than to market growth. In the care sector, this means that providers are evaluated and compensated based on measurable wellbeing outcomes – such as better mental health, increased participation in society, maintaining work ability, reduced loneliness, and longer independent living – rather than on the volume or cost-efficiency of services.

Public–private collaboration in the rebellious care ecosystem is based on shared values rather than profit motives. **The private sector** includes social enterprises, ethical health-tech firms, and local cooperatives that co-invest in community-led solutions. **Public authorities** and policies act as enablers and guardians of equity, ensuring that innovation remains accessible and aligned with social goals. **Practical cooperation** takes the form of co-funding models, open data partnerships, and joint training programs that blend social purpose with technological capability. These alliances demonstrate that when economic and ethical incentives are aligned, private actors can strengthen – not distort – the life-centred care system.

The self-named "rebellious care professionals" are supported by a new leadership culture rooted in facilitation and autonomy. **Managers** engage their teams with a collective vision, mission, and strategy for better care, and act as orchestrators of change: they are trained in cross-sector project work, participatory leadership, and ensuring quality of life at work.

A key tension is emerging between professional autonomy and system accountability. Leaders must navigate **how to enable decentralised decisions** while still ensuring quality and equity across care settings.

A culture of openness, strengthening professional autonomy, shared learning, continuous reflection, and experimental methods is actively nurtured. **Community** wisdom, intergenerational learning, and peer knowledge are respected alongside formal qualifications. Training in adaptive, human-centred leadership is embedded in every career path. Success is no longer measured in efficiency or compliance, but **in meaning, cohesion, and the capacity of organisations to evolve together.** In this system, leadership is not about steering others – it is about enabling everyone to steer towards a shared vision of life-centred care.

The transformation of care has also redefined the role of education and training. Universities serve as ethical and methodological hubs, evaluating the societal impact of care innovations and embedding the principles of life-centredness across disciplines. **Vocational Education and Training** (VET) providers, higher education institutions, and community learning hubs collaborate to design adaptive curricula that respond to emerging roles and ethical challenges. Training no longer follows a linear path but functions as a lifelong ecosystem, blending classroom learning with immersive practice in care environments. Micro-credentials and peer-recognised modules certify new competences in leadership, trauma awareness, digital

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ethics, and participatory design. **The education system** thus acts as an active partner in the care movement – nurturing the reflective, human-centred, and technologically confident professionals the new era demands.

Families and Participation as Pillars of Solidarity

The roles of social and healthcare professionals, as well as those of people with long-term care and support needs, are central to improving processes, enhancing collaboration, and ensuring more person-centered care and support.

Cross-sector collaboration has deepened between health, social, and community services, ensuring that medical, psychological, and social dimensions are integrated rather than siloed. **The role of family caregivers has also evolved**: they are formally recognised as partners, provided with structured training, financial compensation, and respite rights. Their lived experience forms an essential bridge between professional practice and everyday life, making them co-architects of the life-centred ecosystem.

Families are not only emotional anchors but also recognised as co-designers of care. The system supports diverse forms of family life – multigenerational households, single-parent families, chosen families, and interdependent communities. Care planning is designed around the *circle of support*: the individual, their family or trusted network, and the professionals who facilitate continuity and balance. Structured dialogue between family members and professionals ensures that care responsibilities remain shared, not shifted. Family caregivers receive formal recognition, flexible respite opportunities, and access to learning programs that build confidence and balance. The relationship between families and professionals is based on partnership, not substitution – ensuring mutual respect, clear boundaries, and sustainable collaboration.

The voice of people in need of long-term care and support is heard strongly and powerfully, and they have the opportunity to influence not only their own support and services, but also society more broadly.

Rising Professional Attractiveness: Towards a Gender-Balanced Workforce

Autonomy in the field, combined with empowering roles, has made **care and support work more attractive than ever**. The profession is regaining prestige and now offers competitive pay. Young people are drawn to the renewed long-term care and support sector with pride and purpose.

New roles have emerged to support justice and trauma-awareness within the system: Diversity & Inclusion Mediators work across organisations to ensure marginalized populations are visible in solution-making, while Community Trauma Facilitators offer support to professionals still recovering from systemic breakdown. New roles such as the Care and Support Coordinator designs, organizes, and evaluates holistically the client's needs and supports to plan an individualised care program.

The attractiveness of the care and support sector, together with more progressive societal values

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that **encourage men to take part** in childcare and domestic responsibilities, **has led to a gender-balanced workforce**. The image of care and support workers has evolved – no longer seen as "burned-out angels," they are recognized as modern, skilled professionals.

Despite greater autonomy and recognition, ensuring fair pay, workload balance, and safe working conditions remains an ongoing concern. **Decentralised management** has empowered professionals but also blurred accountability in some regions. **The new leadership culture** requires constant calibration – maintaining flexibility without allowing fragmentation. Collective negotiation structures and well-being compacts have emerged to maintain coherence between autonomy and equity across the system.

Meaningful Care Tailored to Each Person's Lived Experience and Life Path

From children with developmental or neurological conditions to adults living with disabilities or chronic illness, and to elders seeking meaning and connection – **care adapts to each life path, rather than expecting individuals to fit a service model**. Prevalent conditions include increasingly common neurological and psychiatric illnesses (such as early-stage Alzheimer's, Parkinson's disease, and mental health challenges), prolonged multimorbidity, the combination of aging and loneliness, and a culturally and linguistically diverse client base. The clientele is highly diverse, and the system acknowledges the complexity of their needs.

This complexity has led to the creation of specialist roles focused on inclusion – such as cultural liaisons and language-sensitive care and support coordinators – ensuring that migrants and diverse populations are not only visible but actively shaping care models. As customer segments and needs have become increasingly complex, many no longer fit into previous service categories and are at risk of falling into systemic gaps, which in turn accelerated innovation in care specialisation.

Efforts are being made to promote active aging and mutual support groups as strategies for prevention and care. Preventive healthcare has reached new depths – even beginning at the fetal stage. Holistic, lifelong well-being strategies have become the foundation of care and support planning. The focus in social and healthcare has developed first into person-centred care and support and is now shifting towards a more holistic view of life referred to as life-centered care.

Through de-institutionalisation, there is a transition from a "care" to **a more autonomous and co-constructed support, responsive system, where people become the authors and players in their own lives**. Customers, once passive recipients, are now active participants. Many previously defined as "patients" are involved in co-creating their own care, often contributing through work, volunteering, or partial self-financing. Participation in meaningful activities is viewed as part of care and support, and individuals are encouraged to develop new skills while receiving care. Participation is supported, not demanded. Those who cannot easily express their views are represented through trained Community Voice Facilitators – professionals and peers who translate personal experiences into collective insight. Digital tools and inclusive design make engagement possible for all languages, abilities, and cognitive capacities.

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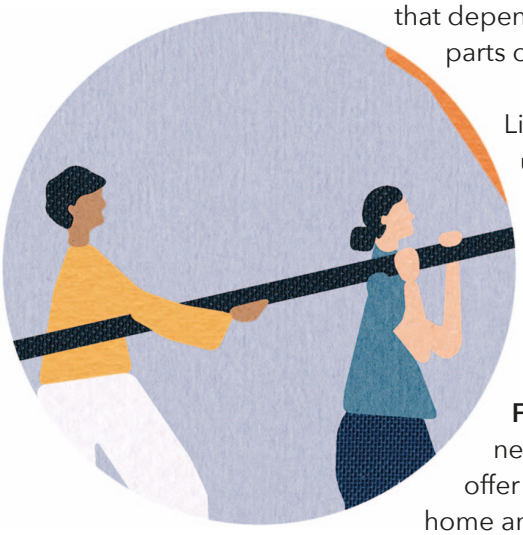
Supported autonomy has become a guiding principle: every person is entitled to the level of involvement that suits their abilities, wishes, and emotional needs. Personal advocates and care coordinators ensure that the voices of those who cannot speak or choose not to lead their own planning are still fully represented. Decisions are made relationally – through dialogue, empathy, and respect – rather than through procedural independence.

The life-centred model is built on cross-sectoral collaboration that unites healthcare, social services, education, and community life. Professionals, managers, supported individuals and their families work together as equal partners, sharing insight and responsibility in decision-making. **Multidisciplinary care circles** replace traditional hierarchies, enabling knowledge to flow freely between nurses, doctors, social workers, therapists, volunteers and family caregivers. **This interconnected structure** ensures that care is not only person-centred but also **systemically holistic**.

Intergenerational care communities have become common: children learn empathy and inclusion from an early age, young adults participate in peer-support and digital mentoring, and older generations contribute wisdom and time to shared spaces of care. The system recognises that dependency and autonomy exist in every age group, and that both are natural parts of being human.



Life-centred care thus reflects the full spectrum of human experience. It understands that care is not about a specific age or condition, but about continuity, belonging, and the shared commitment to help each other live well – throughout the **whole lifespan**.

The New Facilities with New Professionals Integrate Communities, Families, and Sustainability

Facilities and services are flexible, inclusive, and based on customer needs. Hybrid care and support models have emerged: facilities now offer short stays, respite care, day programs, and flexible transitions between home and residential settings. Care no longer implies permanence – it means **support where and when it is needed**. The ecosystem offers the possibility of flexibly combining formal and informal care and support.

Activation and participation are core principles, ensuring that **people who are receiving care and support are encouraged to develop their potential** – including through employment and education. **Psycho-emotional development programs are provided**, and people needing care and support are matched with a consistent personal assistant trained not only in care tasks but also in emotional support and communication. Staffing models have been redesigned to prioritize relationship-based care and support.

The need for individuals to care for others, for living beings, and for nature is also recognised as part of this new logic of care and support. The new care architecture increasingly intersects with ecological resilience thinking, as new facilities integrate sustainable design into care delivery, supporting life-centeredness by respecting nature and all living beings.

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Technology with a Human Face

People with long-term care and support needs have advanced digital skills, including elderly people, which facilitates the integration of digital tools into care and support. **Technology supports rather than replaces human interaction.** It improves health and social diagnostics and monitoring through shared medical records and technological tools, enabling more efficient and personalized care and support management. **By reducing administrative tasks, technology improves the quality and efficiency of care and support while freeing up time for its relational aspects.** AI and digital tools streamline workflows and eliminate unnecessary paperwork, significantly improving job satisfaction.

Care and support environments are evolving to match the needs of empowered individuals. Technology supports remote work from care and support facilities and enables care and support to be **location-independent**. With AI assistants, voice recognition, and digital communication tools, services are personalized and accessible. Care and support professionals are trained to deliver remote, high-quality services while individuals gain support to acquire necessary digital skills.

Various digital systems enable individual caring and supporting solutions such as alternative forms of therapy and robotic home care and AI assistants. These technological applications do not, however, replace social and human-centered forms of care and support; rather, they serve as a complement, providing individualized support and enhancing care from a qualitative perspective. It is understood that direct human care and support has irreplaceable emotional and relational dimensions.

Beyond health and support, **home technologies play a vital role in social inclusion and cultural participation**. Digital ecosystems connect people to art, education, and community events, reducing isolation and fostering creativity. Assistive and ambient technologies empower individuals to live independently while staying socially connected. Technology is thus not only a tool for care efficiency, but a bridge to meaning, belonging, and joy.

The European Union plays a central role in ensuring that health tech and data are handled **safely, transparently, and in the public interest**. Beyond regulation, new cross-border care alliances and pan-European ethical data protocols are being developed, signaling a growing continental collaboration.

Digital access to information and services enables individuals, families and caregivers to make informed decisions. Innovations are guided by human values, and trust in digital solutions is growing – both among professionals and the public. This transformation is also supported by legal frameworks and EU regulations that create space for innovation while protecting people's rights and data. The legislative environment is designed to foster trust and participation in the evolving care and support ecosystem.

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Artificial intelligence has also become an ethical companion in care – not only a technical one. Predictive AI systems help **anticipate emotional distress, loneliness, or burnout among both clients and professionals, enabling early, human-led intervention**. Algorithms are trained through participatory design, integrating the lived experiences of users, families, and caregivers to reduce bias and increase trust. AI thus acts as a partner in empathy, foresight, and relational understanding – supporting human judgement rather than replacing it. **Through this collaboration, technology itself learns to care.**

Funding the Future Together

The new financial architecture has created stability without bureaucracy. It rewards collaboration, not competition, and continuously **reinvests profits and savings into local well-being initiatives**. Care funding is no longer seen as an expense but as a regenerative flow – a collective investment in life, dignity, and community resilience.

While the new life-centred model has inspired creativity and collective ownership, questions remain about its long-term financial sustainability. Balancing shared responsibility with predictable funding continues to test the system's resilience. Periods of economic downturn or shifting public priorities have occasionally strained community-based funding streams. Tensions have also surfaced between emerging local models and traditional institutions still anchored in hierarchical funding logics. Managing this coexistence – between experimentation and accountability – has become a defining challenge for the movement's maturity.

By 2040, the financing of care and support has transformed into a resilient hybrid ecosystem that reflects shared responsibility and collective trust. Social design, co-construction with supported individuals, and collective intelligence approaches are helping to develop practices that are more cross-functional and adaptable. The once rigid separation between public, private, and community funding has dissolved. Care is now sustained through interconnected streams of resources – public baseline funding, private impact investment, and community-driven micro-contributions – all transparently coordinated through trusted and secure digital platforms. The structure and care model significantly improve the quality of life for individuals and foster innovation across sectors.

A major turning point occurred in the mid-2030s, when European social innovation frameworks allowed member states to channel part of their social budgets into impact-based partnerships – collaborative funding models in which public authorities, private investors, and civil society organizations share responsibility for achieving measurable social outcomes. Instead of financing services directly, governments invested in projects that demonstrated clear improvements in wellbeing indicators such as health, inclusion, and work ability. This opened the door for local ecosystems – municipalities, cooperatives, and private organisations – to co-finance life-centred care initiatives that demonstrably improved well-being and social participation.

Public institutions continue to guarantee universal access and equity, but they no longer fund or operate welfare systems alone. They define the ethical and legal foundations – safeguarding rights, setting impact metrics, and ensuring transparency in financial flows. Around these frameworks, **a mixed funding ecosystem has emerged: public budgets are complemented by social investment funds, philanthropic capital, and private impact investors**.

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These actors, ranging from social enterprises to technology firms and care cooperatives, contribute agility, design capacity, and long-term resources. Their returns are increasingly tied to measurable outcomes – such as enhanced quality of life, reduced isolation, and improved autonomy – rather than to the sheer volume of services delivered.

Citizens and communities have also become active funders of care. Through salary-linked micro-donations and neighbourhood well-being funds, people contribute directly to projects that matter to them – from inclusive housing to community-based rehabilitation. This has led to funding initiatives from both public and private sources, including crowdfunding and micro-investing.

To remain stable over time, the ecosystem stress-tests itself. Periodic equity checks, transparent impact dashboards, and citizen juries review whether autonomy has drifted into inconsistency or privilege. When resources tighten or values collide, temporary coordination cells step in to balance local freedom with shared standards. **The promise of life-centred care holds only if accountability evolves alongside autonomy.**

New Roles and Skills for a New Era

Care in this scenario is grounded in experimentation, solidarity, and autonomy. Professionals, families, and communities co-create solutions that challenge traditional systems and bureaucratic constraints. The sector values self-organisation, ethical reflection, and the ability to bridge lived experience with systemic change.

TO SUCCEED IN THIS NEW LANDSCAPE, CARE AND SUPPORT PROFESSIONALS NEED THE FOLLOWING KEYSKILLS:

- Facilitation, coaching, and co-design with clients and families
- Emotional and social intelligence
- Ethical reflection and critical thinking
- Cross-sector collaboration and partnership building
- Communication and conflict mediation
- Project-based and adaptive leadership
- Digital literacy for creative solutions
- Advocacy and civic engagement
- Self-managing skills

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EMERGING ROLES:

- **Diversity & Inclusion Mediator** – works across organisations to ensure marginalized populations are visible in solution-making
- **Community Trauma Facilitator** – offers support to professionals still recovering from systemic breakdown
- **Care and Support Coordinator** – designs, organizes, and evaluates holistically the client's needs and supports to plan an individualised care program.
- **Cultural Liaison Coordinator** – ensures that migrants and diverse populations are not only visible but actively shaping care models.
- **Community Voice Facilitator** – professionals and peers who translate personal experiences into collective insight.
- **Digital Ethics Steward** – ensures responsible use of AI and data in care, balancing efficiency with dignity and inclusion.
- **Impact-outcome evaluator** – follows the measurable outcomes and impacts of the providers.
- **Digital Innovation Facilitator** – connects local initiatives, public services, and informal networks to co-develop life-centered digital care innovations.
- **Community Innovation Broker** – acts as a bridge between everyday experience and system reform, making sure that innovations emerge from real needs.
- **Peer-Support and Digital Mentoring Specialist** – designs and sustains digital and hybrid learning and peer-support.

Professionals act as connectors, enablers, and catalysts of change rather than service deliverers. Competence is measured by collective outcomes and human dignity rather than compliance.

Main drivers and hinders for this scenario evaluated by partners on October 2025

Drivers

– Inclusion: emphasis on human rights and individual perspectives
– Human-centred digital care transformation
– Empowerment of professionals
– Cross-sector collaboration
– Better recognition of care work
– Use of technology to support care.

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Hinders

– Resistance to change (among policymakers, professionals, families, and care recipients)
– Low digital skills
– Unstable or fragile funding
– Unclear public role

Concrete Signals of Change

REBEL NURSE LEADERSHIP DRIVES INNOVATION IN CARE

A recent thesis introduces the concept of "rebel nurse leadership"—nurses who challenge restrictive norms to improve patient care, teamwork, and workplace wellbeing. The model highlights five drivers of impact: internal reflection, strong professional competence, collaborative relationships, peer networks, and partnership with managers.
–> Empowered nurses become catalysts for innovation, quality improvement, and more adaptive care environments.

Source:
Utrecht University: *Rebel Nurse Leadership Practices*
https://dspace.library.uu.nl/handle/1874/433226

RIGHTS-BASED & LIFE-CENTRED CARE FRAMEWORKS GAIN TRACTION IN EUROPE

The European Care Strategy (2022) strengthens a shift toward affordable, high-quality, and life-centred care systems, supporting both informal and professional carers. Parallel evidence shows that well-designed long-term care systems are not only socially essential but also powerful drivers of economic growth and workforce participation.
–> Care is increasingly recognised as a social and economic investment – embedding rights, dignity, and wellbeing at the core of European welfare reform.

Sources:
European Commission – *European Care Strategy update*
https://employment-social-affairs.ec.europa.eu/news/european-care-strategy-one-year-after-adoption-2023-09-07_en
WHO Europe – *Why invest in long-term care?*
https://www.who.int/europe/news/item/23-04-2025-why-should-societies-invest-in-long-term-care--new-evidence-makes-the-case-for-action

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DEMENTIA CAFÉS STRENGTHEN MEANINGFUL PARTICIPATION IN JAPAN

Japan hosts thousands of dementia cafés – from permanent community venues to weekly gatherings run by volunteers and municipalities. These spaces support people with mild dementia by offering routine, companionship and meaningful participation, sometimes even enabling them to contribute as hosts or helpers.
–> Community-based social infrastructure is becoming a vital element of dementia care, reducing isolation and supporting dignity, agency and everyday belonging.

Source:
Dementia Platform Japan – *Dementia cafés across Japan*
https://dementia-platform.jp/en/article/436/

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SCENARIO 2: SHARED CARE

A Collective Turn: Values, Communities and the New Care and Support Culture

The global geopolitical situation that started in the early 2020s remained unstable for a long time. Long-term care and support costs were left to be paid by families and people with care and support needs. Increased responsibility and scarcity sparked a wave of caring, shifting the focus from individual concerns to solidarity, compassion, and community. The shortage of caregivers, a harsher economic and political climate, and widespread frustration toward the system **brought people together**.

In moments of crisis, **it is not the government that takes the lead but the power of the community**. During challenging times, people instinctively come together, helping one another, reinforcing the idea that **collective care is not just a responsibility but a shared mission**.

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Uncertainty was met with a parallel interest in softer values and diversity – creating a space for innovation and inclusion.

By the 2040s, deinstitutionalization has evolved into a values-driven care model where communities and individuals take voluntary and dignified responsibility for care. **Rather than replacing formal systems, people see caregiving as a shared social commitment** – an act of solidarity that strengthens trust, belonging, and interdependence within society.

Yet solidarity does not emerge effortlessly. In some moments, fear and self-protection override cooperation, leading to local tensions and fragmentation. Shared care systems have learned from such crises: **empathy, trust, and cooperation are continuously cultivated, not assumed**. Research suggests that when people share tangible responsibilities (e.g., maintaining communal gardens), they often show higher levels of commitment – and this insight may be applicable to organising local care shifts. **Familiarity, shared rituals, and repeated social contact reinforce accountability and belonging.** Regular dialogue circles, peer learning sessions, and social events nurture this cohesion, helping communities rebuild cooperation even after breakdowns.

The public sector acts as a platform enabler and regulator, while communities provide the core services. Society has made a profound shift in its values: it has left behind competitive and individualistic logic and embraced collaboration, solidarity, and empathy as the pillars of coexistence. However, the drive for achievement has not disappeared – it has evolved. The drive to excel and innovate now fuels collaboration rather than exclusion. **People see caregiving not as a burden or a job but as a common task and a shared responsibility.**

Many private small entrepreneurs have also developed their own small supported living units, where elderly people or others in need of long-term care and support can live in homelike settings as part of a community.

The state retains ultimate responsibility for those unable to actively participate in co-created care. For individuals living alone, with severe disabilities or complex vulnerabilities, public services provide continuous professional support and guaranteed access to essential care. The platform state not only enables communities but also safeguards those beyond their reach.

Long-Term Care as a Civic Skill

Shared care extends across the entire life course. Communities support not only older people but also children, youth, and adults living with disabilities, chronic illnesses, or long-term mental health needs. **The idea of "long-term care" has evolved into lifelong support – a continuum that accompanies people through different stages of life. Long-term care and aging skills are now seen as civic skills.** It has become common to say: "I'm planning for my future care, just like I planned for my career."

Feeling cared for is recognised as a fundamental human experience, not a sign of dependence. Care itself is viewed as a shared act of dignity and presence: sometimes to act, sometimes simply to be there. This understanding of mutual care – where both autonomy and being cared for are honoured – has grounded the entire transformation in genuine humanity.

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This transformation is not about returning to traditional family care or nostalgic community ideals, but about **reinventing interdependence in contemporary forms – digital, urban, multicultural, and equitable**. Shared care redefines what it means to give and receive support: not as a burden or a budgetary cost, but as an expression of social vitality and collective intelligence. **It positions care as a generative force – sustaining communities, ecosystems, and economies alike.** In this sense, the future of care is less about preserving dependency and more about **co-creating resilience and belonging**.

Diversity, fragility, and aging are no longer seen as barriers but as sources of wisdom, empathy, and social wealth. Each generation and life condition contributes a unique form of knowledge that strengthens the community fabric.

Older individuals are seen not as burdens but as integral members of society who have an active and visible role; they contribute wisdom, experience, and skills. **Aging is viewed positively – as a stage of dignity and value.** This revaluation of aging creates a society where the elderly are embraced and empowered rather than sidelined. Rather than being passive recipients, they are mentors, local historians, and well-being ambassadors. **Many lead intergenerational activities, teach life skills, or volunteer in neighbourhood networks. Their contribution is recognised as a civic asset – a cornerstone of shared care culture.**

Shared care is not a return to unpaid domestic labour but a redefinition of social contribution. Community involvement complements – not replaces – public services, and is supported by **structural recognition** such as training credits, care income, or pension benefits. **Participation is shared across genders and generations, ensuring that caregiving no longer falls disproportionately on women or specific social groups.** Care equity policies were originally inspired by Nordic parental leave reforms.

This evolution represents a social contract for the 21st century – one that balances autonomy and solidarity, recognises invisible work, and transforms care from a source of exhaustion into a foundation for collective well-being. **Participation is designed to be flexible and time-scaled, ensuring that individuals can contribute according to their capacity without risking overcommitment or burnout.**

Transformation to Eco-Social Values and Awareness of Otherness

The values underpinning Shared Care and support expanded beyond solidarity and empathy to include **regeneration, sustainability, and stewardship. The view emerged that caring for one another must go hand-in-hand with caring for the planet that supports all life**.

Communities responded not only by turning inward to human relationships, but also by **embracing broader eco-social values – recognizing that long-term care and support is embedded in both societal structures and the natural environment**. Communities began integrating ecological thinking into their caregiving philosophy – gardens, circular economies, and nature-based care were seen as part of healing. The shared care model has also redefined

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society's relationship with otherness. **The connection to nature mirrors this philosophy: gardens, natural materials, and circular living are not decorative but relational – reminders that care extends beyond humans to the ecosystems that sustain us.** In this sense, shared care is profoundly ecological in the social sense of the term: it cultivates belonging not only among people, but between people and the living world.

This approach of shared care resonates with what many Indigenous cultures have long practiced – **a holistic understanding of care as reciprocity with all living beings**. It recognises that humans, animals, plants, and ecosystems are interdependent participants in a shared web of life.

Local Synergies and Leadership in Action

Care and support are family- and community-based and considered everyone's shared responsibility. Communities, families, and volunteers manage long-term care and support, and volunteering is seen not only as a moral act but also as a recognized contribution to society.

The old boundaries between "providers" and "recipients" have dissolved; care now functions as a living network sustained by shared purpose and transparent governance. **Local communities act as living laboratories for social innovation, where trust, belonging, and local culture shape how care is organised.** Their role extends beyond co-funding – they are the relational backbone of the system, transforming neighbourhoods into networks of shared responsibility.

Families and close relations remain a cornerstone of shared care. In this model, **family members are recognised as co-professionals**: they participate in planning, decision-making, and evaluation together with formal teams. The notion of family is understood broadly, encompassing partners, friends, and chosen communities. For those without relatives, neighbourhood circles and volunteer companions provide the same continuity and emotional bond. **This inclusive view of kinship makes caring a shared, not imposed, responsibility.**

The community – citizens working together with professionals–is the primary vehicle for ensuring quality care. **Local collaboration is central to how long-term care is structured**, with neighbours, volunteers, and professionals coming together to form a support network and partnerships that are more sustainable and flexible than the previous institutionalised model.

The relationship between professionals and communities has evolved into a mutual learning partnership. Professionals bring clinical and ethical expertise, while community members contribute lived experience, social knowledge, and contextual understanding. Together, they co-design care strategies, evaluate outcomes, and adapt practices based on continuous dialogue. This reciprocity ensures that professional standards and community wisdom strengthen each other rather than compete. **Clear ethical frameworks guide boundaries, accountability, and trust, ensuring that professional roles remain distinct yet deeply integrated within community life.**

Teams are self-managing, which means they have the power to make decisions when it comes to how they see care and support. Interdisciplinary teams form naturally and organize their work independently. Decision-making and responsibility are shared. Best practices have been taken from pioneers of self-managing teams.

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A New Professional Architecture

At the core of the new professional architecture are **trained professionals – community care managers, nurses, and social facilitators** – who anchor quality and safety. Surrounding them is a flexible ring of **semi-professionals and trained volunteers**, such as family caregivers, peer mentors, and neighbourhood supporters. Together, they co-manage care situations using open digital platforms that allow transparent coordination and shared decision-making.

Local "care compacts" define the boundaries of responsibility, outlining who is accountable for what in daily practice. Professional mentors oversee peer trainers and volunteers, while mobile inspection and support teams – coordinated by regional authorities – monitor outcomes, ensure safety, and provide conflict mediation when needed. This hybrid model allows flexibility without losing reliability or equity.

Professionals receive specific training in network leadership and ethical facilitation, enabling them **to guide communities without reverting to hierarchy**. This distributed professional ecosystem sustains both the autonomy of communities and the reliability of care.

For individuals with complex or intensive needs – such as advanced dementia, severe mobility challenges, or multiple chronic conditions – specialised mobile support cells ensure continuity and safety. These multidisciplinary units, composed of professionals and trained community responders, provide on-site medical, psychological, and social support. They act as the community's "extended arm", bringing hospital-level competence into people's homes while preserving the sense of belonging and autonomy.

To ensure quality and safety in this distributed system, communities operate within clear ethical and procedural frameworks. In practice, volunteers are coordinated through community-based care managers, who oversee matching, scheduling, and training. Professionals share responsibility for supervision but are supported by **digital coordination platforms** and peer trainers. **Digital inclusion training** is available for all generations, ensuring that everyone can participate confidently in shared care. Volunteer management is recognised as formal work time, not an additional burden, and is integrated into professional training pathways.

In this new landscape, **the roles of professionals** have evolved. Care and support professionals act not as supervisors, but as connectors and enablers within informal networks. Their task is to **translate professional knowledge into accessible community practice, bridging medical, social, and voluntary dimensions of support.**

Balancing Solidarity and Autonomy

Despite the emphasis on solidarity, some people perceive participation as taking a normative tone, making them feel pressured rather than empowered. New forms of caregiver burnout and social exclusion among those unable to contribute are emerging. This highlights a key tension: while the ethos is solidarity, it risks becoming coercive – especially for those who are physically or mentally unable to contribute.

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To prevent solidarity from becoming a hidden obligation, communities operate with clear respite entitlements, rotating care rosters, and micro-grants for caregiver recovery. Equity stewards monitor participation patterns to ensure that those with less time, health or social capital are supported rather than judged. Opt-out remains legitimate; belonging is never conditional on contribution. Structured support – such as respite services, peer groups, and mentoring by experienced caregivers – ensures that no family carries the responsibility alone.

To ensure inclusivity and dignity for all, structural safety nets remain in place. Specialized outreach teams – composed of professionals and trained community responders – support individuals with complex needs, such as those living alone, with advanced dementia, or facing digital exclusion. These mobile care and support units bridge gaps in the system, ensuring that care is not conditional on social capital or existing networks. Local "care and support sentinels" are also embedded in neighbourhoods to detect early signs of isolation or neglect. The principle remains: no one is left behind, regardless of their ability to engage in co-care.

In an increasingly digital world, shared care relies on making community participation tangible and accessible. **A three-level engagement model helps individuals find the form of care contribution that matches their life circumstances**: "Light", "Medium", and "Large". Light participation offers micro-acts of care – short, flexible contributions such as neighbour check-ins or digital time-credit donations. Medium participation includes recurring community involvement, like mentoring, peer support, or shared caregiving rosters, often rewarded with training vouchers or tax reliefs. Large participation refers to long-term commitment, recognised through formal titles, income supplements, or pension credits. This structure ensures that care is shared fairly – not demanded – and that participation strengthens rather than burdens everyday life.

By balancing engagement and rest, the model also prevents caregiver burnout, protecting both volunteers and professionals from excessive emotional or physical strain. To strengthen resilience, communities maintain "care continuity reserves" – networks of trained substitutes and standby volunteers who can temporarily step in during crises. These reserves ensure that they do not collapse when individuals have too much burden on their shoulders as life situations change.

Dedicated learning circles, counselling, and rotation schemes help informal carers manage multiple loads – work, family, and care – while maintaining emotional distance and personal well-being. Over time, these new social contracts re-anchor care as a normal, meaningful, and supported part of civic life.

A Respected Mission: Culture, Roles, and Learning

Work appreciation in long-term care and support has increased significantly. **People see pride and purpose in caregiving.** New skills such as digital inclusion, ecological and planetary care skills, and the knowledge of different therapy methods – have emerged, and as solidarity, collaboration, and empathy are the defining values for care and support, softer skills are actively studied. The education system reflects this broader

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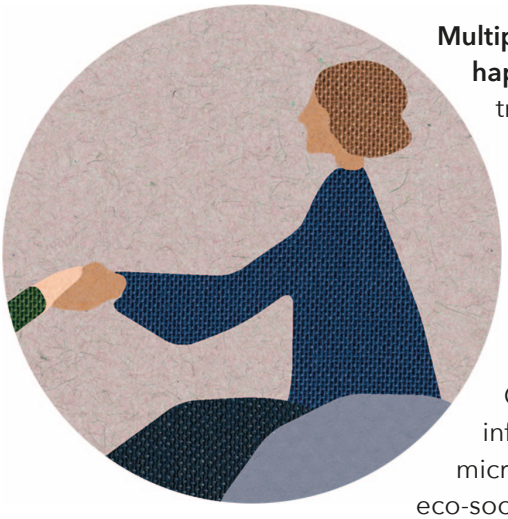
perspective. **Public awareness campaigns have reshaped cultural narratives: caregiving is seen not as a burden but as a shared honor.** Family members, the community, and unpaid volunteers make up much of the workforce. A wide range of backgrounds and lived experiences is accepted as valid.

A proposal to introduce educational processes around care and support from an early age in schools was integrated into the schooling system in the early 2030s, fostering a culture based on mutual support and shared responsibility. This ensures that everyone has at least the minimum required level of formal education to provide care and support.



Multiple types of training are accepted. Training is flexible, continuous, and happens alongside work. Anyone from the community can become a trainer if they feel passionate and have strengths they wish to share for the community. Peer-endorsed certification and light-touch quality assurance help maintain safe and trusted care. Both formal and informal training are valued. Most learning takes place in real-life care and support environments, with recognition for experiential and on-the-job learning. Community knowledge, intergenerational skills and peer learning are respected alongside formal education.

Continuous learning also extends to how professionals operate within informal systems. Certification is modular and portable – people gain micro-credentials for mentoring, care coordination, digital inclusion, or eco-social skills. Communities themselves endorse and validate competences, blending formal and experiential recognition. Different kinds of requirements are also applied in the incentive model.

A typical local team might include a registered nurse acting as *Health & Well-being Coordinator*, a trained community volunteer as *Peer Mentor*, and a digital inclusion navigator assisting families with technology. The fluid composition of these teams ensures that **formal and informal expertise complement each other in real time**.

The education system also includes nature-based and eco-social care and support modules, ensuring that care and support professionals are equipped to connect health and social well-being with environmental responsibility.

Digital Tools for Coordination and Prevention

Digitalisation in shared care is invisible but ever-present – a quiet infrastructure that strengthens relationships rather than replacing them. Communities use digital platforms to coordinate care, match volunteers and families, and maintain personal care plans that evolve with life stages.

Informal caregivers and family members rely on shared digital scheduling tools that distribute daily responsibilities – from doctor visits to medication reminders and emergency calls. These cooperative systems reduce the cognitive load of care, ensuring that no one person carries the full emotional or practical burden. When signs of overload appear, automatic alerts trigger peer

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or professional support, activating rest periods or short-term replacement by trained volunteers. **Digital design in shared care is therefore deeply humane: it does not replace empathy, but organizes it.**

Digital coordination tools are also used across all care networks to ensure that decentralised structures remain coherent and safe for clients. The platforms enable transparent communication among professional, volunteer, and family caregivers, reducing the risk of information loss or conflicting interventions. Community Care Managers oversee these systems locally, guaranteeing that clients experience continuity and consistency, regardless of which organisation or actor delivers the service. Clear communication protocols and shared ethical standards ensure that collaboration strengthens – rather than fragments – the customer journey.

Artificial intelligence supports preventive action by identifying early signs of isolation or health decline, while respecting privacy and human judgement. **Every person has access to their own data and can decide who shares it.**

Inclusive Living and Intergenerational Spaces

Due to this new model of shared responsibility, **innovative supported housing, personalized small spaces, and community service hubs have been built**. By cultivating stronger connections with local networks and community initiatives, these service hubs can be transformed into genuine actors of territorial development. **Nursing homes, as we once knew them, no longer exist. Instead, care and support are integrated into local communities, where people age in place, surrounded by their families, friends, and neighbors.**

Intergenerational living and community life have taken new forms: some facilities integrate childcare centers, coworking cafés, and public events – creating places of shared life, not isolation. This has had a huge positive effect on the loneliness epidemic. People in these new facilities take new roles and become for instance mentors, volunteers, and caring neighbors.

It also allows for more autonomous end-of-life choices that reflect personal meaning and dignity. For example, access to multidisciplinary palliative care teams now enables people to choose to die at home – with expert care, spiritual support, and surrounded by loved ones.

Furthermore, these multi-generational care spaces host early rehabilitation programs for children, accessible creative workshops for young adults with disabilities, and mentoring networks where older people share skills with younger generations in return for companionship or digital assistance. People who once risked being invisible in the system – children with complex conditions, neurodivergent adults, refugees with trauma backgrounds – are now fully recognised as co-authors of their care and support.

Each community ensures that accessibility, inclusive communication, and cultural sensitivity are embedded in design and everyday practice. The principle is universal: everyone belongs, everyone contributes, everyone is cared for.

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Flexible Funding and Community Investment

Care and support is funded through individuals, families, communities, and charities. **Funding follows a multi-layered model that balances solidarity and sustainability**, such as 'public baseline funding' that guarantees universal access to essential care and support, provided through state and municipal budgets; 'community co-funding' that enables local initiatives to raise complementary resources through cooperative funds, neighbourhood donations, or social impact bonds; 'private partnerships' that supply innovation funding – for example, sustainable housing, digital inclusion tools, or eco-social projects and 'EU and foundation programmes' that sustain cross-national experimentation and scaling of successful models. The for-profit care sector is small and tightly regulated to prevent inequality, ensuring that public and non-profit collaboration remains the backbone of the system.

Those with financial means can supplement care and support through private services or insurance.

Digital participation and transparency remain essential: communities use open-source budgeting platforms to track spending and co-decide on priorities. This participatory budgeting model has largely replaced earlier experimental crypto-based funding.

However, flexible funding models also carry vulnerabilities. In practice, community and donation-based financing can deepen inequalities between regions and customer groups. Wealthier communities tend to attract more resources, while low-income or rural areas may struggle to sustain care networks. To prevent polarization, shared funding mechanisms – such as redistributive public funds, have been established to ensure that every individual has access to essential, high-quality care regardless of their community's financial capacity. Stable funding has allowed the system to expand beyond efficiency into a deeper exploration of meaning and identity in care.

A significant risk is geographical inequality: the model of shared care tends to flourish most easily in urban areas with dense networks and diverse actors, while rural or sparsely populated regions may struggle to sustain the same level of community participation. Without targeted support, these differences can deepen exclusion and create uneven access to shared care across the country.

Economic downturns, inflation, and global crises have occasionally tested the limits of solidarity. In some regions, temporary state intervention was required to stabilise funding or prevent care disruptions. These moments have revealed that shared care is not linear progress, but a balancing act between autonomy and interdependence.

Holistic Care Models and Identity-Oriented Support

Care philosophy is person-centered and built around individual needs. **Customers are seen as unique individuals.** Care and support is tailored to their personal life context, goals, values, and sense of identity. **People actively co-create their care and support alongside families and communities.** This is supported by the state who provides a framework for efficient and holistic planning.

The traditional focus on medical care has shifted. Now, social well-being and emotional

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connection are equally vital. **Holistic and identity-oriented practices expand what care and support can include**: ecotherapy, art and music therapy, biographical care, reminiscence methods, therapeutic gardening, and dignity-focused projects. The holistic logic also applies to people who require continuous or high-intensity support.

Shared care also embraces the reality of suffering, dependency, and cognitive decline. Community-based palliative networks and dementia-companion programs ensure that even those unable to participate actively are surrounded by dignity, presence, and continuity. Care here is not idealised happiness, but the collective holding of pain, memory, and meaning – a human practice that acknowledges fragility as part of life.

The integration of nature into care and support practices – from forest therapy to renewable energy-powered buildings – has made ecological care a living practice. This happens naturally through the people that have diverse backgrounds and interests in the community. Eco-social values have already started to become a bigger phenomenon in the 2020s.

To maintain coherence across this diverse ecosystem, local and national *Care Partnership Councils* bring together public authorities, private providers, NGOs, and citizen representatives. These councils coordinate funding, training, and ethics oversight, ensuring accountability without bureaucracy.

A new portfolio of social services supports this holistic vision, integrating cross-sectoral approaches that blend formal care with community support.

Skills for Shared Care and Support

In this collaborative ecosystem, care and support are shared responsibilities. The boundaries between professionals, families, and communities blur. Skills revolve around trust, communication, and the ability to nurture networks of care that are both personal and planetary. The system relies on distributed leadership, peer learning, and emotional competence.

TO SUCCEED IN THIS NEW LANDSCAPE, CARE AND SUPPORT PROFESSIONALS NEED THE FOLLOWING KEY SKILLS:

- Co-creation and participatory facilitation
- Empathy, deep listening, and emotional literacy
- Mentorship and community education
- Self-leadership and resilience
- Intercultural and intergenerational collaboration
- Digital inclusion and data ethics awareness
- Ecological and planetary care skills
- Knowledge of different therapy methods such as ecotherapy, art and music therapy, biographical care, reminiscence methods, therapeutic gardening, and dignity-focused projects.

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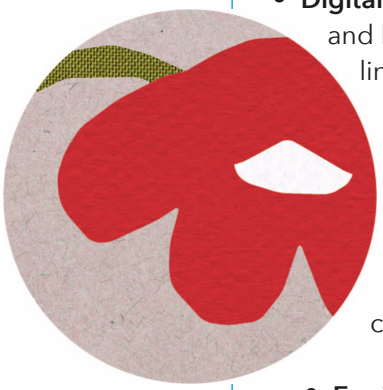
EMERGING ROLES:

- **Community Care Manager** – coordinates local care networks and ensures balance between professional and volunteer input.
- **Peer Mentor** – provides lived-experience guidance and emotional support to others in similar life situations.
- **Intergenerational Skills Facilitator** – bridges learning between youth and elders through shared activities and knowledge exchange.
- **Digital Inclusion and Intersectionality Navigator** – ensures equal access to digital tools and literacy for all community members. Ensures care systems address inequalities linked to gender, disability, race, or migration.



- **Planetary Care and Healing Space Facilitator** – designs and animates restorative environments that foster wellbeing and presence. Connects environmental stewardship with daily care practices and local sustainability.
- **Death Doula** – provides end-of-life presence, practical support, and emotional continuity for individuals and families.
- **Equity Steward** – monitors participation patterns to ensure that those with less time, health or social capital are supported rather than judged.
- **Community Equity Council** – ensures fair distribution of responsibilities among citizens.
- **Inclusion Fund Coordinator** – guarantees access to support for those unable to give back materially.
- **Care Partnership Council** – coordinates funding, training, and ethics oversight within different stakeholder groups.

In Shared Care, professionals and citizens become co-creators of wellbeing. Competence means being able to build relational ecosystems that balance autonomy, belonging, and sustainability.

Main drivers and hinders for this scenario evaluated by partners on October 2025

Drivers

- Integrating care awareness into education from an early age
- Building community solidarity
- Long-term political and financial commitment
- Stronger collaboration between communities and professionals.

Hinders

- Reluctance to participate
- Cultural and religious differences
- Financial inequality
- The risk of excluding those who cannot afford to contribute
- The complexity of durable funding structures

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Concrete signals of change

COMMUNITIES AND INFORMAL CARERS PROVIDE THE MAJORITY OF LONG-TERM CARE

Across the EU, informal carers – predominantly women – deliver up to 80% of long-term care, often without adequate financial, social or professional support. Community contributions are essential to keeping people at home, yet reliance on unpaid labour exposes significant inequalities and sustainability challenges.
–> Care systems are increasingly dependent on informal networks, pushing policymakers to strengthen rights, recognition and resources for family and community carers.

Sources:
Joseph Rowntree Foundation – *Future of Care Needs a Whole-Systems Approach*
https://www.jrf.org.uk/care/the-future-of-care-needs-a-whole-systems-approach
European De-institutionalisation Initiative
https://deinstitutionalisationdotcom.wordpress.com/cbc/

DEATH DOULAS REDEFINE END-OF-LIFE CARE AND LITERACY

Organisations like *Going with Grace* train "death doulas" – non-medical companions who guide individuals and families through emotional, practical and spiritual aspects of dying. With courses, workshops and community-based education, death doulas help normalize conversations about death and improve end-of-life experiences rooted in personal meaning and peace.
–> End-of-life care is expanding beyond clinical boundaries, empowering communities to support dying as a relational and dignified life phase – reducing isolation and fear.

Source:
Going With Grace – *Death Doula Training & Resources*
https://goingwithgrace.com/

INDOOR NATURE INTERVENTIONS SUPPORT WELLBEING IN LONG-TERM CARE

Research shows strong associations between exposure to nature and improved cognitive, physical and emotional health. As many older adults in care settings struggle to access outdoor environments, indoor nature initiatives – such as plant installations, green walls and natural materials – are being explored to bring the benefits of nature inside. Evidence is still emerging, but early findings suggest potential gains in wellbeing, sleep and social engagement.
–> Indoor nature design could become a scalable wellbeing intervention in long-term care, reducing barriers to restorative environments.

Source:
The Gerontologist – Indoor Nature Exposure Study
https://academic.oup.com/gerontologist/article-abstract/60/3/e184/5382625?redirectedFrom=fulltext&login=false

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SCENARIO 3: INSTITUTIONALISED CARE

Historical Continuity: A Power-Driven System

The future of long-term care remains rooted in the institutional structures. The underlying culture and structures of institutionalism continue to influence care practices. Care homes and health centres often reflect institutional logic.

The long-standing institutional history of care emphasizes the contradictions between human rights, economic factors, and societal operating environments. Industrial care has historically been driven by cost considerations, leading to power imbalances and restrictive conditions.

While care transitioned from family-based support to a professionalized system, the foundations of institutionalism persist. These structures define care through the values of the welfare state and are governed by power dynamics that shift with political leadership. "Good care" is defined from above – by policymakers rather than caregivers, people who need care, or families. The

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state takes care of everyone, sustained by a lingering belief – rooted in post-socialist welfare systems – that care will always be publicly funded and available to all.

The system continues to operate under rigid frameworks. Institutional logic shapes care and support homes and services, leading to a confusion between medical and long-term care. Public social services evolve slowly, struggling to meet the changing needs and lifestyles of citizens. **Cultural assumptions about caregiving roles remain deeply embedded.** Informal care, though essential, is often invisible. **The prevailing mindset insists that people must adapt to the system – not the other way around.**

Despite growing public discourse around equality and person-centered care and support, **systemic inertia blocks progress.** Preventive healthcare and social support are often viewed suspiciously, even as intrusive.

Digitalisation has become the modern face of institutionalism – efficiency technologies reinforcing, rather than replacing, old power structures. Public trust has turned into passive acceptance: citizens no longer expect participation or dialogue, only predictability from the system.

Despite decades of policy rhetoric around deinstitutionalisation, integrated care, and person-centred approaches, their practical implementation faced growing obstacles. Economic crises, workforce shortages, and uneven regional performance gradually eroded public trust in decentralised systems. As scandals around care quality and safety emerged, governments responded with tighter regulations, centralised control, and the reassertion of institutional care as the safest, most manageable option. What began as an attempt to protect citizens from inequality and neglect ultimately reinforced the very structures reformers had sought to dismantle. Over time, this logic hardened into belief – that the system itself, not the individual, knows what is best. When someone is the subject of care, someone else gets the power to define what a good everyday life is like.

System Logic: Administration, Categorisation and Control

Care is seen as a cost rather than an investment. Public funding at national and EU levels is vital, and it dictates how, where, and by whom care is provided.

The system is based on a disability-centered model, with services narrowly tailored to functional limitations or diagnoses. Needs are categorized and matched to service packages, often at the expense of emotional or social well-being. Care is made efficient by streamlining processes – without recognising care's complexity.

The sector is still marked by a medical culture of "care", centred on protection and safety, which slows down the transition to a logic of "doing with" people. This difficulty in accepting risk-taking, while managing it, limits the real autonomy of the people supported. Safety has become the system's moral anchor. **Every policy and procedure is justified through the language of protection**: protecting people from harm, from error, from uncertainty. Yet this pursuit of security has created its own risks – the risk of disempowerment, dependency, and invisibility.

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Institutions measure safety through the absence of incidents rather than the presence of trust. As a result, professionals spend more time documenting compliance than engaging with the person. For many, protection has become synonymous with control.

The institutional system encompasses a wide range of people in need of long-term support – the elderly, children with congenital conditions and adults with chronic illnesses or psychiatric diagnoses. The model, however, treats all these groups through the same categorical lens, reducing complex life situations to functional assessments.

The lack of a life-course perspective means that transition phases – from childhood to adulthood, or from active life to old age – are poorly managed. Many individuals fall through administrative cracks when responsibility shifts between sectors. **Diversity of need and background is acknowledged in policy, but rarely translated into differentiated care practice.**

Care workers face relentless administrative burdens: documentation, reporting, audits, and regulatory compliance. Time for actual care is limited, adding to emotional stress.

Alongside the public system, private and non-profit care providers continue to exist, yet their role remains marginal and tightly regulated. Private facilities often cater to wealthier clients or those seeking faster access, creating subtle inequalities within a formally universal system. Charitable organisations fill gaps in service delivery, particularly in rural or underfunded regions, but they struggle with unstable funding and bureaucratic restrictions.

Public–private collaboration remains fragmented, limited to pilot projects rather than systemic partnership. The rhetoric of universal access conceals growing divergence between those who can afford complementary private services and those entirely dependent on the public infrastructure.

Private actors are often caught between public regulation and market pressure. Their financial sustainability depends on short-term contracts and shifting political priorities, leading to instability in service continuity. **The fragmentation between public, private and non-profit providers weakens accountability, as responsibility becomes diffused across administrative layers.**

The long-term care sector is becoming more professionalised and interconnected, but also more demanding for professionals, who have to cope with expanded roles, increased workloads and performance-driven thinking.

Workforce Under Pressure: Training and Recognition

The care workforce is in crisis. One of the major challenges is the availability and qualification of care workers.

Despite efforts to recruit new workforce into the sector, results have been limited. This is due not only to poor working conditions and low prestige among young people, but also because

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qualification requirements and rigid institutional cultures make it difficult for immigrants to enter or remain in the field. As a result, the system fails to benefit from potential, qualified, international labour solutions – not because of explicit exclusion, but because of structural inflexibility and lack of attractiveness.

The increasing reliance on migrant care workers also raises ethical and structural concerns. While migration temporarily alleviates labour shortages, it also contributes to a care drain in countries with less developed social services, where local systems lose skilled workers to wealthier regions. This dynamic reinforces global inequalities and challenges the long-term sustainability of the care workforce – an issue often overlooked in national policy debates.

The caregiving profession is often viewed as vocational, based on the idea that anyone can provide care without specialized training. **The profession remains undervalued, gendered, and misunderstood.** Women dominate the sector, reinforcing assumptions that caregiving is about empathy and basic nursing rather than leadership, strategy, or tech use. This frequently justifies the social and economic undervaluation of the sector.

Due to chronic staff shortages, training happens on the job. Learning is recognized in practice, but the dual burden of care work and learning creates resourcing difficulties. Many care workers are learning while understaffed, and new skills are adopted unevenly. There is a tendency to downgrade jobs in response to recruitment difficulties. **Training programs are often seen as a stepping stone to other jobs, rather than as a path to a stable professional career.** This hinders the consolidation of a committed professional workforce in long-term care. **Mandatory digital reporting systems** further intensify administrative pressure, transforming every care encounter into a data entry task.

Training has mainly shifted from voluntary education to a mandatory, state-enforced requirement – a form of 'care obligation' comparable to other civic duties. In an effort to address labor shortages, states introduce mandatory care training for unemployed individuals or those on social benefits, blurring the line between civic duty and forced labor.

Despite the introduction of a civic 'care obligation' aimed at filling workforce gaps, labour shortages persist. Mandatory recruitment measures address the symptom, not the cause: poor working conditions, lack of autonomy, and low social status make retention nearly impossible. **The result is a paradoxical system where care is both an obligation and a scarcity – sustained by compulsion rather than attraction.**

Leadership in a Constrained Context

Leaders operate within **an increasingly digital bureaucracy where decisions are shaped by metrics, audits, and compliance dashboards rather than human relationships.** Managers are held personally accountable for compliance failures, pushing them to enforce rigid hierarchies and minimise discretion at every level. **Leadership is thus less about guidance and more about surveillance – a vertical chain of responsibility built on fear of sanctions rather**

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than trust in professional judgement. Metrics replace meaning; authority flows downward, while responsibility flows upward.

Leadership in this model is primarily managerial rather than visionary. Hierarchies define both authority and identity: senior staff oversee compliance, while frontline workers execute care plans with limited discretion. Innovation is discouraged by fear of error and administrative sanctions. For many leaders, success is measured not by outcomes for clients but by the absence of deviations from protocol. As a result, **leadership culture reinforces the very rigidity it seeks to manage — maintaining order at the expense of responsiveness and trust**.

Leadership must navigate complex relationships between professional and informal caregivers. Projects are often designed to include family members in planning and delivery, but this hybrid model introduces tension. Conflicts arise over responsibilities, finances, and expectations. Underfunding and unequal geographic access further limit what leaders can offer locally.

Regulation as a Stabilizing Force

Institutional care and support remains highly regulated. Governance remains highly complex, with a tangle of national and regional levels that sometimes hampers the effectiveness of initiatives. National legislation such as the Social Services Act and National Health System reforms from the 21st century continue to define social services, quality standards, and client rights.

Following recurring regional disparities in service quality and client rights enforcement, national authorities intervene decisively. The central government reclaims regulatory control over social services, client protection, and quality assurance, effectively recentralising power. While this move restores administrative coherence and accountability, it also further entrenches institutionalised care structures and limits local flexibility. In doing so, it reinforces the perception that safety and equality can only be guaranteed through top-down governance, narrowing the space for customized, place-based innovation.

There is political will for inclusion and deinstitutionalisation but the resources are often insufficient to achieve these ambitions. This mismatch between public policy and reality on the ground is a source of strain for professionals. Delays or inconsistency in legislative reforms further hinder innovation and system transformation.

EU-level policies have tried to push reforms, but are often mismatched with national-level realities and bureaucratic overload. Regulatory uncertainty discourages innovation and contributes to system stagnation. Yet at the same time, regulation remains essential in maintaining minimum standards and safeguarding client rights. Digital regulation tools — centralised registries, performance dashboards, and algorithmic audits — are presented as guarantees of transparency but have entrenched bureaucracy instead.

The apparent stability of the institutional model is repeatedly tested by crises — from pandemics and cyberattacks to workforce strikes and scandals over care quality. Each disruption initially

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triggers calls for transparency and reform, yet the institutional reflex remains the same: more control, more oversight, more layers of regulation. Paradoxically, every shock intended to modernise the system ends up reinforcing its dependency on bureaucratic mechanisms, demonstrating both its resilience and its rigidity.

Decision-making in this system remains highly centralised. Governments, administrators, and institutional leaders shape care policy and resource allocation, while those who live and work within the system are largely unheard. **Despite its promise of universality, the institutional model continues to marginalise key voices – those of care users, families, and informal carers who carry much of the system's invisible work.** Their lived experience rarely informs decision-making or service design. Workforce pressures, moral fatigue, and gendered expectations are treated as operational issues rather than structural inequalities. In doing so, the system reinforces the very rigidity and imbalance it was designed to overcome. Without addressing these underlying dynamics, institutional care risks perpetuating an inflexible and inequitable order under a new bureaucratic guise.

In this system, the voices of citizens and communities are largely absent from decision-making. Participation is limited to consultation processes with little real influence. The institutional logic assumes that collective welfare is best managed by professional authorities, leaving community initiatives peripheral and largely symbolic. However, beneath the system's stability, signs of quiet public frustration surface. Citizens still question how well the institutional model reflects their values and expectations.

From Personalization to Standardization

For many individuals, the experience of receiving care has become one of quiet resignation. **Care plans are drawn up on their behalf rather than with them. Care covers basic needs and prioritises safety first. Services are designed to meet essential physical needs with minimal personalisation.** Choice is formally available: personalization is promised, but standardization is delivered. Customers can select between predefined service packages – but in practice decisions are guided by system convenience and risk management.

Some people try to advocate for more personalised options, yet bureaucratic complexity and rigid eligibility criteria often silence their efforts. Families act as intermediaries between the person and the system, translating needs into administrative language. The result is a care culture where compliance is rewarded, and self-determination is treated as a complication rather than a goal.

Person-centered approaches were officially retained in strategic documents, but in practice replaced by performance indicators and procedural compliance. **Over time, the concept of "personalization" became a bureaucratic category – a checklist confirming that a choice was offered, not that it was meaningful.** It was faced with chronic staff shortages, rising costs, and political promises of equality and safety, decision-makers gradually replaced dialogue with procedure.

Digital profiles and algorithmic assessments now determine eligibility and service levels, presenting objectivity while masking the absence of genuine choice. **Personalisation has been**

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automated: every need translated into data categories that fit system templates.

The narrow institutional logic leaves little room for shared decision-making or family-driven initiatives. Families and close relations remain essential yet often invisible actors in the institutional system: they fill gaps left by understaffed facilities, provide emotional continuity, and navigate bureaucracy on behalf of their relatives. This hidden family labour sustains the system's stability, even as it reinforces unequal burdens between genders and generations. Despite their contribution, they are rarely seen as partners – more often as sources of pressure or complaint.

Technology Under Pressure

When care is primarily viewed through a cost lens, **the use of technology is imposed rather than chosen**. Digital systems are introduced mainly to compensate for workforce shortages and to monitor compliance, not to enhance relationships. Algorithms prioritise efficiency over empathy, and data-driven evaluations frequently override professional judgement. Remote monitoring tools and AI-assisted assessments have improved safety metrics – yet at the cost of relational depth and trust. For many professionals, digital reporting consumes more time than care itself.

Artificial intelligence is seen both as a tool for simplifying administrative tasks, prevention, and remote assistance, and as a vector of uncertainty. **Privacy-aware data systems allow for some cross-sector use of information.** Artificial intelligence supports assessment tools and resource allocation but remains tightly controlled by central authorities.

Robots and automation have been introduced alongside human labour, but instead of alleviating the workforce crisis, they require extensive adaptation from staff and have added technical dependency and additional maintenance tasks. Technologies such as data platforms, documentation software, and centralized dashboards dominate everyday work, turning care into a measurable performance rather than a human encounter.

For clients, technology appears as surveillance rather than empowerment. Information flows mainly one way – upward, into the administrative core of the welfare state. Those with limited digital literacy or complex conditions often experience exclusion rather than inclusion. The promise of digital participation remains largely unmet, reinforcing the passive role of care recipients.

Despite ongoing innovation rhetoric, technology in this system has not revolutionised care. It sustains the institution, not the individual. **Artificial intelligence is a managerial tool, not a human-centred transformation.** What was once presented as modernisation has become a new layer of bureaucracy – a digital skin covering the same old structures.

Facilities and Everyday Realities

Professionals agree that people with severe disabilities can only be cared for in large residential institutions, not in small supported housing. It is taken for granted that some people (i.e. with serious disorders or high dependency) must live in residential facilities, without exploring other more community-based or personalised alternatives. Standards of care and

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housing have remained unchanged. There is often little questioning of current expectations for facilities and services, despite pressure for higher standards, personalization, and comfort.

Despite its unified appearance, the institutional landscape varies widely across Europe and within countries. In urban regions, large multipurpose facilities dominate, operating as complex bureaucratic ecosystems with integrated health and social services. In contrast, rural areas often rely on smaller, under-resourced institutions or hybrid models combining public subsidies with private provision.

If one cannot access the facility, proper care cannot be delivered. Availability of services is constrained by low capacity, lack of funding, or geographic disparities. In many areas, there simply aren't enough beds or services to meet demand. Those with financial means can bypass waiting lists by purchasing regulated private care locally, even though it is also subject to capacity limits. Others must rely solely on limited public options, which deepens inequality in access to essential support.

Caregivers must manage complex systems while maintaining their well-being, often with minimal support. The system demands resilience, routine, and the ability to function under administrative load.

Digital facility management systems track occupancy, safety, and staffing levels but rarely translate into better living conditions.

Skills for Institutionalised Care System

Institutional care is defined by hierarchy, compliance, and stability. Skills focus on maintaining operational continuity, managing risk, and navigating complex regulation. The professional identity is shaped by duty, control, and responsibility – not innovation. Training is standardised, and new technologies serve the institution more than the individual.

TO SUCCEED IN THIS NEW LANDSCAPE, CARE AND SUPPORT PROFESSIONALS NEED THE FOLLOWING KEY SKILLS:

- Traditional nursing and support competencies
- Documentation and administrative precision
- Time and stress management
- Communication and conflict resolution
- Digital tool use and data literacy
- Regulatory and compliance expertise
- Emotional regulation and coping under pressure
- Fast-paced decision making

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EMERGING ROLES:

- **Documentation Coordinator** – ensures accurate and timely data entry to meet audit and reporting requirements.
- **Family Liaison Officer** – maintains communication between institutions and families, translating complex procedures into accessible language.
- **Service Integration Manager** – aligns medical, social, and administrative workflows to ensure consistent care pathways.
- **Digital Care Technician** – manages digital systems used for monitoring, scheduling, and reporting across care facilities.
- **System Adherence Supervisor** – Ensures that daily care practices strictly follow standardised protocols, safety rules, and algorithmic recommendations.
- **Compliance Analyst** – monitors audit data and ensures that care units adhere to national standards, mediating between inspectors and frontline staff.
- **Algorithmic Ethics Officer** – oversees fairness and bias in AI-based assessment systems, balancing efficiency with ethical integrity.
- **Resident Rights Ombudsperson** – acts as an intermediary for clients and families navigating complaints and appeals, ensuring that voices are heard within bureaucratic limits.
- **AI assessment specialist** – manages and trains care staff with AI assessment tools
- **Digital Facility Manager** – tracks occupancy, safety, and staffing levels with the help of digital tools

Competence in this scenario is measured by order and predictability. Innovation exists mainly within procedural and administrative limits. Professional care identity is defined by endurance rather than empowerment.

Main drivers and hinders for this scenario evaluated by partners on October 2025

Drivers

- Public and political acceptance of centralized care
- Population aging
- Economic incentives favour institutional care
- Stable funding structures
- Overall economic and cultural stability

Hinders

- Growing public opposition to institutionalization
- Persistent budget cuts that weaken community alternatives

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Concrete Signals of Change

SCANDALS RESHAPE LONG-TERM CARE TOWARD STRONGER REGULATION

A series of high-profile neglect cases in the United Kingdom and Finland has eroded trust in decentralised, market-driven care models. Regulators have responded by increasing inspections, tightening quality standards and introducing mandatory staffing requirements to ensure resident safety and accountability.
–> Quality failures are driving a return to stronger state oversight in long-term care, reinforcing monitoring, compliance and risk management across the sector.

Sources:
The Guardian – *Private firms ran almost all care homes forced to shut for breaches in England*
https://www.theguardian.com/society/2024/oct/06/private-firms-ran-almost-all-care-homes-forced-to-shut-for-breaches-in-england
Yle – *Embattled CEO of elder care home quits over negligence*
https://yle.fi/a/3-10619015

AGEING CARE WORKFORCE INTENSIFIES PRESSURE FOR INSTITUTIONAL MODELS

EU assessments highlight persistent staffing shortages, a rapidly ageing care workforce, and heavy dependence on women and migrant workers. As workforce resilience weakens, policymakers increasingly turn toward standardised and tightly regulated institutional approaches to manage risk and ensure continuity.
–> Without a new generation of care professionals, system pressures may further shift care away from personalised community support toward more centralised, institutional models.

Source:
Eurofound – *Long-term Care Workforce: Employment and Working Conditions*
https://www.eurofound.europa.eu/en/publications/all/long-term-care-workforce-employment-and-working-conditions

STATUTORY FAMILY DUTY LAWS SHIFT ELDER CARE TO ADULT CHILDREN

Filial-support legislation in countries such as China, India and Bangladesh legally obligates adult children to financially support and care for their ageing parents. These laws formalise family responsibility as a core component of long-term care systems, especially where public provision is limited.
–> Elder care is increasingly framed as a legal and moral duty within families – raising concerns about gender inequality and uneven care capacity, while reinforcing the role of kinship in ageing societies.

Source:
The Gerontologist – Laws on Filial Support in Four Asian Countries
https://pmc.ncbi.nlm.nih.gov/articles/PMC5677618/

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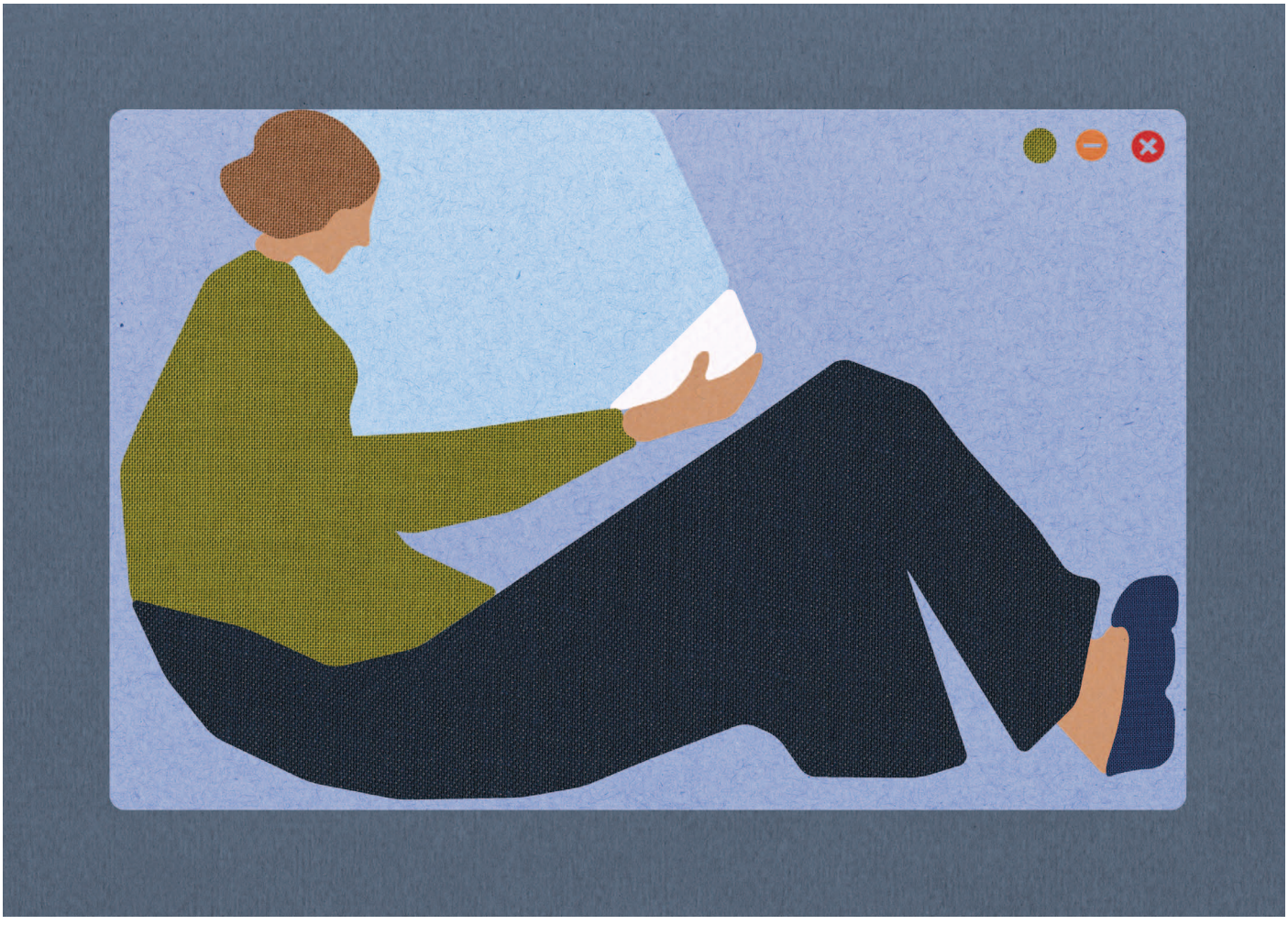
SCENARIO 4: TECHNOCRATIC CARE

Optimized and Forgotten: When Efficiency Replaces Empathy

Economic crisis, war in Europe, and increased immigration have intensified political polarisation and reinforced a technocratic worldview in which efficiency, control, and self-sufficiency override social solidarity. At both the EU and national levels, **technology is seen as a cost-saving solution, and the exponential development of AI has enabled the use of robots and remote technologies in place of human caregivers**. The technocratic care model raises the risk of deep societal tensions as European human-centred values are increasingly challenged by efficiency-driven logic. Hard values dominate public discourse, and inequality is widely accepted.

A prolonged period of underfunding and political instability, digital solutions were rapidly adopted as the only scalable answer – regardless of ethical or social worries and consequences.

There has been a prevailing assumption that technology can solve every challenge in care – improving both quality and access. Thus, **the future of long-term care and support is driven by**



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immersive technological development and productivity, dominated by private sector funding and shaped by economic values. There remains a high demand for performance and rationalisation.

The processes are streamlined for efficiency. T**here is no room for human-centered care and support**, thus the needs and wishes of customers and their families are not considered. Health and social care are viewed as costs to be rationalized for savings rather than as investments in human well-being, typically through the use of new technologies.

The concept of **person-centered care**, once a guiding principle of European welfare, **has gradually dissolved into a system-centered model of efficiency**. Personal choice and participation still appear in official strategies and service design, but in reality, they have become administrative gestures – symbolic rather than lived.

Contradictions are mounting: while AI promises hyper-personalization, in practice the system standardizes care delivery. Protocols are rigid, inflexible, and unresponsive to nuance.

This erosion of person-centred care stems from the belief that technology can objectively define needs better than people themselves. Algorithmic systems translate human experience into data points, stripping care of its emotional and relational depth. The human voice – once central to care planning – has become a variable in a data model, adjusted for efficiency rather than empathy. **The individual adapts to the logic of the system, not the other way around.**

Political guidance is reducing the influence and resources available to advocate for vulnerable groups. In addition, **due to social media influence and populistic movements, science-based knowledge has lost its legitimacy, and deep ideological divides shape care policies**. The LTC sector is torn between its heritage of solidarity and participation, and a transformative dynamic pushing it toward greater economic rationalization, driven by funding that is insufficient to meet actual needs. This paradigm shift is disrupting professional practices and raising fundamental questions about meaning, ethics, and the role of supported individuals.

The gap between people with high and low socioeconomic status (SES) is widening, and this is increasingly reflected in access to appropriate care and resources.

The widespread use of robots in care is causing unemployment, especially among lower-skilled workers, while existing social security systems are struggling to adapt to these changes. Care coordination operates through **decentralized digital platforms** that connect multiple providers across sectors. These “satellite networks” are managed by algorithmic systems rather than by human case managers, ensuring standardization but eliminating relational continuity. Clients move fluidly between providers – yet often without ever meeting a consistent human face.

Families are rarely involved in care planning, as algorithmic systems determine eligibility, treatment plans, and even emotional needs based on predictive data. Professionals no longer act as caregivers but as monitors of automated processes – ensuring compliance rather than connection. Care users, too, have been reduced to datasets; their voices enter the system only through satisfaction metrics or error reports. Decision-making, once relational, has become procedural and opaque.

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Fragmented Governance and EU Control

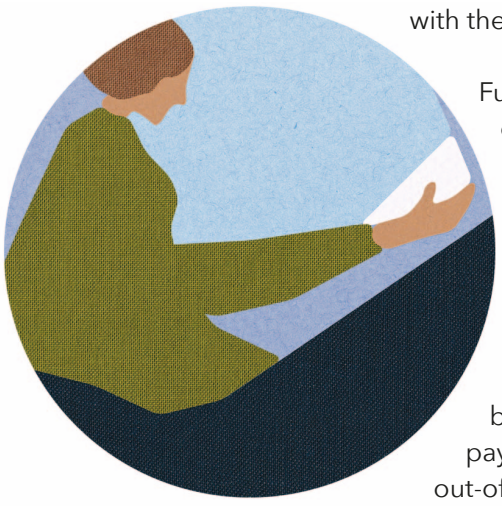
The care and support system is fragmented, with multiple actors – primarily private companies – competing in the field. There is intense rivalry between technological systems, and **resources are needed to manage the competition and select cost-effective solutions**. Since funding determines decision-making, care services vary dramatically, and different technologies often fail to interoperate. The political visions favour stricter control, cost-efficiency, or limited public responsibility. There is a lack of coordinated national strategy, which further reinforces the emphasis on private sector services.

Simultaneously, data is siloed and strictly regulated by the EU, and scandals surrounding certain large profit-making structures have increased demands for transparency and reporting–tasks that come at the expense of time spent with supported people. While strict EU data regulations aim to build trust, they also slow down experimentation and the integration of cross-border care systems. The siloed and protected data hinders innovation and development, maintaining an atmosphere of uncertainty about what is governed at the EU level and what can be decided locally.

National governments and municipalities still play a residual but crucial role in maintaining accountability and access within the fragmented system. They define minimum service standards, manage essential procurement, and regulate cross-border data and funding flows in coordination with EU institutions. Public–private partnerships operate under these frameworks, but oversight has shifted from quality and equity to compliance and efficiency metrics. While governments no longer drive innovation, they remain responsible for preventing systemic collapse and ensuring that basic care functions are not fully market-dependent.

Private Dominance and Algorithmic Oversight

Private technology companies dominate the field, while public responsibility and funding are limited to covering only the most essential medical needs. With the private sector controlling most care delivery, services are expensive. There is a structural lack of resources, leading to the need for co-payments and the privatization of services, which many people cannot afford. Regulation often arrives late in response to emerging challenges and fails to keep pace with the evolving needs of society.



Funding is inadequate and unstable – social care providers often depend on short-term or project-based funding, which makes it difficult to plan for the long term. Annual uncertainty in funding allocation affects staff stability, development, and investment in infrastructure. Lack of long-term continuity affects the uncertainty of which practices and technologies will persist in the future.

Despite its inequities, **the system remains operational through a complex patchwork of funding streams**. Local authorities purchase basic care packages through competitive procurement, while individuals pay for enhanced or personalized services via private insurance or direct out-of-pocket payments. EU-level subsidies support digital infrastructure and

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regulatory compliance, ensuring interoperability between national systems. Communities and small local providers act mainly as subcontractors, operating within frameworks defined by corporate care conglomerates and municipal administrations. This model keeps the system financially functional – but socially fragile.

This private-driven system reduces the need for strict quality standards, simultaneously increasing the risk for equity. There is no clear or coherent monitoring system in place to ensure the quality and ethical standards of care across the fragmented landscape of service providers. Instead, care is essentially monitored by AI-based algorithms, which guide decisions about what type of care each customer receives and how. Consequently, **care models are imposed from the top down**.

Work and Professional Roles Under Market Logic

Despite increasing professionalization, caregiving is perceived as 'lesser' work in society, which affects recruitment, retention, and public perception. Thus, the attractiveness of the care sector has declined in recent years. The growing role of the for-profit private sector is raising questions about the meaning and purpose of support, against a backdrop of budgetary rationalisation. There is a need for the sector to be more professionalised and interconnected, which also increases the workload for professionals, who have to cope with expanded roles and performance-driven thinking.

There are particular difficulties in recruiting managers: the required skill set often leads to hiring individuals from outside the care sector, with a more commercial outlook. At the same time, fewer care workers are upgrading their skills to move into managerial roles.

Education is formal, role-specific, and data- and operations-oriented. It excludes social and emotional skill development. The prevailing societal belief is that there aren't enough jobs for local people, and political polarization and dominant values further restrict the inclusion of foreign workers.

In this highly technocratic care system, robots have become the primary workforce in both home-based and institutional care and the professional role of caregivers has expanded significantly. Traditional caregiving skills remain essential, but they now intersect with technical competencies and system-level responsibilities. Automation is not merely an aid but the backbone of service delivery: robotic assistants administer medication, monitor vital signs through embedded sensors, lift and reposition patients, and execute hygiene routines with mechanical precision.

Care workers increasingly act as mediators between humans and machines: they interpret algorithmic recommendations, adjust automated workflows, ensure the safe use of robotics, and intervene when systems fail. Their role requires constant monitoring of digital dashboards, oversight of smart-home sensors, and the ability to troubleshoot basic technical issues. Instead of providing only hands-on support, professionals now combine care work, clinical judgement, and technical supervision. This hybrid role demands adaptability, continual learning, and confidence in navigating both human needs and technological infrastructures.
Roles such as Remote Robot Manager, AI-Assistant Facilitator, and Robot

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Maintenance Specialist have become central to daily operations, demanding advanced digital literacy, ethical oversight of AI-driven decisions, and continuous coordination between human and non-human actors. This shift promises reliability and efficiency – yet it also raises unresolved questions about emotional presence, the meaning of care, and the erosion of relational competence in a system optimized for throughput rather than human connection.

The reliance on interconnected digital systems and robotics introduces a new layer of security risk – from vulnerabilities, cyberattacks, and system failures to the potential misuse of care robots for criminal purposes. As dependence on technology deepens, any malfunction, disruption, or breach can ripple across the entire ecosystem, jeopardising continuity of care and exposing communities to risks that are both unprecedented and difficult to control.

Abandoned to Care: Isolation and Automation

Family structures have changed: people often live far apart and are disconnected. Fewer and fewer people visit or take home their family member who needs support. If there is a connection, due to immersive digitalisation, the communication happens mainly through digital applications. In addition, the birth rate is lower than ever in human history, and quite simply, there is no one left to care for people who need long-term care and support – other than the formal service providers.

In the technocratic era, long-term care still touches people of all ages – from children with chronic conditions to adults with disabilities, and families navigating lifelong support needs. Yet the system, designed for efficiency and categorisation, fails to see the full human continuum behind its data.

People are increasingly abandoned in their need for care. Those requiring long-term support now include individuals with no family, people from diverse cultural backgrounds, neurodivergent adults, and others with long histories of marginalisation – many of whom fall outside standard service models. As informal care networks collapse, isolation has grown, leading to mental health crises among older adults. Although technology, particularly artificial intelligence, is expected to enhance the autonomy of people with disabilities and long-term support needs, in reality it leaves many even more isolated and fails to replace direct human care.

The notion of self-optimized care, by contrast, introduces a troubling reversal in the ethics of care. In this model, individuals in need of support are expected – or even pressured – to make themselves "easier to care for," for instance through implants, neuro-enhancement, or other forms of technological self-modification. Those who resist such interventions, or cannot access them, risk receiving less attention and fewer resources. As a result, people are increasingly adapted to the requirements of care systems rather than the systems adapting to human vulnerability. In this logic, fundamental ethical questions about autonomy, dignity, and equality are sidelined in favour of efficiency and control.

Families worry about care quality. High-quality services that combine digital tools with human care and support are a privilege, not a right.

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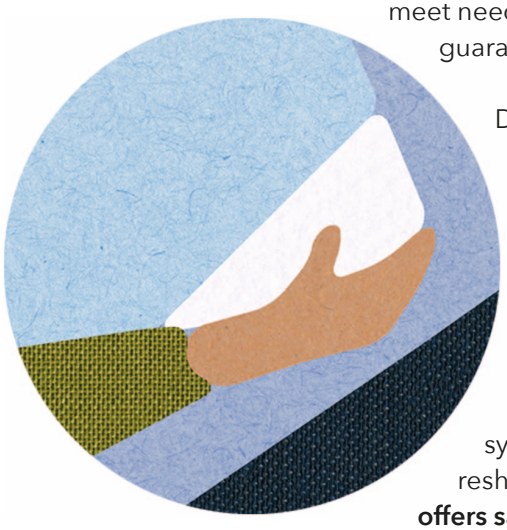
Digitalisation has fulfilled its promise of accessibility and efficiency, yet it has redefined care into a technical performance rather than a human relationship. Automated solutions respond to needs faster than people can, but they rarely understand them. In the absence of presence, data has become the dominant language of care.

Robotic Care Environments

Digital access and literacy are widespread and most care now takes place at home, supported by fully automated systems that manage medication, hygiene, and monitoring. Physical care facilities have become rare and are located only in major urban centers. They exist only for those with the most complex medical needs. For the majority, home has become the primary care environment – one shaped more by sensors and screens than by human presence. As a result, many people receive care exclusively through digital channels: remote therapies, electronic patient records, and digital facilitation by therapists are available, but they are not sufficient to meet needs or replace in-person sessions. In emergencies, human contact is not guaranteed.



Domestic care robots autonomously manage medication cycles, mobility assistance, daily hygiene routines, and environmental monitoring, while specialised clinical robots perform rehabilitation exercises and emergency stabilisation. Institutional facilities rely on coordinated fleets of robots that communicate through shared sensor networks, adjusting their behaviour in real time as patient needs fluctuate. The design of care environments has shifted accordingly: rooms are built for robotic accessibility, surfaces are sensor-friendly, and spatial layouts prioritise machine movement over human interaction. Although these systems deliver consistent outcomes and minimise human error, they also reshape the emotional architecture of care. **For many, the presence of robots offers safety but not solace** – a form of care that is efficient, predictable, and impeccably managed, yet often devoid of the relational warmth that once defined the human experience of being cared for.

The environmental footprint of technocratic care is significant: the production and operation of robots increases demand for rare earth materials, generates electronic waste, and puts additional strain on energy systems. Despite the focus on operational efficiency, the long-term sustainability of digital infrastructures and their environmental impacts remain largely unaddressed.

Standardised Needs and Algorithmic Care Plans

The needs of individuals are treated as fixed and categorized: they are defined based on algorithmically determined criteria. Individuals' background information – such as medical records, family situation, and medication – is fed into a system that categorically generates a care plan, without taking into account human aspects. Customer rights are externally defined, and while medical needs are met, social and emotional needs are not.

Children in need of continuous support grow up in digital ecosystems where algorithms decide

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what kind of rehabilitation they receive and when. Parents are often reduced to data managers, coordinating virtual therapies and automated schedules, while emotional presence becomes a luxury. For young adults with mental health or neurodiverse conditions, automated monitoring tools and AI-driven care plans replace human contact, often missing the subtle signals of distress or growth.

Adults with disabilities experience both empowerment and exclusion: technology promises independence but delivers isolation. Personalisation is replaced by predictive profiling. Under the assumption that it is "one-size-fits-all", without considering diverse needs and values. This system makes people as passive recipients, instead of active, self-defined, equal actors. People with dementia, complex trauma histories, or communication impairments are especially at risk in a system that relies on standardised, automated care plans. AI-driven models may fail to identify nuanced needs or detect emotional distress, leading to under-care or even neglect.

The value of human life has become conditional – measured by functionality, productivity, and data accuracy. **Technology no longer supports care; it defines it.** The moral inversion is complete: rather than using technology to enhance humanity, people have become extensions of the systems meant to serve them. **What was once a relationship of support has turned into one of dependency – not on others, but on the logic of machines.**

Rising Human Resistance

Even under the dominance of market logic, **small counter-movements have begun to re-emerge**. Fragmented yet persistent, they include trade unions advocating for humane working conditions in the digital care economy, civil society networks campaigning for transparency and human rights in algorithmic governance, and small cooperatives experimenting with alternative, solidarity-based care models. Their influence remains limited under technocratic rule, yet they serve as moral counterweights – keeping alive the public debate on what it means to care in a data-driven world. New, however marginal, roles like "Critical Tech Ethicist" and "Human Contact Defender" have emerged in activist circles, aiming to restore humanity into algorithmic systems.

Underground care and support cooperatives have started to emerge, offering human presence and dignity where the formal system has failed. They provide emotional support, community-based practices, and companionship that the formal system no longer guarantees – though their work remains precarious and often at the margins of legality.

Skills for the Technocratic System

In this scenario, the care system is built on technology, privatization, project-based funding, and strict regulation. The roles of the sector focus on overseeing automated processes, teaching AI systems, coordinating data governance, and ensuring technological solutions are applied efficiently. Human presence is limited, but technological expertise is essential.

The technocratic care system reflects a deep shift in societal values: from human connection to mechanical efficiency, from shared responsibility to market-driven solutions.

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What was once a social contract has become a business transaction. Yet small activist movements emerge to re-humanise care, defending ethical values and emotional connection in a data-driven environment.

TO SUCCEED IN THIS NEW LANDSCAPE, CARE AND SUPPORT PROFESSIONALS NEED THE FOLLOWING KEY SKILLS:

- Advanced digital literacy and AI system supervision
- Data management and privacy compliance
- Project management and funding acquisition
- Interdisciplinary collaboration between tech and care fields
- Ethical reasoning and algorithmic accountability
- Critical incident management
- Human-centered design in automated environments
- Fundamental caregiving skills

EMERGING ROLES

- **Remote Robot Manager** – oversees robotic operations in home and institutional care settings, ensuring functionality and safety.

- **AI-assistant Facilitator** – interprets and refines AI-generated care recommendations for human oversight.

- **Data Privacy Coordinator** – ensures compliance with EU-level data protection standards and monitors data-sharing protocols.

- **Care System Integration Specialist** – harmonises multiple care technologies and platforms for seamless service delivery.

- **Care Technology Strategist** – plans technological investments and evaluates long-term system sustainability.

- **Robot Maintenance Specialist** – maintains and updates robotic equipment and AI interfaces used in daily care operations.

- **Project Funding Specialist** – coordinates and applies for grants and subsidies for project-based initiatives.

- **Implant and Enhancement Care Consultant** – advises on assistive technologies and devices required for self-optimised care.

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TRANSFORMATIVE ROLES

- **Critical Tech Ethicist** – challenges harmful algorithmic practices and promotes human rights in digital care governance.

- **Relational Care Activist** – builds alliances that keep empathy and human dignity visible in policy and design debates.

Main drivers and hinders for this scenario evaluated by partners on October 2025

Drivers

- Economic and political incentives
- Rapid AI and digital technology developments
- The influence of big tech companies
- Populist or far-right political trends

Hinders

- Dehumanization of care
- Loss of human interaction and autonomy
- Workforce and skills shortages
- Uneven technological capacity across countries
- Ethical oversight of human-centred guidance in digital care development

Concrete signals of change

ROBOTICS AND AI EXPAND THEIR FOOTPRINT IN ELDER CARE

European pilots in elder-care robotics and social assistive robots are moving from experimentation to implementation – supporting mobility, cognitive interaction and routine tasks in long-term care settings. The global elder-care assistive robots market was valued at USD 2.93 billion in 2024 and is projected to reach USD 9.85 billion by 2033, with a CAGR of 14.31% from 2025–2033.
–> AI-enabled automation is becoming a strategic answer to workforce shortages – but raises critical questions about dignity, relational care and equitable access.

Sources:
European pilot study on social assistive robots
https://www.sciencedirect.com/science/article/pii/S2950307824000535
Market forecast
https://www.grandviewresearch.com/industry-analysis/elder-care-assistive-robots-market-report

TELECARE AND REMOTE MONITORING BECOME MAINSTREAM IN AGING SUPPORT

Digital safety and monitoring solutions are rapidly spreading across home- and community-based care. The number of telecare users in Europe and North America reached 14.2 million at the end of 2023, signalling a major shift toward remote presence technologies supporting ageing in place.

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–> Remote support is strengthening autonomy and safety – while deepening reliance on digital infrastructures and data-sharing models in care ecosystems.

Source:
Berg Insight – *Telecare users in Europe & North America*
https://www.berginsight.com/the-number-of-telecare-solution-users-in-europe-and-north-america-reached-142-million-at-the-end-of-2023

EXPERIMENTAL NEUROSCIENCE SHIFT TO REAL-WORLD ASSISTIVE TECHNOLOGY

Neuralink's fully implantable, wireless brain–computer interface (BCI) enables people with severe paralysis to operate computers and robotic devices using only neural signals. The PRIME Study aims to evaluate the safety and functionality of the implant and surgical robot, allowing individuals with spinal cord injuries or ALS to regain digital independence without physical movement.
–> BCIs are shifting from experimental neuroscience to real-world assistive technology – potentially transforming autonomy, communication and participation for people with profound disabilities, while raising new ethical and regulatory considerations.

Source:
Neuralink – *The PRIME Study*
https://neuralink.com/

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Online survey: Care4Skills project, conducted in ten European countries, Spring 2025.

Focus group workshops: Care4Skills project, conducted in ten European countries, Spring 2025.

Scenario review: Care4Skills project, conducted in ten European countries, Autumn 2025.

More information

During the project, a collaboration with Service Innovation Design Master's Programme at Laurea University of Applied Sciences was done on the course: Futures thinking and foresight methodologies. Students gathered signals for the future of Care4Skills project. The following signals emerged from this analysis:

In 2024, 93.3 million people in the EU (21.0% of the population) were at risk of poverty or social exclusion. https://ec.europa.eu/eurostat/web/products-eurostat-news/w/ddn-20250430-2?utm_source=chatgpt.com

The Unspoken Crisis: Tackling Staffing Challenges in Long-Term Care
https://www.centuryrehab.com/the-unspoken-crisis-tackling-staffing-challenges-in-long-term-care/

Making good on promises: Long-term care workers' mental health is a shared long-term responsibility
https://theconversation.com/making-good-on-promises-long-term-care-workers-mental-health-is-a-shared-long-term-responsibility-205372

Will You Still Want Me Tomorrow? The Dynamics of Families' Long-Term Care Arrangements
https://journals.sagepub.com/doi/10.1177/09697330221085774?icid=int.sj-full-text.citing-articles.207

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The Use of Contract Staff in Nursing Homes Remains High After the COVID-19 Pandemic
https://aspe.hhs.gov/sites/default/files/documents/0efd4ee9d0d0e9e67c5442141053d71c/contract-staff-nhs-high-after-covid.pdf

Workplace skills are changing. Here's how to support employees
https://www.weforum.org/stories/2023/06/workplace-skills-changing-how-to-support-employees-amnc-23/

Updating Your Skills Section for Evolving Job Markets: A Comprehensive Guide
https://www.1template.io/blog/updating-skills-section-for-evolving-job-markets

The levers to increase your skills quickly!
https://www.edflex.com/en/posts/levers-to-increase-your-skills-quickly

How can you encourage the development of your employees' skills in your company?
https://www.ipag.edu/en/blog/skills-upgrading

Social Isolation Among Older Adults in Long-Term Care
https://pmc.ncbi.nlm.nih.gov/articles/PMC8236667/

Loneliness in Long-Term Care: The Importance of Social Support
https://www.centralfloridalifestyle.com/health/best-doctors-orlando/loneliness-in-long-term-care-the-importance-of-social-support/

Well-being in long-term care: an ode to vulnerability
https://www.tandfonline.com/doi/full/10.1080/13607863.2021.2008869#abstract

Substance Abuse Among Older Adults
https://pmc.ncbi.nlm.nih.gov/articles/PMC4146436/

Prepare now: Europe must get ready for the coming long-term care surge
https://www.bruegel.org/policy-brief/prepare-now-europe-must-get-ready-coming-long-term-care-surge

Medical implants /wearable gadgets https://www.linkedin.com/pulse/medical-implantswearable-gadgets-making-life-easier-sathya-kumar

The Gift of Time: Simplifying Your Senior Life for More Meaningful Moments https://seniorsbluebook.com/articles/the-gift-of-time-simplifying-your-senior-life-for-more-meaningful-moments

Tips for Seniors to Simplify and Enjoy Life https://miraclemedicalcare.com/2024/07/04/simplify-your-life-week-tips-for-seniors-to-simplify-and-enjoy-life/

The Pursuit of Senior Happiness: A Recipe for Enjoying Life
https://www.accessiblehomehealthcare.com/blog/recipe-for-senior-happiness

Several pilot projects in Scandinavia and the Netherlands use Artificial Intelligence (AI)-powered devices to assist with fall detection, medication reminders, and cognitive assistance. These systems necessitate LTC workers to be comfortable interpreting AI outputs, maintaining AI-driven devices, and engaging with

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remote monitoring dashboards.
https://norden.diva-portal.org/smash/get/diva2:1667628/FULLTEXT02.pdf

Tech Savvy Caregiving for 2024
https://www.linkedin.com/pulse/tech-savvy-caregiving-2024-faigie-horowitz-qzo3e/

Growing Demand for Digital Homecare Platforms
https://techfundingnews.com/uks-latest-unicorn-cera-raises-150m-to-reduce-nhs-strain-with-ai-healthcare-platform/

Disability rights activist Alice Wong edited an anthology discussing broader and more inclusive definitions of what it can mean to be intimate with another person. How do different forms of intimacy manifest themselves in long term care?
https://www.youtube.com/watch?v=SPzRYumUKVs
https://www.goodreads.com/book/show/150247408-disability-intimacy

Valued-based recruitment in care. Research suggests that certain personality traits and values can translate into good-quality care
https://curiousaboutcare.org.uk/

Increase in formal care. More of us will need care in the future. This will lead to an increase also in informal care because not all people who need care receive paid care. Will future see paid care leave?
https://www.jrf.org.uk/care/the-future-of-care-needs-a-whole-systems-approach

Care as human to human activity. Demos report argues that as care has been industrialised, its essential nature as something happening between humans has been hidden. This core of care should be refocused to open up new perspectives for better care in the future
https://demoshelsinki.fi/wp-content/uploads/2024/04/Demos-Hoivan-aika-0704.pdf

In 2024, a larger proportion of respondents across all income groups expressed a belief that moving a family member with dementia to a care home, even against their wishes, would be the best option.
Source: World Alzheimer Report 2024

Dementia remains the biggest killer in the UK and is on track to be the nation's most expensive health condition by 2030. If nothing changes, one in two of us will be directly affected by it - either by caring for someone with the condition, developing it ourselves or both. More research, better diagnostics and care for the illness if needed.
Source: https://www.alzheimersresearchuk.org/about-us/our-influence/policy-work/reports/tipping-point-the-future-of-dementia/

Globally: There were over 55 million people worldwide living with dementia in 2020 - this number will reach 139 million in 2050. Source: https://www.alzint.org

Finland: In 2021, there were approximately 150,000 diagnosed dementia patients in Finland, with around 23,000 new cases detected annually. According to Statistics Finland's population forecast, the number of dementia patients could rise to as many as 247,000 by 2040, representing a 64% increase compared to the figures from 2021. Source: muistiliitto.fi

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Nurses often look at a person suffering from dementia as a patient whose mood can improve only with medication. Sociologists care with different methods - they are available for discussion, listen and are patient, which often improves the well-being of a person without additional dose of medication. Sociologists highlight a need for common space such as gardens & greenhouses, that could destress people suffering from memory loss.
Source: interview with social care worker in Finland

During the project data was collected from participating countries and analyzed to inform the development of scenarios. The following signals emerged from this analysis:
Keyring
https://www.keyring.org/

Finland: Stadin AO recently highlighted the use of simulated learning labs that replicate real nursing-home environments and homecare settings. Students practice administering care to older adults with mild dementia or reduced mobility under realistic conditions—often with digital patient record systems and wearable health devices.

Hungary: government introduced free smartwatches for the elderly. All people over 65 are entitled to. The smartwatch is linked to a dispatch centre and the elderly person can call for help through the smartwatch, which we call a care watch.

Hungary: The adopted Hungarian legislation and directive states that large institutions should be phased out by 2030.

Holland: In the Netherlands, we are having such a debate called Over Morgen (About Tomorrow):https://www.vvtwerktaanmorgen.nl/

Holland: Rebel leadership in nursing practice: https://research.umcutrecht.nl/news/rebel-leadership-in-nursing-practice/

Holland: Concept of positive health: https://www.iph.nl/en/knowledge-base/what-is-positive-health/, especially regarding the need for reablement of client/residents and the role of informal carers.

Holland: We have the concept of the "care cooperative" a network of residents in a village or neighborhood who arrange help and care themselves. It is an association with members who run a business together. The members are jointly owners of the cooperative. They are also jointly responsible for the well-being of the residents in the village or neighborhood.Those who are members of a care cooperative may be members as clients, suppliers, or employees of the cooperative. The members invest profits back into the cooperative. A care cooperative provides services to its members and often works together with professional care organizations, municipalities, and volunteers. About 20 cooperations exist in NL. They are considered as successful however highly dependent on social cohesion, proper funding, and cooperation with formal carers.

Holland: -There is evidence for the cost efficiency for the ecosystem of the "caring community" (bottom up approach with a network of formal and informal care) in terms of social return on investment: https://www.vilans.nl/actueel/nieuws/zorgzame-gemeenschappen-financieel-lonend

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Holland: The action plan on shared governance: https://zeggenschapindezorg.nl/faq/wat-wordt-bedoeld-met-professionele-zeggenschap-2/ gives an overview of the stronger voice of professionals.

Holland: For initiatives in reablement and what this means for the nurses and care workers:
https://www.actiz.nl/actueel/reablement-verbetert-de-zelfredzaamheid-van-ouderen
https://www.actiz.nl/actueel/elly-branderhorst-reablement-de-zorg-van-de-toekomst

Holland: Restaurant Misverstand: In this TV program, relatively young people with dementia work as restaurant staff under the guidance of a chef. The idea is to give them a meaningful and valuable role, thereby enhancing their self-esteem and engagement.

Holland: Social Gym: The Social Gym combines a serious workout with a social component. Older adults in wheelchairs or with walkers participate in boot camp activities alongside other athletes, promoting both physical health and social interaction.

Holland: Sarcofaag for Voluntary Death: This proposal involves the development of a device, the 'Sarcofaag,' which would allow people to end their lives voluntarily. While this would raise significant ethical and care-related issues, it offers a possible solution for those who wish to end their lives on their own terms.

Holland: Innovative housing models such as "Fully Packaged Care at Home" (VPT in Dutch)

Holland: Concepts such as quality of life, positive health, and reablement (aimed at restoring self-direction and functioning) are gaining ground.

Holland: A type of housing for “young seniors” and “older youth” who enjoy helping each other and want to live independently for as long as possible.
https://knarrenhof.nl/

Holland: General Compass (Generiek Kompas in Dutch) reflects a broader cultural shift: moving away from rigid quality standards toward a focus on what truly matters to people—their quality of life.

Italy: Non-self-sufficiency reform, the National Chronic Disease Plan, and the Rare Diseases 2030 strategy. UNESCO

Italy: Several visions and frameworks guide developments in society and organizations, including Agenda 2030 (UN Sustainable Development Goals), PNRR (Italy’s National Recovery and Resilience Plan), and EU guidelines on culture, health, and inclusion. Important references include Law 62/2024 (Italian legislation on early diagnosis) and the implementation of the UN Convention on the Rights of Persons with Disabilities. These emphasize early diagnosis in medicine, neurogenesis, and the rights of older persons, caregivers, and persons with disabilities, amid economic interests and political challenges such as populism.

Chechia: "Freya” project Chechia Ambulance of last wishes

Chechia: Böhm method

Chechia: Aging in place

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Chechia: Ambulance of last wishes

Belgium --> Local integrated care initiatives with comprehensive care for care users which contribute to more collaboration between services and workers (more information: https://www.inami.fgov.be/fr/professionnels/info-pour-tous/plan-interfederal-soins-integres

Belgium: "Territoires proxi santé": The aim is to establish a common approach and vision among the various front-line actors, by coordinating the interdependencies between professionals to enable them to work together.
https://www.aviq.be/fr/proxisante

Belgium: Buurtzog model: currently being implemented at federal level, with the objective to organize self-managed care

Belgium Coordinated Act of 10 July 2008: reform of the hospital landscape with the aim of creating local and regional hospital networks (voluntary collaboration between hospitals). Objectives: accessibility, quality and rationalisation of care and costs.

Belgium: 2010: Reform of mental health care for adults 2010: 107 networks model, aimed at deinstitutionalising psychiatric patients, reducing hospitalisation and developing ambulatory and mobile care in patients' living environments.

Belgium: Reform of the hospital landscape in 2020: context of an ageing population, budgetary pressure on healthcare, rationalisation and specialisation of provision to improve quality. As a result, hospitals will be required to form networks, specialised tasks will be shared between network members, and care will be organised in a coordinated fashion, with regional planning.

Belgium: --> Innovate management methods:- Create participative management.
Example in Wallonia: experimentation in retirement homes in which workers and managers can exchange views on their reality during open training sessions.

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Attachment: Questions that were used in data gathering in the focus group workshops.

The partners conducted focus groups in Spring 2025, which provided the data and the basis for the scenario creation. In this attachment are the themes and questions that guided the focus group working. Partly the same questions were utilized in the online survey conducted also in Spring 2025 to enrich and broaden the focus groups outcome. The questions are derived from Inayatullah's 7 Foundational Questions. 7 Foundational Questions is a foresight method designed to help map and build a deep understanding of the future. Developed by Sohail Inayatullah, it is primarily used at the early stages of the foresight process to structure the present situation, explore future possibilities, and identify underlying beliefs and assumptions.

1. The history and evolution of Long-Term Care

– What historical events, policies, or decisions have shaped this issue?
– What innovations have you witnessed?
– What completely new things have been made available?
– What long-term patterns or cycles can be observed?

2. Where to: Emerging trends, signals and uncertainties

– What changes indicate the direction we are heading in LTC?
– Are there some visions that pull in some direction?
– What do you think are the biggest uncertainties we face that affect LTC?
– Are there any changes in customer or stakeholder expectations and/or behaviour that stand out to you?
– Have you come across any new or unusual ideas, innovations, technology or experiments that could significantly impact long-term care?

3. Assumptions

– What assumptions concerning the future of LTC and skills are being made concerning the topic?
– What kind of assumed futures are there?
– What kind of simplifications are made about the LTC and LTC skills futures?
– What unspoken rules, cultural narratives or taboos shape thinking related to LTC and LTC skills future?

4. Visioning exercise for imagining the desired futures

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ChatGPT 5.1 and Copilot were used to support the proofreading of the report, the translation and formatting of the text, information retrieval and verification, and the sparring of scenarios.
The scenarios are based on data produced by participants from ten EU countries.

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