

The European Care Contract

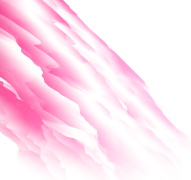
From crisis to transition

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Executive summary

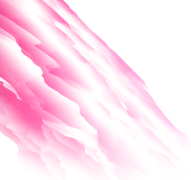
Europe's ability to care for its people is falling behind the need for care, and the gap is usually framed as a crisis: a shortage of workers and money to be closed so the system can return to normal. This report argues the frame is wrong. There is no prior normal to return to. The old-age dependency ratio is heading toward one to two by 2050 and stays there; this is a new shape of the population's structure, not a temporary peak. At the same time, the need itself has changed character: chronic illness, multimorbidity, mental ill-health and isolation make the need for support continuous rather than episodic, and they attach to no single generation. **What Europe faces is a care transition, a society-wide reorganisation on the scale of decarbonisation or digitalisation, and transitions are designed, not waited out.**

Understood this way, care becomes a question about the social contract rather than about health budgets. Care runs through the agreement between citizens and institutions, and through the everyday relations between citizens themselves. Because care encounters are among people's most frequent and least avoidable contact with institutions, how fairly it is distributed shapes how much they trust those institutions and one another. The question this report answers is therefore distributive: how to deliver a fair distribution of care, in an age of heightened vulnerability. The standard we have chosen is the one of universalism, taken from the welfare-state tradition and extended beyond universal access to services: everyone is entitled to receive care, and the obligation to sustain it is shared across the whole population rather than assigned by gender, means or circumstance.

Measured against this standard, the answers that dominate European debates fail in opposite directions. Many welfare states preserve universal entitlement on paper while rationing it in practice. This results in re-familialisation that abandons universal obligation, compelling some, mostly women, and exempting others. The cash-for-care instruments Europe has expanded most, monetise the distribution without redistributing care responsibilities.

The report develops a third option, collective care: the obligation to care held reciprocally and distributed across the whole population, so that each person both gives and receives. Realising it means reorganising the resources care actually depends on: time, relationships and individual capabilities, and developing the accountabilities and collective tools that govern them. These sit across the whole of society, so the transition cannot be delivered from within health and social policy alone; it changes who carries the obligation, not only how the carrying is compensated.

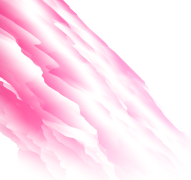
The report introduces four mechanisms for that reorganisation, operating in the space between formal services and private households: relational hubs in existing civic infrastructure; time-for-care guarantees and credits, with time policy negotiations as their



collective extension; employer care compacts and a universal care service. Three scenarios set in 2050 show ways transition could take place.

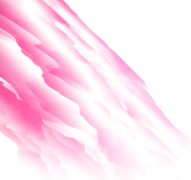
In conclusion, we want to highlight that **the European Union has agency in care**. Despite having no legal base in the Treaties, the EU holds many useful instruments, given the inherently multi-sectoral and systemic nature of the transition. Furthermore, realising collective care would co-benefit many EU-core policy arenas. The recommendations accordingly target coherence rather than invention, in three horizons:

- **pilot** the mechanisms with existing instruments now;
- **commit**, principally through the European Care Deal expected in 2027, to the instruments already under discussion;
- and **build the durable architecture**, including dedicated care funding.



The argument in brief

- **The need for care is growing and changing character:** not a temporary spike but a lasting shift, driven by ageing, chronic illness, mental ill-health, isolation and recurring social and economic shocks (Section 1)
- **Treating this as a crisis misreads it:** a crisis implies a return to normal, and there is no normal to return to. It is better understood as a transition, a society-wide reorganisation to be designed rather than waited out. (Section 1.1)
- **A transition of this scope is a matter for the social contract,** running through the relationship between citizens and institutions and between citizens themselves, with direct bearing on trust and cohesion. Care has no legal base in the EU Treaties, but the transition runs cross-sectorally through, work, housing, public space, where the EU does hold instruments and agency. (Sections 1.2, 1.3)
- **Care is defined as a cycle that renews itself only in a steady state.** When needs and resources are unbalanced, the cycle no longer holds, but has become a spiral that can degrade or regenerate. (Section 2.1)
- **We propose collective care as the alternative:** in this approach the obligation to care is held reciprocally and distributed across the whole population, so that each person both gives and receives. (Section 2.2)
- **Our fairness is universalism:** care available to all as of right, with the obligation to sustain it shared across the population rather than assigned by gender, means or circumstance. Measured against that standard, the three answers that dominate European practice each fail. Service care rations entitlement in practice; familialisation exempts by gender and class; cash-for-care monetises the existing distribution without redistributing the obligation behind it. (Section 2.2 and 2.3)
- **Realising it means reorganising the resources care depends on;** namely time, relationships, individual capabilities, and developing the accountabilities and collective tools that govern their distribution. The foundational care resources are held across the whole of society, and require multiple forms of cross-cutting governance and policy arenas. Realising a just transition cannot be done with health and social policy alone. (Section 2.4)

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- **We examine four mechanisms as policy objects:** relational hubs, time-for-care guarantees and credits with time policy negotiations, employer care compacts and a civic care service. Three scenarios, set in 2050, show these mechanisms working together in practice. (Section 3 and 4)
 - **The EU's leverage is soft and fragmented, but most of the missing instruments are already there.** A coherent response needs a binding framework, shared targets and earmarked funding, and the European Parliament has already called for them: the task is to draw them together. (Section 5)
 - **Governing the transition is a matter of institutional redesign, not administrative adjustment:** building the tools and accountabilities that make care's resources governable. The EU recommendations target coherence over invention, across three horizons: pilot now with existing instruments, commit through the 2027 Care Deal, and build the durable architecture, including dedicated funding. (Section 6)

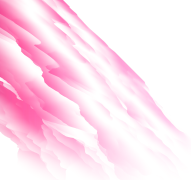
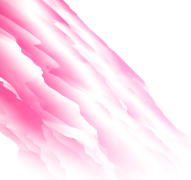


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1. Introduction

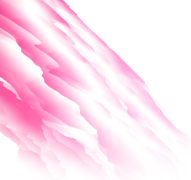
Europe's requirement for care, the relational effort, both compensated and communal, addressing human fragility, is expanding and evolving in fundamental ways. The primary driver is demographic: the old-age dependency ratio within the EU is shifting from its current one-to-three balance toward a projected one-to-two ratio by mid-century, with the most significant growth occurring among those over eighty, where care requirements are most acute (Eurostat, 2023).

While the Commission projects a deficit of 1.6 million formal caregivers by 2050 (European Commission, 2022), the statistics alone mask a deeper structural transformation. The (industrial) **service model of care** was designed for bounded, diagnosable events: an isolated injury or a brief period of decline. Today, however, vulnerability is becoming a chronic and lifelong state. Multimorbidity is increasingly the baseline for later life rather than the exception (OECD/European Commission, 2024), while mental ill-health and social isolation further deplete the relational resources society depends upon (OECD/EU, 2018; JRC, 2022). **These are not temporary interruptions to a normal state of autonomy; they represent a permanent shift in the human condition that the prevailing transactional model is ill-equipped to manage.**

This is not a temporary shortfall, nor a crisis confined to the healthcare sector. It is a structural cross-sectoral gridlock, with consequences extending across sectors, societies and borders and one that calls for a transition¹ rather than a repair.

How we drive this transition, that is, how we redistribute the resources of care, extending beyond money and labour to time, relationships and individual capabilities, is a question that goes beyond social and health sectors. It requires action across sectors to contribute to the cumulation, growth and distribution of these foundational resources. Many of these are areas in which Europe has a mandate and agency, such as work and housing.

¹ We use "transition" in its plain sense of a long, society-wide reorganisation. The term also has a technical life in sustainability-transitions research, where established regimes change under landscape pressure and through niche experiments (Geels, 2002); the parallel is instructive, and the mechanisms in section 3 can be read as niche institutional experiments in that sense, but this report does not depend on that framework. Geels, F. W. (2002). Technological transitions as evolutionary reconfiguration processes: A multi-level perspective and a case-study. *Research Policy*, 31(8–9), 1257–1274.



Care underpins most social systems, and is one of the basic arrangements through which citizens and institutions look after one another, and how it is organised says something about the wider agreement, formal and informal, that holds a society together. **Building on the idea of a social contract, we argue that care is a crucial dimension of it**, and that reinforcing the resilience of Europe's social contract requires understanding how the care transition can be conceptualised and governed. This is especially important, we argue, in regard to the horizontal dimensions of social contract, such as social cohesion and mutual regard², leading to the question shaping this report: *How can we refine the social contract of care to increase the societal cohesion in Europe?* In other words,

how do we deliver a fair distribution of care, in an age of heightened vulnerability?

The following subsections set out the foundation of why care needs to be reframed as a transition rather than a crisis, why this matters for the social contract and why this matters for Europe. Section 2 then develops the understanding of care this report is built on, before section 3 introduces illustrative mechanisms for driving this transition, and section 4 sets out scenarios for imagining how they might work in practice. Section 5 examines the current European care policy landscape, and section 6 sets out how to govern this; and EU policy pathways through which its existing instruments could be used to drive this transition.

Key terms:

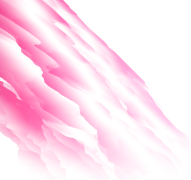
Care. The activity, paid and unpaid, that responds to human vulnerability and interdependence through relationships of responsibility, together with the social arrangements that distribute it. The first clause keeps care relational rather than transactional; the second is the one a contract governs. (*Section 2.1*)

The service model of care. The prevailing mode of organising care in the welfare state: care as a bounded product, delivered in short transactions, triggered by diagnosis, and resourced through money and paid labour alone. (*Sections 1, 2.1*)

Care transition. The society-wide reorganisation of how care is resourced and distributed, comparable in scope to decarbonisation or digitalisation. Distinct from a

² With the lead of Istanbul Bilgi University, the CO3 Project has developed social contract indicators to operationalise the concept of the social contract further empirically. Social cohesion and mutual regard is one of the domains. See “Unpacking the Social Contract: A Data-Driven Exploration” by Emre Erdogan and Pinar Uyan Semerci:

<https://www.co3socialcontract.eu/post/unpacking-the-social-contract-a-data-driven-exploration>



crisis, which implies an exception followed by a return to normal. (*Section 1.1*)

Service care. Care organised as professional service provision, public or marketised. It preserves universal entitlement on paper while rationing access in practice by eligibility or ability to pay, and fragments the caring relationship into transactions. (*Section 2.2*)

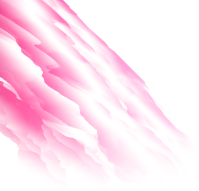
Familialisation. The return of care to the household when service systems retrench. A binding institution in its own right, compelling through social expectation: it assigns the obligation asymmetrically, mostly to women, without reciprocity or recognition. (*Section 2.2*)

Collective care. Care held as a shared responsibility, reciprocal and distributed across the whole population, so that each person both gives and receives. Distinguished from familiarisation not by the absence of obligation but by the obligation's reciprocity and universal distribution. (*Section 2.2*)

The resources of care. Time, relationships, and individual capabilities: what care draws on but the service model of care does not recognise or account for. (*Section 2.4*)

The enablers. Accountabilities, and collective tools and institutions: the two factors that govern how the resources of care are distributed. Responsibility names the relational fact of being answerable for another's wellbeing; accountability names its institutional assignment and enforcement. (*Section 2.4*)

The mechanisms. The four institutional levers this report proposes for reallocating the resources and enablers of care: relational hubs (3.1), time-for-care guarantees and credits with time policy negotiations as their collective extension (3.2), employer care compacts (3.3) and civic care services (3.4). These are illustrative rather than exhaustive.



1.1 Reframing care: from crisis to transition

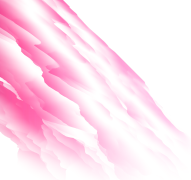
Crisis language implies an exception after which the system returns to normal. There is no normal to return to: the frame of crisis hides the true scope and scale of the change in people's need for support. Naming a transition is a necessary step in making that scope governable.

Generally speaking, care has become profoundly embedded in the crisis discourse, both as something strained by the implications of other crises, and as a crisis in itself. However, we argue that it is of fundamental importance to **shift care and caregiving away from the crisis frame into that of a transition**: crisis implies a state of exception and a moment which legitimates, and even sometimes requires, exceptional and drastic decisions for short term solutions³. The logic of crisis pressurises democratic social contracts in general, potentially causing erosion and friction to existing and emerging contracts. From the perspective of care, the idea that the care crisis as a state of exception as a liminal space results in some kind of familiar state of normality, seems unrealistic as an assumption.

Table 1. Comparison of the resources behind the industrial care economy and the care transition economy.

	The industrial service care economy	The care transition economy
Foundational scarce resources	Labour and funding	Time, relationships, individual capabilities
Ways to enable them	Reducing the cost per unit of service, and economic growth	Reorganising and leveraging different parts and structures of society, enabled by shared accountabilities and collective tools and institutions

³ On the concept of crisis and temporalities, see Koselleck, R., & Richter, M. W. (2006). Crisis. *Journal of the History of Ideas*, 67(2), 357–400; Jordheim, H., & Wigen, E. (2018). Conceptual synchronisation: From progress to crisis. *Millennium*, 46(3), 421–439. Specifically on the erosion of democracy and the crisis of democracy discussion, see Wiesner et al (2025) in <https://www.co3socialcontract.eu/post/is-democracy-eroding-nine-fields-of-change-in-contemporary-democracies>. The CO3 consortium has also worked extensively on the impact of crises on social contracts, and will publish the results more widely in 2026–2027.



Reframing care from a narrative of crisis to one of systemic transition allows for an enhanced political and societal envisioning beyond the rigid timeframes, governance options and technocratic solutions of a crisis situation. However, moving from crisis to transition requires treating care as a society-wide transformation comparable to decarbonisation or digitalisation, and this is far from being a simple exercise of political will and decision-making from a narrow group of stakeholders. Rather, **it necessitates a profound reallocation of time, relationships, and responsibilities** and, as such, beyond the state of the art conceptualisation and clear steps forward.

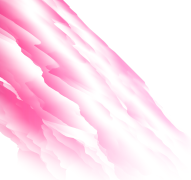
Alongside with the move away from the crisis discourse and mentality, the transition requires looking beyond narrow healthcare budgets to unlock the untapped potential for generating wellbeing and social cohesion embedded in care and caregiving. At the same time, it requires a shift in discourse and policymaking from narrowly relying on budget cuts to building and enabling broad capacity. Below, we explore how care is part of the social contract, and suggest the core logic behind renewing it: understanding the renewed care contract in terms of renegotiation of the core resources which, we argue, are the fundamental levers of the care transition we seek to realise, **time, relationships and capabilities**. To develop these subcontracts further, we look at them individually and seek to understand how they are interconnected with the current European debates and policies on care.

1.2 Care as part of the social contract

The social contract is the formal and informal agreement over how rights, responsibilities and resources are distributed, and it is renegotiated continuously rather than settled once. Care runs through both its dimensions: between institutions and citizens, and between citizens themselves. How fairly care is distributed therefore bears directly on trust and cohesion.

The social contract can be understood as both a normative-theoretical framework and a descriptive reality of lived practices⁴. At its core, it represents the foundational agreement, both formal and informal, between citizens and governing agencies, as well as other institutions and actors that are central to people's lives, regarding the distribution of rights,

⁴ This has been the starting point of the Horizon Europe funded CO3 project (2024–2027), which has influenced the interpretation of the social contract also in this project. The project's resources, based on the work of all consortium partners, are openly available on its website, see <https://www.co3socialcontract.eu/>



responsibilities, and resources. However, in a decade defined by overlapping crises, demographic shifts, and geopolitical instability, the traditional assumptions underpinning these agreements are facing unprecedented strain. To build democratic resilience, it is necessary to move beyond static conceptualisations and **recognise the social contract in a dynamic way** and recognise the need for continuous reconstruction that meets changing socio-political realities.

Classical social contract theory⁵, from Hobbes to Kant, imagined the contracting party as a self-sufficient, independent individual, and treated the contract as settled once. Feminist and critical theorists have since shown what that image left out: **the contract was silently underwritten by those who did the caring, mostly women**, who were excluded from full political subjectivity while making everyone else's independence possible (Pateman, 1988; Mills, 1997). Today, thinking around social contracts has shifted from these closed models toward empirical sensitivity, inclusivity and openness to renegotiation.

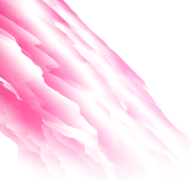
In recent years, the "social contract" has been revived across European and global political discourse⁶. Notably, the purpose and reference points for the use of the contract have varied. Some of the examples include:

- **National Governance:** In France, President Emmanuel Macron convened union leaders in 2018 to negotiate the basis of a new social contract. In Finland, former Finnish Prime Minister Juha Sipilä was employing the concept in the context of economic competitiveness. In the UK, the former Prime Minister Keir Starmer has framed the need for a renewed contract around intergenerational fairness and youth disillusionment. Finally, the Netherlands witnessed a political movement for a party named the "New Social Contract" led by Pieter Omtzigt.
- **Supranational and Global Governance:** At the European level, the European People's Party (EPP) has called for a post-COVID societal contract. Globally, the United Nations Research Institute for Social Development (UNRISD) has advocated for an "eco-social contract" that fundamentally links social justice with planetary boundaries and climate resilience.

In this report, we are basing our understanding of care and caregiving on previous work in projects and by others (see section 2.1). However, here we have sought to link this understanding within the social contract framing. This, we argue, is helpful especially when discussing accountabilities and the forms of formal and informal care below and in future

⁵ For an overview of the classical and evolving social contract theories, see Colin-Jaeger (2025) for the CO3 project, available at <https://www.co3socialcontract.eu/post/continuous-construction-of-resilient-social-contracts-through-societal-transformations-co3>

⁶ For a summary of recent discussions, see Björk et al in <https://www.co3socialcontract.eu/post/co3-framework>



work.

Care and caregiving as central to the human condition are crucial for different fundamental dimensions of the social contract. These dimensions include the question of who is included in the contract and what is expected of the individuals as part of it; whose subjectivity the contract is protecting and from what; and what is considered to be the role of the collective, the state and the institutions.

Currently, the demographic changes in Europe are pressurising care and caregiving in multiple ways⁷. As populations age and, simultaneously, welfare states face fiscal constraints for different reasons, **care responsibilities are increasingly shifted onto migrant and racialised workers**. The simultaneous trend of increasingly fast developing digital technologies is also interwoven with the visions for how to organise care and caregiving in the future, bringing in additional ethical, political and economic questions.

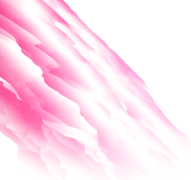
By placing care within the context of a contract, it is possible to re-examine what is driving the visions, perceived implications and accepted outcomes of our current social contracts. This re-evaluation concerns especially our fundamental assumptions about citizenship and recognising that **interdependence and vulnerability, rather than strict, rationality driven autonomy, are baselines for human experience**.

The link between care and cohesion is not merely rhetorical; it runs through institutional trust, and it is one of the better-evidenced mechanisms in welfare-state research. Citizens form their judgements of institutions less from constitutional principles than from their concrete encounters with public services, and care encounters are among the most frequent, most intimate and least avoidable contacts a person has with the institutional order (Kumlin & Rothstein, 2005).

Comparative research finds that **universal institutions, which treat people as equals as of right, are associated with higher generalised trust**, while selective and means-tested arrangements, which require people to prove need and invite discretion, tend to corrode it (Rothstein & Uslaner, 2005). Care sits at the sharp end of this mechanism: when care fails or is rationed, the failure is experienced bodily, within families, and at moments of dependency when exit is not an option. European survey evidence points the same way, with unmet care needs and perceived unfairness in access associated with lower trust in public institutions (Eurofound, 2023).

The claim this report builds on is accordingly modest but consequential: how fairly a society distributes care shapes, through lived encounters with its institutions, how much citizens

⁷ The CO3 project has developed drivers and scenarios for the future of the social contract in Europe, forthcoming (Hyvärinen et al 2026)



trust those institutions and one another. A care settlement is therefore also a cohesion settlement, which is what makes it social-contract material rather than sectoral policy.

1.3 Why this is a European question

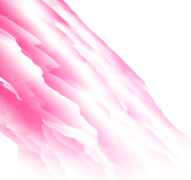
Care has no legal base of its own in the EU Treaties, but a transition that runs through work, housing and public space runs through sectors where the EU does have instruments. The question is whether that soft and fragmented leverage can be pointed in one direction.

To operationalise the shift from a narrative of crisis and cuts toward one of systemic transition and increased capacities, we propose to restructure the European care paradigm across three intertwined domains, namely the **currently undervalued resources of time, relationships and individual capabilities**. This addresses both horizontal and vertical dimensions of the social contracts, and seeks to expand the collective pool of resources across societies.

Even if care as a sector is formally not the European Union's responsibility, the idea of a care transition invites us to ask what the role of other sectors, such as housing, work, infrastructure and transportation have in providing better care for all. So while the Member States are in charge of their national approaches to care institutions, funding and scope, the EU has its own policies and stance for care, and agency in shaping that.

Three features of the EU's position matter here.

- **Care has no legal base of its own in the Treaties:** it remains a national competence, which the EU steers through soft law, funding and monitoring rather than legislation (see section 5.1).
- **The framing, however, is moving in this report's direction** – from care as a labour-market lever towards the 2022 European Care Strategy's life-course approach, the Parliament's framing of care as a public good grounded in interdependence, and the European Care Deal announced for 2027 (see section 5.1).
- **And the instruments to carry such a shift largely exist but remain non-binding and disconnected** (see section 5.2).



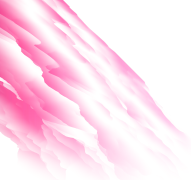
The European level thus offers real leverage for a renewed care contract, though that leverage is soft and fragmented.

We argue that to realise the shift from the crisis to transition in care, the imagination needs to change beyond the national level ideals. Thereby, the European level take on how care should be conceptualised, its related responsibilities shared, and e.g. public spaces utilise as relational hubs (see section 3) could drive the shift forward. Furthermore, to ensure that the EU can continuously support social cohesion, perceived political legitimacy and wellbeing, it should continue to ensure the realisation of the principles of the European Pillar of Social Rights⁸. Our approach to care and caregiving, and the suggested measures to redefine them as central to a European social contract, is linked with the principles and related policies.

To entertain the idea that a social contract marks an agreement, imagined or material, between the individual and the collective, be it a community or a state organised through government, we employ the idea of a contract on these sublevels of the broader social contract as well. The three contracts, **the Time Contract, The Relational Contract, and the Accountability Contract**, are systemic envisionings of how these resources (time, relationships and individual capabilities) could be reorganised in practice, each offering a different lens on the same transition. They serve an illustrative purpose, helping to picture what the care transition looks like in practice (see section 4).

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https://employment-social-affairs.ec.europa.eu/policies-and-activities/european-pillar-social-rights-building-fairer-and-more-inclusive-european-union_en



2. What care is, and what it runs on

This section proposes an understanding of care and sets it in relation with care literature. We see care as a relational and cyclical societal capacity: a cycle that begins in vulnerability and renews itself only when adequately resourced. It repositions care as a collective action, rather than a service, and shows why the resources that cycle depends on cannot be reorganised from within any single sector.

Driving a care transition requires first establishing a clear understanding of care itself that does depend on its current institutional setting yet one that tells us, what it entails and what it requires, and why reorganising it demands more than adjustments within existing systems. This section develops this foundation. Section 2.1 is a discussion with key bodies of care literature. Section 2.2 sets out the care's transitional state, which can spiral upward or downward, section 2.3 discusses the issue of justice and fairness, while section 2.4 explores what governing a genuinely cross-sectoral transition entails.

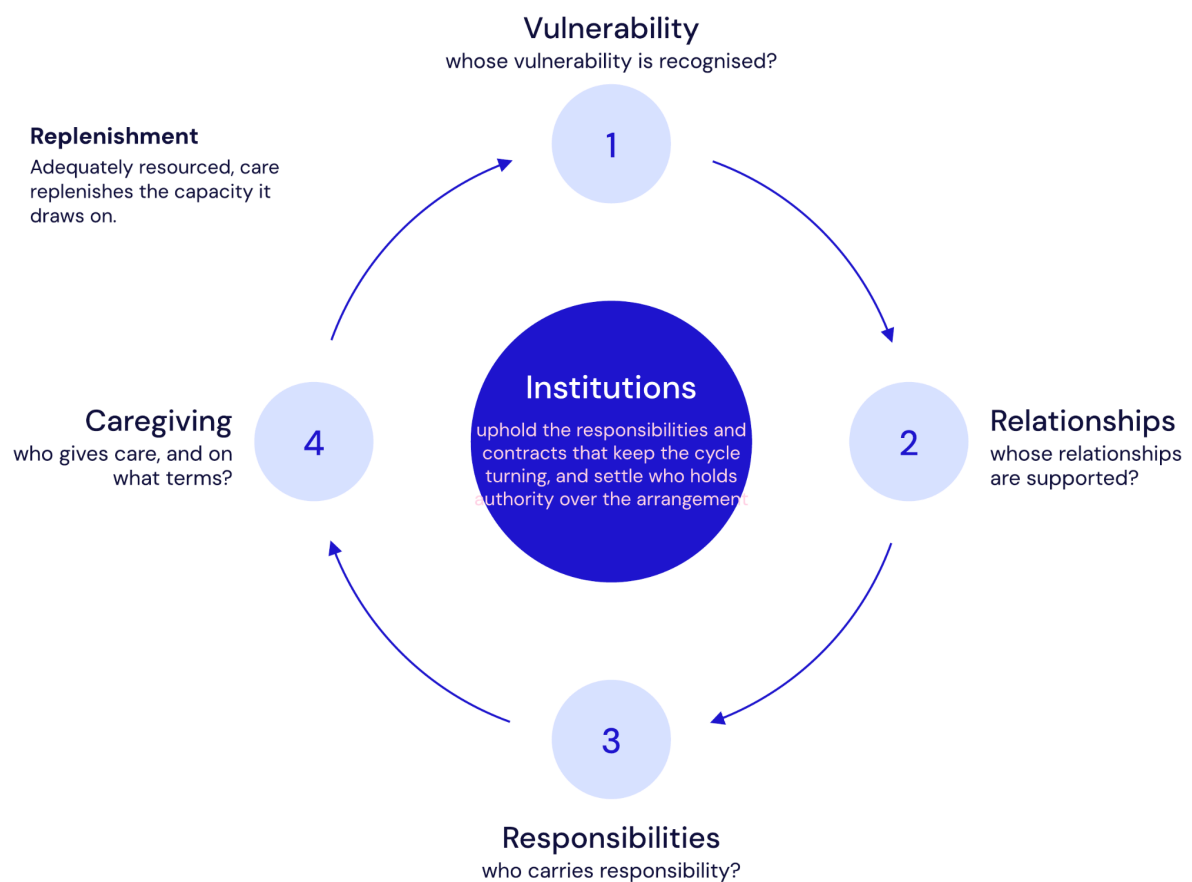
2.1 Care as a relational and cyclical capacity

Care is the paid and unpaid activity that responds to vulnerability through relationships of responsibility, together with the arrangements that distribute it. Modelled as a cycle, care renews itself only in a steady state. Under the crisis frame the cycle has become a spiral, which is currently run down.

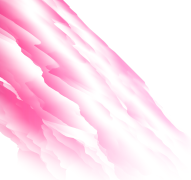
Consider a home-care worker on a scheduled visit. Within the allotted time they serve the meal, wash the client, and record both tasks in the system. Every performance the system can measure has been delivered, and the client still does not feel cared for, because neither the schedule nor the mental state of the carer left room for an encounter between two people. The service was provided; the care did not happen. Such is far too often the case in transactional care provided as a public (or private) service.

This report treats care as a cycle rather than a service. It begins in vulnerability, the ordinary condition of beings who are dependent across the whole of life rather than only as very young or old. Vulnerability calls forth relationships; relationships develop into accountabilities over others' health and wellbeing; accountabilities organise caregiving; and that caregiving, when adequately resourced, replenishes the capacity from which further care is drawn.

Figure 1. *The care cycle in a steady state.*



Politics runs through every stage rather than arriving at the end, because each stage allocates something contestable: whose vulnerability is recognised, whose relationships are supported, who carries the accountability, whose caregiving and on what terms, and who holds authority over the arrangement. **The distribution of care is produced from the first stage, not discovered at the last.** We work from a deliberately bounded definition:

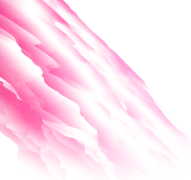


Care is the activity, paid and unpaid, that responds to human vulnerability and interdependence through relationships of responsibility, together with the social arrangements that distribute it.

The first clause keeps care relational rather than transactional. The second is the policy-relevant one: a contract, and the institutions that uphold it, govern not the activity of caring but its distribution. This report is concerned with that distribution.

The conceptual basis for this argument exists across several bodies of work, which this report draws on selectively rather than reconciling in full.

1. **The (feminist) ethics of care** establishes that care is a practice and a political orientation, not a private sentiment (Fisher & Tronto, 1990; Tronto, 1993), and that democratic institutions might be organised around the giving and receiving of care rather than around market autonomy (Tronto, 2013). What this tradition specifies is the disposition; it is less specific about the institutions that would carry it when goodwill is insufficient.
2. **Dependency and vulnerability theory** supplies the ground on which a care contract stands. If vulnerability is universal and dependency recurrent rather than exceptional, the self-sufficient contracting individual of classical social-contract theory is untenable, and equality must be anchored in shared vulnerability and in institutions responsive to it (Kittay, 1999; Fineman, 2008). This is what connects care to social-contract theory rather than to health budgets alone. It establishes what institutions owe without specifying the instrument.
3. **The welfare-state and social-policy literature** describes the terrain(s) of care. Care is already distributed across four dimensions: state, market, family, and community, and regime theory analyses how different countries balance them (Williams, 2001; Rummery & Fine, 2012). It describes these distributions without proposing to renegotiate one, which is the direction this report makes.
4. **Feminist political economy and social reproduction theory** identify the structural driver of the spiral: care is labour, that labour is gendered, racialised, and classed, and capitalist economies tend to consume it while declining to pay for or replenish it (Yeates, 2004; Mezzadri et al., 2022; Fraser, 2016; Sihto & Zechner, 2025). It is worth being explicit about the resulting position. Fraser locates the contradiction at the level of financialised capitalism, from which institutional redesign within existing



arrangements appears palliative rather than curative. The present argument is reformist by design: better institutions do not resolve that contradiction, but they determine whether the spiral degrades or regenerates, and that difference is what matters most directly for carers and those they care for.

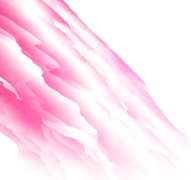
5. **Caring democracy and the literature on care commons** supply the third option directly. Care organised collectively, neither purchased as a service nor assigned as a private family duty, but held as shared and democratically governed capacity, has been developed as an ethos of caring-with (Tronto, 2013), as a programme for universal care (Care Collective, 2020), and as the practice of commoning care (Dengler & Lang, 2022; Power, 2019). We do not claim to originate it. This literature tends to underplay the redistributive backing without which a commons becomes the offloading of care onto communities and volunteers, disproportionately onto women. Collective care that is genuinely shared requires rights, resources, and durable public support; without them, 'community care' reproduces austerity.

From a transitional perspective, we want to build upon these theoretical stances and bodies by recognising their limitations:

- **care ethics** supplies the disposition but not the institutions;
- **dependency theory** connects care to contract theory but names no instrument;
- **welfare-state research** describes the distributions without renegotiating one;
- **social reproduction theory** identifies the engine of the spiral and the reformism caveat;
- **caring democracy** supplies collective care but underplays redistributive backing.

2.2 Why the care cycle becomes a spiral

The cyclical definition holds only in a steady state (see figure 1 above). The post-war welfare settlement approximated one: public systems absorbed a growing share of care under demographic and fiscal conditions that allowed the capacity drawn down to be replenished. It should be said plainly that this steady state was itself subsidised: it **rested on the unpaid and largely unrecognised care work of women** in households, a universalism of receipt built on a familialism of provision. This is a key part of why the settlement cannot be restored, but should instead be replaced.



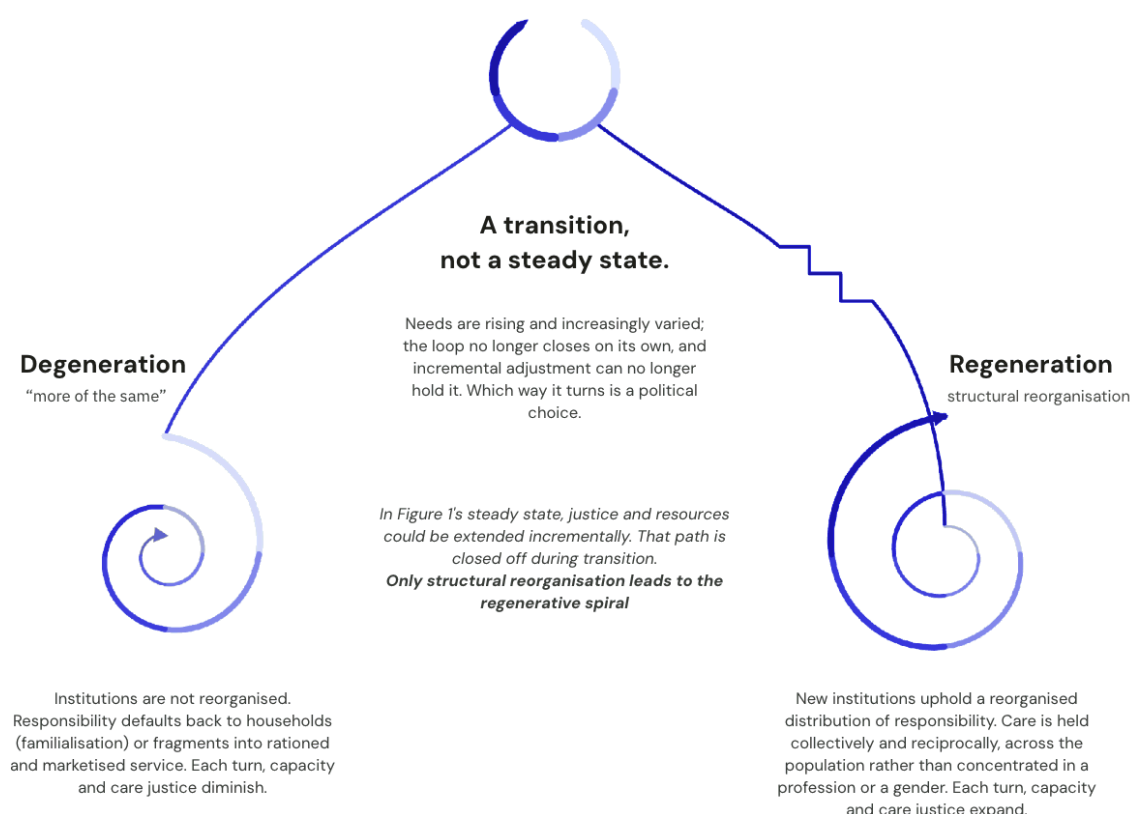
Furthermore, the steady conditions that allowed the care cycle to replenish no longer hold. Demand is rising as ageing, chronic illness, mental ill-health, and social isolation generalise vulnerabilities across the life course, while the resources the service model recognises, primarily labour and money, do not keep pace in slow growth ageing economies. The cycle becomes a spiral (see Figure 2 below). Feminist care studies has for long identified this gridlock: financialised capitalism draws on care faster than it permits care to be replenished, depleting the social capacities it depends on (see for example Fraser, 2016).

Depletion is not only a theoretical diagnosis; it predicts observable things, and they are observable. If care were being drawn down faster than replenished, one would expect to see needs going unmet, the workforce thinning at both ends, and those who carry the remaining load deteriorating. All three are documented.

1. Across the EU, a substantial share of older people with long-term care needs receive no formal care at all, with estimates for home care indicating that **roughly half of those with difficulty in daily activities lack access to services**, and coverage varying sharply by income and region (European Commission, 2021).
2. **Long-term care is among the sectors with the most severe and persistent labour shortages in Europe.** It has high vacancy rates, turnover well above economy-wide averages, and an ageing workforce whose replacement is not keeping pace, which is the gap behind the Commission's projection of a deficit of 1.6 million formal caregivers by 2050 (European Commission, 2022; OECD, 2023). Comparative surveys of Nordic care workers, the systems long considered the best case, show working conditions deteriorating over two decades. These include rising workloads, more tasks per shift, less discretion over the content of work, and a growing share of workers seriously considering leaving, with the deterioration steepest where marketisation and time-per-task management have gone furthest (Szebehely & Meagher, 2018).
3. **Those who absorb what the formal system does not are measurably worse off than non-carers in health, income and employment**, with strain rising with hours of care provided, and the burden falling predominantly on women in mid and late working age (Eurofound, 2020; Zigante, 2018).

These are not separate problems awaiting separate fixes. They are one process seen from three sides: the drawing down of caring capacity faster than any current arrangement replenishes it.

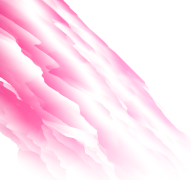
Figure 2. *The transitional present: the transition and its two directions.*



This leads to the transitional present: the replenishing of the care cycle becomes a downward spiral. A spiral can move in either direction, (as shown in Figure 2 above). Without intervention it runs downward and degrades, through workforce attrition, deteriorating health, and privatised compensation only available to those who can afford it. Reorganised on new institutional terms, it can run upward and regenerate. **This report works toward the second possibility, not by restoring the previous conditions, but by proposing the institutional redesign that a renewed care contract requires.**

2.3 A universalist standard for distributing care

Not only should care resources renew and grow again; they should do so justly. This report takes universalism as its standard of fair distribution. The answers that dominate European debate, service care and (re)familialisation, each fail that standard in opposite directions, and cash-for-care, the instrument Europe has expanded most, monetises the failure rather than correcting it. We therefore propose the logic of collective care: universalism applied to a site of care provision the debate has so far left ungoverned, the collective.



The question set out in the introduction, how to deliver a fair distribution of care in an age of heightened vulnerability, requires a standard of fairness. We base ours in the welfare-state tradition: universalism. In welfare-state research the term has a reasonably settled meaning: a benefit or service is universal when it is available to all as of right, on the basis of residence or citizenship rather than means, merit or market position, at a quality uniform enough that the well-off do not exit into private alternatives, and financed collectively (Anttonen and Sipilä, 1996; Anttonen, Häikiö and Stefánsson, 2012). Universalism so defined is a matter of degree and has never been fully realised anywhere⁹.

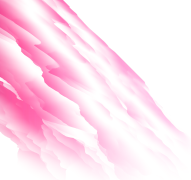
Whilst classical universalism universalises the right to receive and shares the cost only in money, through taxation, this report extends the principle to the contribution side. The obligation to sustain care, in time and activity and not only in tax, is likewise shared across the whole population rather than assigned by gender, means or circumstance. The extension is not ours alone; it follows Fraser's (1994) argument that a fair settlement requires making caregiving a universal condition rather than compensating those on whom it happens to fall.

Other standards of justice are emerging: particularly the idea that we should provide sufficiency for those in greatest need, targeting by capacity to pay, allocation through markets. We however start from universalism because, whatever the distance between ideal and practice, it is the standard that carries legitimacy across otherwise different European welfare traditions, which makes it the workable premise for European policy. Survey evidence bears this out: across the EU, large majorities in every welfare regime hold the government responsible for ensuring care for older people, with support for public responsibility in care consistently among the highest of any welfare domain (Eurobarometer, 2007; ESS, 2016).

The question the report answers is accordingly not whether to be universalist about care, but what universalism requires once care is understood relationally rather than as a service to be dispensed.

Social policy research distributes the provision of care across four institutional sites: the state, the market, the family, and the community (Razavi, 2007; Daly and Lewis, 2000; see section 2.1). The European debate conducts itself almost entirely within the first three.

⁹ First, the postwar settlements that came closest to universal care entitlements rested on a base the theory did not count: the unpaid and largely female care work of households. Universalism in receipt was subsidised by familialism in provision. Invoking universalism is therefore not a proposal to restore that settlement; it is a commitment to complete what it left half-built. Secondly, even in the Nordic countries it was achieved earlier and more completely in education, health care and childcare than in care for older people, and it has been retreating under marketisation and tightened targeting for three decades.



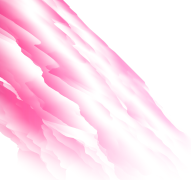
Service care, whether public or marketised, undervalues and underfunds the work, fragments the relationship into billable units, and rations access by eligibility or ability to pay. **Familialisation**, the default when service systems retrench, returns care to the household, where it falls disproportionately on women, goes unpaid and unrecognised, and largely follows the existing distribution of disadvantage. Each is a way of distributing care, and each distributes it unjustly in opposite directions. Across the EU, women provide the large majority of informal long-term care, and the gap widens exactly where formal services retrench. Each is a way of distributing care, and each distributes it unjustly.

The instrument European welfare states have in practice expanded most over the past three decades is a form that combines familialisation and service care: cash-for-care. Schemes such as *Germany's Pflegegeld*, *Austria's Pflegegeld* and *Italy's Indennità di Accompagnamento* pay a benefit to the person needing care or their family rather than providing a service, and personal budgets in several other systems follow the same logic (Da Roit & Le Bihan, 2010). The rationale is real and worth stating fairly: cash schemes grew partly out of the disability movement's demand for autonomy and choice against paternalistic service provision, and at their best they deliver exactly that (Ungerson, 2004).

Measured against a universalist standard of distribution, however, cash-for-care does not constitute a genuine third option.¹⁰ Cash-for-care monetises the prevailing distribution of care; it does not renegotiate it. It therefore fails the universal-obligation test in the same direction as familialisation, with a market layer added, and it clarifies by contrast what a genuine third option would have to do: **change who carries the obligation, not only how the carrying is compensated.**

The remaining site is the **collective**: care organised neither as a service to be purchased or allocated, nor as a family duty, but held by a community as shared capacity. The idea has a literature. It has been developed as an ethos of caring-with (Tronto, 2013), as a programme of universal care (Care Collective, 2020), and as the practice of commoning care (Dengler and Lang, 2022; Power, 2019); this report does not claim to originate it. **What none of these accounts designs, however, is the governance under which participation would be universal rather than elective.** Left voluntarily, the collective site fails the universalist standard in a familiar way: where community provision substitutes for retrenched services, it reproduces austerity and the work returns to women. The commons literature itself carries this warning (Dengler and Lang, 2022).

¹⁰ The money follows the care to wherever the existing arrangement has already placed it: in Germany, predominantly to unpaid family carers, subsidising familialisation without redistributing its obligation; in Italy and Austria, into a largely informal market of migrant care workers, reproducing service care's rationing by household means while stripping away its professional and employment protections (Da Roit & Le Bihan, 2010; Ungerson & Yeandle, 2007).



Collective care, as this report uses the term, is therefore a proposal rather than a description: the collective site governed to the universalist standard.

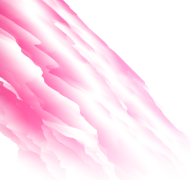
Care is held as a shared obligation, reciprocal and universally distributed, publicly organised and resourced rather than left to volunteering. The case for attempting the following notion: care is too consequential for the cohesion and trust of a society to be delegated entirely to a paid profession, and something is lost when the obligation to others becomes solely the work of an employed class. Whether the collective site can carry universal weight is a question of governance, and governance, in the form of accountabilities and institutions designed for the purpose, is what the mechanisms of section 3 aim to redesign.

The immediate objection is that a collective duty to care merely re-familialises it under another name. The objection misreads where familialisation goes wrong. Familialisation is itself a binding institution, compelling through social expectation as effectively as statute, which is why caring for a relative registers as choice rather than duty; the presence of obligation is not what distinguishes the two. Nor does legitimacy require its absence: schooling in Finland is compulsory, military service likewise, and both are widely accepted.

The difference is whether the obligation is reciprocal and universally distributed.

Familialisation compels asymmetrically: some carry the work, others are exempt by gender or means, and the carer is rarely cared for in return on fair terms. Collective care distributes the obligation across the population and returns care to it, so that each person both gives and receives. That is the test a just care institution must pass, the test familialisation fails, and the test collective care is constructed to meet. It is not an abstract concern: Germany's care sector shows what removing a shared obligation actually costs (see section 3.4).

Collective care in this full sense exists nowhere. The collective site, by contrast, is demonstrably real, and public institutions have shown they can build on it. The cases below show cities and states reallocating time and relationships toward care at the collective level; each proves something about the site, and each stops short of universalising it.



Case study: Fureai Kippu, Japan's time-banking system for elder care

Since 1973, Japan's Fureai Kippu ("ticket for a caring relationship") has let volunteers earn time credits for caring for older people, credits they can save for their own future care or transfer to a relative elsewhere in the country. It is the **clearest long-running test of treating care time as a resource that can be banked**, valued, and moved between people rather than simply spent. Its record is instructive rather than triumphant: participation has fluctuated over five decades, coverage has remained modest relative to Japan's care needs, and since the introduction of public long-term care insurance in 2000 the scheme has functioned as a complement to formal provision, not a substitute for it. The proof it offers is of concept, not of scale.

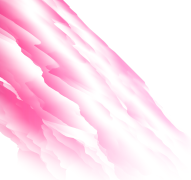
Sources: Hayashi (2012)

Case study: Care blocks in Bogotá

Bogotá's Care Blocks (Manzanas del Cuidado) are the closest **real-world realisation of relational hubs currently**. The Care Blocks are neighbourhood centres built specifically for unpaid carers, most of them women, whose work has traditionally gone unrecognised and unsupported. By bringing education, training, health, and caregiving support together in one physical location, the programme treats care as something a city organises collectively rather than something a household absorbs alone.

Launched in 2020, the blocks repurpose existing public buildings into hubs within a 15–20 minute walk of the people they serve, with mobile units and a home-visit service reaching carers who cannot travel. By 2024, 24 blocks were operating across the city, and the programme had reached over 400,000 caregivers in total; in 2023 it was written into Bogotá's city master plan, securing its continuation regardless of who holds office.

Sources: OECD Observatory of Public Sector Innovation (2023), Mullahy, L. (2024).



Case study: Barcelona's Ciutat Cuidadora

Barcelona runs **Europe's most developed municipal care strategy**. Its Vila Veïna programme applies the relational-hub model at neighbourhood scale, piloted across ten districts, giving residents access to care-related support in one place. A citywide reference centre, Espai Barcelona Cuida, helps carers navigate existing services rather than duplicating them, and a Targeta Cuidadora card grants unpaid carers access to fourteen free resources. Together these have reached over 16,400 people.

Sources: *Barcelona Caring City*. Barcelona City Council (2026), VinclesBCN (Ajuntament de Barcelona) (2022).

Read together, the cases establish that **the collective site can be institutionalised**: written into a city master plan in Bogotá, run as citywide infrastructure in Barcelona, sustained across five decades in Japan. They equally establish its ceiling under voluntary governance: coverage stays modest, participation self-selects, and the underlying distribution of the obligation is untouched. The distance between proof of concept and universal standard is the distance the mechanisms in section 3 are designed to close.

One further clarification. Defining care primarily as a burden misses much of what care is. The work has intrinsic goods, meaning, connection, and at times satisfaction, and, organised and resourced appropriately, a far larger share of it could be experienced as such rather than as strain. These goods are conditional on the resources available to the carer, which is why naming them obliges the provision that makes them possible rather than serving as a reason to leave care where it falls.

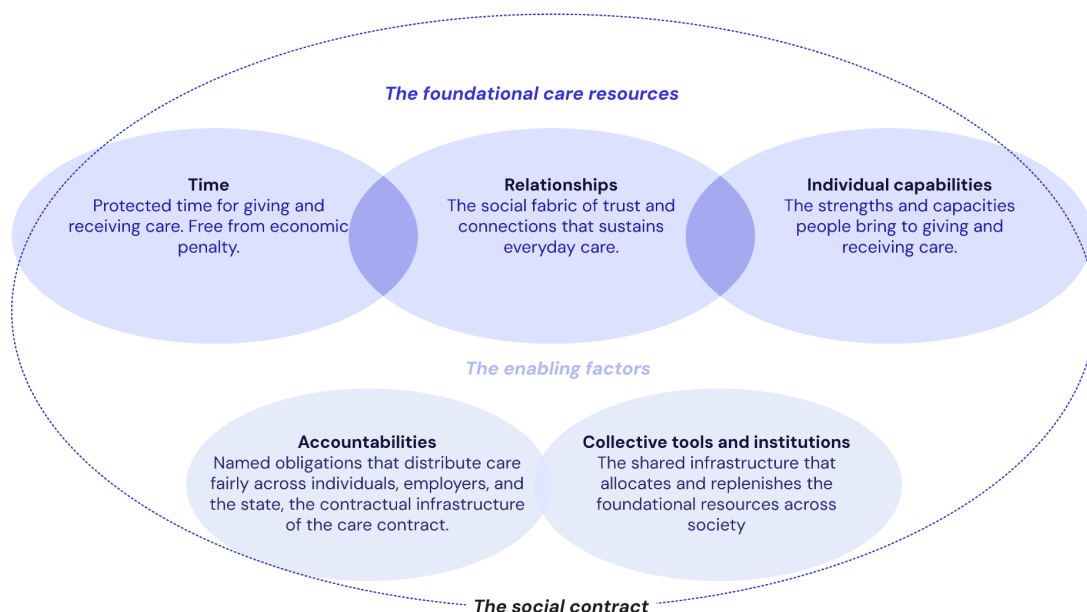
This is what distinguishes a transition from a crisis. A crisis invites stabilisation: restoring the service system and locating the missing workers and funds. A transition raises the question of how the resources care depends on, time, relationships, individual capabilities, and the institutions that hold them and the accountabilities that distribute them, can be reorganised across society so that the spiral goes upward and regenerates rather than degrades.

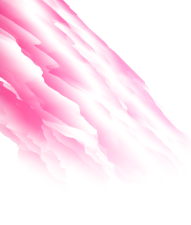
2.4 Care as a cross-sectoral transition

The resources care runs on; time, relationships, and individual capabilities, and the accountabilities and collective tools that govern them, are held across the whole of society, not within the health and social sector. Adjusting services alone leaves their distribution, and its inequalities, untouched.

The resources care depends on; time, relationships, and individual capabilities, are not held in any single sector or institution. They are distributed across the full breadth of the social contract simultaneously, across its vertical dimension between the state and citizens, and its horizontal dimension between citizens themselves. How they are distributed is governed by enabling factors: accountabilities, and collective tools and institutions (see Figure 3). The remainder of this section examines how both are currently fragmented, and builds the foundation for section 3 that sets out mechanisms that work through them to reallocate and redistribute these resources.

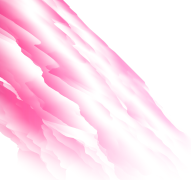
Figure 3. The foundational care resources, enabled by accountabilities and collective tools and institutions, as part of the larger social contract.



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- **Time** is allocated partly through state policy, such as parental leave and working hours, and partly through informal arrangements within families and communities, leaving households with secure employment and income, savings, and flexible employers far better placed to create care time than those without.
 - **Relationships** are sustained both through institutions and through the everyday social fabric of neighbourhoods and civic life, which depends on housing stability, mobility patterns, and access to public space and third places, all of which are unevenly distributed.
 - **Individual capabilities**, the different strengths and capacities people bring to giving and receiving care, are shaped by education, health, economic security, and social connection, conditions that vary considerably across European communities.

The enabling factors that govern these resources are similarly fragmented. Accountabilities for care are currently split between public services and private households. As needs are increasing, so are responsibilities to meet them, however nowadays it is unclear who will be accountable for them. **Even more so responsibilities fall disproportionately on women and on migrant and racialised workers** and the inability to meet them erodes trust, social cohesion and incurs costs to other sectors of society and ultimately also on tax payer's wallets. The collective tools and institutions that could distribute these accountabilities more fairly are either absent or disconnected from one another across policy silos.

It follows that a care transition cannot be achieved through adjustment within any single sector. A reform that only adjusts existing services, without altering this wider structure, leaves the underlying distribution of time, relationships, and individual capabilities untouched, and the inequalities built into those distributions intact. Notably, the care transition can be driven from many sectors. The levers and mechanisms we introduce in the next section are one set among several, and are offered as imaginative proposals showcasing new possibilities of organising care, and of organising society around care.



3. Four mechanisms for redistributing care

The mechanisms introduced here are illustrative policy levers: a set of entry points among several, aimed at the space between formal services and private households where today's asymmetries are produced. Their purpose is not to settle the design of a renewed care contract, but to demonstrate that collective care offers a different logic of distribution, one that reorganises the obligations and narrative behind existing services rather than replacing the services themselves.

The mechanisms were developed in two stages. The first drew on the theoretical and empirical literature reviewed in section 2 to identify the gap where existing institutions can't reallocate the resources of care and where an alternative design might intervene. The second tested and revised these early proposals against practitioner and policymaker judgement, through two policy observatories, bringing together 70 participants: policymakers from healthcare, housing, and labour, alongside researchers and think tanks.¹¹ Participants were asked to validate the mechanisms, imagine what implementing them would actually require, and identify where they fall short.

As argued in section 2.2, the two options that dominate European care debates each distribute care unjustly: service care rations it by eligibility or ability to pay, and familialisation returns it to the household, where it falls disproportionately and invisibly. The mechanisms aim to build **the third option instead: collective care**, in which the obligation to give and receive care is held reciprocally across the population, reshaping the logic of the service model of care. What makes this reciprocal, rather than simply another form of compulsion, is that the obligation to contribute and the entitlement to receive fall on the same population, rather than being split between those who provide care and those who receive it.

This same logic extends to the social contract itself (see section 1.2): care operates across both its vertical and horizontal dimensions, and by reallocating the obligations and accountabilities within the contract, the mechanisms aim to strengthen not only the care transition but the trust and cohesion it depends on. Importantly, what the mechanisms aim

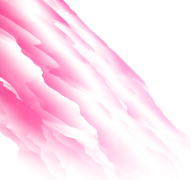
¹¹ The first policy observatory was held online on the 21st of April 2026 and the second one was held at the Creative Bureaucracy Festival in Berlin in June 2026.

to achieve is to apply the logic behind collective care, rather than prescribe a single system for delivering it.

Table 2 gives an overview of the mechanisms, showcasing the resources it aims to reallocate, the primary actors involved, as well as the existing evidence base or existing case studies, where the logic has been applied. Each mechanism is introduced in more detail in the section indicated.

Table 2. *The four mechanisms at a glance, the resources it aims to reallocate, the primary actors and the existing evidence base.*

Mechanism	Resources it reallocates	Primary actors and key logic	Current evidence base
Relational hubs (3.1)	Relationships	Municipalities repurpose civic infrastructure; civil society organisations hold connector roles and co-manage	Bogotá's Care Blocks (24 hubs, 400,000+ carers reached); Barcelona's Vila Veïna and Espai Barcelona Cuida
Time-for-care guarantees and credits, with time policy negotiations as their collective extension (3.2, 3.2.1)	Time	State and municipalities set entitlements and hold time budgets; employers convert flexibility into protected time; social partners negotiate the population-level distribution	Japan's Fureai Kippu time-banking system (running since 1973, roughly 70,000 active participants); no European application of negotiations yet, wage bargaining supplies the institutional template
Employer care compacts (3.3)	Accountabilities, within working life	Sectoral social partners negotiate minimum terms; employers implement; public policy sets the floor and monitors	No full implementation; elements exist in collective agreements on carer leave and flexible scheduling in several member states
Civic care service (3.4)	Accountabilities, across the whole population	State legislates the obligation; citizens aged 15 to 75 serve in roles matched to ability; costs shared between individual, employer and state	No contemporary implementation; historical precedent in civilian alternative service, whose abolition cost Germany's care sector tens of thousands of workers



As noted, no single mechanism can carry this transition on its own. Each addresses a different part of the system, and together they aim to shift the current logic behind the service model of care moving towards one that recognises, reallocates, and enables the resources fairly. This effort requires pressure and support from several directions at once rather than a single lever pulled at national level, and new ways of organising how we govern.

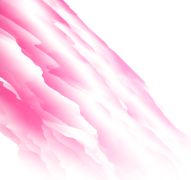
3.1 Relational hubs: Rebuilding the social infrastructure of care

Libraries, cultural venues and civic spaces are repurposed as neighbourhood-level navigation and respite points, an institutional layer between households and services. They make relational support a public resource rather than something better-off households purchase privately.

Relational hubs repurpose existing civic infrastructure, libraries, cultural venues, community spaces, into neighbourhood-level points for care navigation, peer support, and respite. Municipalities establish and fund them; civil society organisations hold the connector roles and co-manage the premises, since they carry relational knowledge that formal institutions cannot replicate. A hub provides wayfinding through the service system, low-threshold peer groups, and a place where care needs can be recognised before they become acute.

The resource the hubs mobilise is relationships. Care is sustained in the social fabric around households, in neighbourhoods, friendships, and the everyday places where people can ask for, offer, or coordinate support. When that fabric is weak, formal systems absorb problems they cannot solve: loneliness, caregiver exhaustion, preventable deterioration, confusion in navigating services.

Welfare states have concentrated resources in professional services while underinvesting in this infrastructure, which is inefficient, since expensive downstream interventions treat what earlier relational support could have mitigated, and unjust, since only better-off households can purchase the missing coordination and respite privately. The hub changes that distribution: **navigational and relational support becomes public provision** rather than a private purchase. It relieves the household without adding demand on the service system, which it complements rather than substitutes, and it carries a democratic gain besides: a care system that citizens encounter only as eligibility criteria or crisis intervention alienates, whereas a hub makes public institutions legible in everyday life.



The nearest existing practice is municipal. Bogotá's Care Blocks and Barcelona's Vila Veïna, described in section 2.3, show the model institutionalised at city scale, and also show its ceiling under voluntary governance. What a European pilot would need to settle is the connector role itself: who holds it, on what employment terms, and with what accountability toward both the municipality and the households it serves.

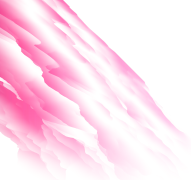
3.2 Time-for-care guarantees and credits: Governing the scarcest resource

The binding scarcity in care is time, and the current regime distributes it regressively: those with secure jobs and flexible employers can create care time, others cannot. Guarantees and credits give protected caregiver time an institutional status, so that caring does not depend on private bargaining power.

Time-for-care guarantees and credits give protected caregiver time an institutional status. The state or municipality defines the entitlement; employers convert scheduling flexibility into guaranteed time windows; caregiving hours are logged as trackable, redeemable credits, compensated through paid leave, reduced hours, or pension contributions, and portable across jobs. The design can vary between these forms; the principle cannot: **whether a person can care must not depend on private bargaining power.**

The resource governed is time, the binding scarcity in care. Caregiving, receiving care, and sustaining a relationship through illness or dependency all take more time than industrial institutions recognise, and the current regime distributes that time regressively. Households with secure jobs, savings, or flexible employers can create it; others cannot; women absorb most of the adjustment, and low-income and precarious workers face the sharpest penalties when care collides with rigid schedules.

Credits change the site of absorption. Time now subtracted invisibly from evenings, careers, and health inside the household becomes an entitlement held against institutions, alongside wages, working hours, and leave in the negotiated architecture of the economy. The contrast with cash-for-care is deliberate: where cash benefits monetise the existing distribution of care (section 2.2), credits redistribute the time itself, and the record they generate makes



the distribution measurable, who has time to care, who lacks it, and what changes when institutions reallocate it.

Elements exist across member states in carer-leave rights and flexible-working provisions; no system yet treats care time as a tracked, portable entitlement. A pilot would need to settle verification, meaning how caregiving hours are logged without surveilling the household, the credit's value across employment types, and its financing between employer and state.

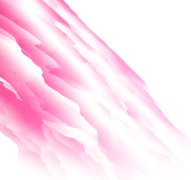
3.2.1 Time policy negotiations: Bargaining over care time collectively

Where guarantees protect individual care time, time policy negotiations distribute it across the population: periodic bargaining among state, employers, workers and municipalities, on the template of wage negotiation. Care time becomes a tracked feature of the labour market rather than an invisible subtraction from it.

Like time-for-care guarantees and credits, time policy negotiations aim to tackle the unequal distribution of time available for care. Where guarantees and credits establish that time can be recognised and protected at the level of the individual worker or household, this mechanism addresses the same problem at a higher level: the distribution of care time across the population as a whole, once demand for it regularly exceeds supply, which, in an ageing society, it will.

Wage bargaining offers a working template for this. It treats a scarce and contested resource, the price of labour, as something negotiated periodically among defined parties, rather than settled bilaterally or left to administrative default. Time for care warrants the same treatment: a shared, limited resource, subject to formal negotiation rather than informal absorption.

What changes under this mechanism is not the underlying entitlement to care time, but its visibility and its price. In practice it could mean that a care bank records care time as it is used and compensated, in the same way payroll systems record wages, so that caregiving hours become a tracked feature of the labour market rather than an invisible subtraction from it. Municipal time budgets sit alongside this record, matching the supply of protected time available locally against the demand for it, and flagging where the two diverge before the gap becomes a crisis for individual households.



3.3 Employer care compacts: Bringing care into the settlement of work

Sectoral and organisational agreements make caregiver flexibility a recognised institutional obligation rather than a managerial favour. What high-skilled workers already negotiate privately becomes predictable for those with the least bargaining power.

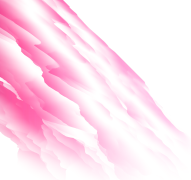
Employer care compacts are sectoral or organisational agreements that set out what every workplace owes workers with care responsibilities: predictable scheduling, protected leave, and support arrangements agreed in advance rather than granted at managerial discretion. Social partners negotiate the minimum terms; employers implement them; public policy sets the floor and monitors compliance.

What the compact reallocates is accountability within working life. Workplaces assume uninterrupted availability while the conditions that produce it are pushed onto families and informal carers; the boundary between work and care is crossed daily in practice and denied in theory, and the cost of the collision falls on whoever has least bargaining power, since high-skilled employees negotiate flexibility privately while lower-paid workers manage it in silence. A compact institutionalises what is now informal accommodation. For the household, caregiving becomes compatible with employment rather than a reason to reduce or leave it; for the service system, fewer carers exit into exhaustion or return the cost as absenteeism, burnout, labour shortage, and early exit from work. The economy rests on social reproduction, and a labour market that refuses to recognise care does not avoid its costs; it relocates them.

Fragments exist in collective agreements on carer leave and flexible scheduling in several member states; no sector has consolidated them into a compact. What negotiation would need to settle is the trade itself: which productivity commitments employers receive in exchange for predictability, and how compliance is verified in workplaces where the schedule currently is the main instrument.

3.4 Civic care service: Reciprocal shared obligations

A universal civic care service, open and obligatory across ages 15 to 75, meets the report's legitimacy test directly: everyone gives, and everyone



stands to receive from the same system in turn. Unlike military service, the paradigmatic civic duty it resembles, it excludes no one by gender; the asymmetry that makes familialisation unjust does not arise.

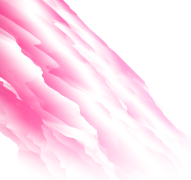
The mechanisms above operate through incentives and negotiation. Civic care service operates through obligation, and needs a different kind of justification.

Section 2.2 sets the test: an obligation is legitimate not because it is voluntary, since compulsory schooling and military service are neither, but because it is reciprocal and universally shared. Familialisation fails that test. A universal care obligation meets it directly: the duty to care applies to everyone, and everyone stands to receive care from the same system in turn. De Vries (2022) adds the historical point: military service, the paradigmatic civic duty, defined citizenship through an obligation women were excluded from, and a care obligation carries no such exclusion. Since care is a resource everyone will eventually need and everyone can in some form provide, sharing the obligation evenly is a matter of justice rather than of workforce planning alone.

Structured on the institutional logic of national service, the obligation would apply across a wide age range, for instance 15 to 75, with roles matched to ability and life stage: caring for one's own family members, supporting neighbours, or supervised work alongside trained professionals in under-resourced services and areas of greatest need. Duration and intensity would flex between part-time and full-time forms, with training, professional supervision, and recognition, such as training credits redeemable in the health and social care sector, built in from the start. **What the service reallocates is accountability across the whole population**, and with it time and individual capabilities now left outside care altogether. The service system gains an auxiliary layer and retains skilled care; the family ceases to be the default carrier of whatever the system does not absorb.

The following is an illustrative calculation, not a forecast; its assumptions are stated so they can be contested.

The scale of what universal participation could add is significant. In Finland, for example, if all residents aged 15 to 75 contributed roughly two weeks a year, this would be broadly equivalent to adding well over 200,000 workers to a care sector that currently employs around 420,000. This number assumes near-universal participation and counts gross hours. Training, supervision, coordination, and the consent and continuity constraints set out below all reduce the net addition at the

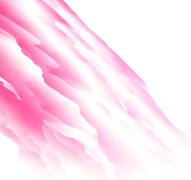


bedside, plausibly by a large fraction. The illustration establishes the order of magnitude available, not the deliverable workforce and this is not a hypothetical effect. Historically, most European countries met a substantial share of their care workforce needs through conscripts serving civilian alternative service in place of military duty. When Germany suspended conscription in 2011, it also ended civilian alternative service, which at its close provided roughly 90,000 placements a year, a large share of them in care, welfare and hospital settings; the voluntary programme created to replace it filled only part of the gap. Financing need not fall on any single party: a period of care service could reasonably be shared between the individual, their employer and the state, in the same way parental leave costs are already divided in several countries.

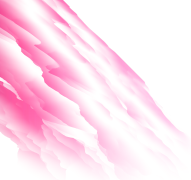
Civic care service reduces the asymmetry of familialisation, but it does not by itself resolve every question of fairness, for instance how service obligations interact with disability, migration status, or existing caring responsibilities, and these would need to be worked through in design rather than assumed away.

There is a second objection: the view from the person receiving care. The disability movement's critique of care has never been aimed at scarcity alone but at care as something done to people, organised around the giver's obligation and the system's convenience rather than the recipient's agency (Watson et al., 2004). Kittay's warning cuts the same way: the labour of care can be delivered without the attentiveness that makes it care, and institutions are efficient producers of exactly that separation (Kittay, 2011). A universal service is more exposed to this failure than the other mechanisms. Its carers are conscripted rather than chosen, present for a service period rather than a relationship's duration, and trained in weeks rather than years; from the recipient's chair, a rotation of well-meaning strangers with an obligation to discharge can be experienced as surveillance, condescension, or simply noise, and no appeal to the giver's civic growth answers that.

The distributive case for a civic care service stands. But distribution is a necessary condition of just care, not a sufficient one, and an institution that passed the reciprocity test while failing the people it exists for would not be a care institution at all. The design consequence is therefore a hard requirement, not an aspiration: recipients hold enforceable choice over whether conscripted care enters their lives at all, and voice over who provides it and how; service roles are matched not only to the giver's abilities but to the recipient's consent; and continuity of assignment is protected wherever a relationship forms, because the relationship, not the shift, is the unit that matters. Where these cannot be guaranteed, service belongs in the supporting roles around care, logistics, respite for family carers, maintenance of the settings care happens in, rather than at the bedside. A care service



designed under this constraint is smaller at the intimate core and larger at the periphery than the workforce arithmetic above implies, and that is the correct trade.



4. Three scenarios from 2050: The mechanisms working together

No single mechanism or lever carries the transition; these scenarios show them combined, in the lived scale of a neighbourhood, a workplace and a household. They are illustrations of a direction, not predictions, and serve to contribute to imagining a different system than the one we are used to.

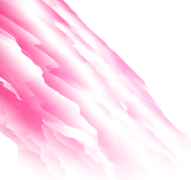
The mechanisms set out in section 3 respond to different parts of the care transition. Relational hubs address the absence of relational infrastructure between formal services and households; time-for-care guarantees, credits and negotiations address the structural misallocation of time; employer care compacts bring care into the institutional settlement of work and civic care services distributes the obligation to give and receive care universally. None can drive the transition alone, but taken together they describe a different way of organising care: one in which time, relationships and capabilities are **governed with collective tools and mechanisms deliberately, as a shared responsibility and accountability**, rather than left to accumulate wherever current arrangements happen to place them.

What follows aims to make the arguments concrete, while supporting the task imagining a new system. Three scenarios, set in 2050, show how these mechanisms might once in place: **the Relational Contract, the Time Contract, and the Accountability Contract**. The scenarios are illustrative rather than predictive. Their purpose is to show what it would mean, in the lived experience of a neighbourhood, a workplace or a household, for care to be governed as a reciprocal, collective responsibility rather than left to service systems or families to absorb alone.

Scenario 2050: *The Relational Contract*

WHAT HAS CHANGED:

Neighbourhoods feel inhabited rather than merely occupied. People know where to turn, and someone is there when they do. But the social fabric that makes everyday care possible, families, neighbours, peer networks, third places, is neither infinite nor



self-sustaining. Without deliberate support it erodes under the pressure of housing costs, mobility patterns, and the withdrawal of public space. Sustaining it is a multilevel governance task. At EU and national level, funding frameworks and planning obligations create the conditions: cohesion funds are directed towards community infrastructure, and housing and mobility planning are assessed for their effect on whether relational care is practically possible.

MECHANISMS:

At municipal level, **relational hubs** are established within existing libraries, cultural venues, and public spaces. These are not service points but places where wayfinding, peer groups, and connector roles are available as a matter of course.

Care resource data and mapping gives all levels of governance a shared picture of where care capacity exists, where it is under strain, and where investment is needed. Civil society organisations hold the connector roles and co-manage the hubs, carrying the relational knowledge that formal institutions cannot replicate.

Scenario 2050: *The Time Contract*

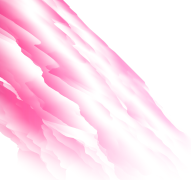
WHAT HAS CHANGED:

Who has room to care, and at what personal cost, is no longer determined by individual circumstance or employer goodwill. Caregiving time was previously extracted from income, rest, and career progression, falling most heavily on women and low-income workers. That asymmetry is now a policy problem with structural answers.

MECHANISMS:

Employer care compacts, established through legislation and agreed between employers and worker representatives, set out what every workplace is obliged to provide: flexible scheduling, protected leave, and predictable working arrangements for those with care responsibilities.

Time-for-care credits function as a public instrument: caregiving hours are logged



through a verified system and compensated, whether through paid leave, reduced hours, or pension contributions, portable across jobs and sectors. Care time is a formal entitlement rather than an informal negotiation. The hours once absorbed invisibly into evenings and weekends are now visible in labour statistics alongside wages and working time. The distribution of care across gender, income, and age is a standard accountability metric.

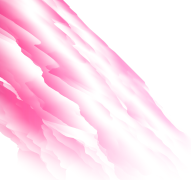
Scenario 2050: *The Accountability Contract*

WHAT HAS CHANGED:

Care is understood as a shared obligation, not a residual burden that falls on whoever cannot avoid it. The increased care responsibilities created a surge of new ways to create accountability: to track, measure and agree on whose responsibility it is to care. At the societal level, the distribution of unpaid care across gender, age, and migration status is a standard reporting metric, sitting alongside employment and housing indicators. Workplace obligations on caregiver support are enforceable, and a Parliamentary Care Steering Group holds institutions and employers to account where those obligations are not met. Care burdens are measurable, attributable, and acted upon.

MECHANISMS:

At the individual level, **a civic care service**, structured on the model of national service, creates a direct and personal experience of care responsibility for citizens across age groups. Over time it builds a shared civic literacy around care: what it involves, what it costs, and why it cannot be left to fall on the same shoulders generation after generation. The service builds the culture; the reporting infrastructure measures whether that culture is translating into practice. Accountability runs in both directions: institutions are held to standards, and citizens to a parallel standard of active contribution.



5. What the EU says about care, and what it can actually do

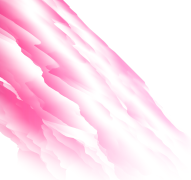
The EU cannot legislate a care system into being: care remains a national competence, steered through soft law, funding and monitoring. But the framing is moving in this report's direction, and most of the missing instruments are already on the EU's own table.

The mechanisms described in section 3 operate at the meso level, where national and municipal institutions hold most of the levers. Whether such experiments remain isolated or add up to a common direction of travel, however, will depend partly on the European level. This section asks what potential the European landscape holds for the care transition. Section 5.1 looks at how the EU talks about care, and section 5.2 at what it can actually deploy. We argue that **the European level offers more leverage for a renewed care contract than is usually assumed**, although that leverage is soft and fragmented.

5.1. From care economy to care society: How the EU talks about care

How the EU talks about care sets the boundary of what is thinkable and fundable. Since the 2022 European Care Strategy the vocabulary has moved from care as a labour-market lever towards care as a public good grounded in interdependence.

The EU has a mismatch between ambition and authority. Care has no legal base of its own in the Treaties and remains a national competence, scattered across the health, employment, gender-equality and disability silos. The EU cannot legislate a care system into being, so it steers through soft law, through funding (notably ESF+ and the Recovery and Resilience Facility), and through monitoring in the European Semester. The Parliament has repeatedly pressed for binding legislation, while the Commission and the Council point to



member-state competence (European Parliament, 2020); the EU, in other words, declares social rights it has no power to deliver, and falls back on money and persuasion.

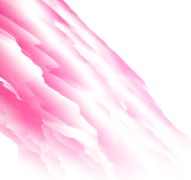
Within these limits, the framing of care has shifted considerably over the past decade. Before 2022, care appeared mainly as a labour-market lever and a demographic cost, a service to be supplied, the transactional understanding section 2.1 argued against. The 2022 European Care Strategy reframed care holistically and across the life course (European Commission, 2022), and the Parliament went further the same year, framing care around interdependence and resisting commodification (European Parliament, 2022). Since then the vocabulary has been moving from a "care economy", a sector to invest in, towards a "care society", a relational foundation of social life. The Parliament's 2026 resolution treats care as a public good grounded in interdependence and solidarity (European Parliament, 2026), and the Commission has announced a European Care Deal, due in 2027. This is the closest the EU's own language has come to the premise of this report.

For a care contract, two features of this discourse matter most. The first is that it remains technocratic: care is justified by employment rates, metrics and funding streams, while its intrinsic, relational value is barely discussed. This is the normative gap the understanding of care in section 2.1 is meant to fill. **The second is the contradiction** section 2.1 identified in Fraser's terms: the European economy needs women in paid work while national welfare states depend on their unpaid care. The Council itself concedes that heavy reliance on informal care will not be sustainable (Council of the European Union, 2022). The silences in the documents point in the same direction. The private household remains in practice an unregulated workplace: only nine of twenty-seven member states had ratified the ILO domestic-workers convention by 2025 (European Commission, 2025). Young carers appear only at the margins (European Parliament, 2026). What the EU's instruments do and do not reach is the question we turn to next.

5.2 The instruments: Present, non-binding, disconnected

Several dozen care-relevant instruments exist, but binding law touches only the edges: the worker, never the system. Three deficits recur: no binding core, no shared targets, no earmarked money. The gaps are weak versions of instruments already demanded, not absences.

The soft and fragmented way the EU frames care is mirrored in the tools it has built. Even a partial inventory of care-relevant instruments runs to several dozen, spanning directives,



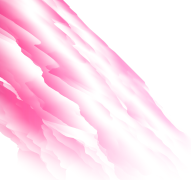
strategies, recommendations, funding streams, monitoring mechanisms, targets and agencies, spread across policy silos and institutions with no consolidated register and no single body responsible for the whole. Where binding law exists, it touches care only at the edges: directives on work–life balance, occupational safety and pay transparency regulate care workers and their leave, but nothing binding governs how care itself is organised or provided. Everything that addresses care as a system, from the Care Strategy and the long-term care Recommendation to the Barcelona targets and the Child Guarantee, is non-binding. Several of these instruments are the funding carriers on which the mechanisms of section 3 would draw. The difficulty, as section 2.2 anticipated, is not that **the tools are missing but that they are disconnected**.

Three deficits follow from this.

- There is **no binding core**: a recommendation on long-term care, but no framework directive and no statute for carers.
- There are **no shared targets**: childcare has the numerical Barcelona targets, while long-term care received a monitoring framework in 2025 whose indicators measure without committing anyone to anything (EPRS, 2025).
- And there is **no earmarked money**: care draws on general funds, and the Recovery and Resilience Facility, unlike its climate and digital spending, sets no minimum for social expenditure (EPRS, 2025).

The missing instruments are, moreover, already on the EU's own table. Since 2021 the Parliament has called for a binding long-term care framework directive, a European Carers' Statute, care targets and a scoreboard, a deinstitutionalisation action plan, earmarked care funding, ratification of the ILO domestic-workers convention, and personalised care budgets (European Parliament, 2022, 2025, 2026). Most of the gaps are weak versions of these demands rather than outright absences. The obstacles are familiar ones: national competence, the diversity of European welfare systems, spending priorities, and the difficulty of regulating the private home as a workplace.

Much now depends on the European Care Deal, which the Commission has announced for 2027. Whether it will carry the binding instruments the Parliament has demanded, or turn out to be another soft-law package, remains open, and we do not attempt to settle it here; the report's contribution does not depend on the answer. **The EU has the pieces, and it has the direction of travel; what it lacks is a binding spine and the coherence to hold the pieces together.** That is the integrating architecture a care contract would supply. Section 3 described what it looks like from below, and the recommendations in section 6 set out how it could begin from above.



6. How to govern the transition?

A care system is administered; a transition is steered. This section outlines what that implies for governance, and what EU recommendations follow.

- The care transition is **long**: it outlasts electoral and budget cycles.
- It is **cross-sectoral**: the resources of care form in housing, work, mobility and civic space, rather than inside the care sector.
- It is **systemic**: the mechanisms interact, and no single lever suffices.
- And it is **reallocative**: it shifts obligations, not only budgets.

It cannot be governed as a service reform, but requires institutional redesign: building and connecting the tools, accountabilities and bodies that make the resources of care governable, rather than adjusting the services that currently absorb it.

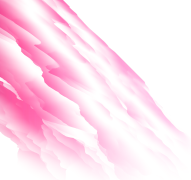
Three principles follow:

Govern conditions, not care. Public policy cannot produce relationships. It can allocate what relationships need: people meeting each other, time, space, money, and knowledge. Every mechanism in section 3 works this way. They don't simply provide care; each of them changes a condition under which people can provide it.

New obligations require participation and knowledge. The transition extends obligation into what was private. That is legitimate only if those who carry the obligations take part in setting them: standing negotiation, not consultation. It can be steered only with knowledge Europe does not collect. There is extensive health data and almost no care data: no systematic picture of time use for care, of care relationships, or of people's changing capacity to care for themselves and others. Mapping these resources is a precondition of governance. The mapping of private resources should be private and purpose-bound, or it risks becoming citizen surveillance.

Pair every shift with resources, every pilot with criteria. Because there is no blueprint, the transition proceeds through experiments. Every shift of obligation towards households, communities, or employers is paired with resources: money, time, or institutional support.

The open question is authority. The mechanisms operate in the space between formal services and private households. No institution owns this space, and civil society, its traditional occupant, is less organised than a generation ago; it cannot be assumed to carry



the coordinating role by default. Who convenes the negotiations, who holds the data, and who decides when a pilot becomes an entitlement are design questions.

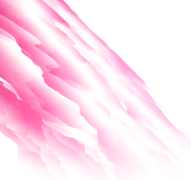
6.1 EU pathways: Three horizons for EU action

The recommendations target coherence rather than invention: pilot the mechanisms with existing instruments now, commit through the Care Deal to the instruments already under discussion, and build the durable architecture including dedicated care funding. Each horizon is judged by one standard: whether it moves the distribution of care towards relational universalism.

6.1.1 Short-term: Use existing instruments to pilot the meso-level mechanisms

This horizon requires no new legal base and no new funding line. It uses the coordination, funding, and monitoring tools the EU already has (see section 5.2) to test the mechanisms proposed in section 3.

- Authority over care is currently spread across several Commission Directorates-General, the Council, the Social Protection Committee, and a range of agencies and social partners, with no single body responsible for coherence across them. As a first step, existing cross-Commission coordination mechanisms, bringing together DG EMPL, DG SANTE, DG REGIO and the Social Protection Committee, should be given **a stronger mandate to drive and align existing instruments** around a shared pilot agenda for care and ensure lessons are systematically fed into future programming.
- **Existing funding instruments should be directed toward piloting relational hubs, time-for-care guarantees and credits, and employer care compacts**, using targeted calls within ESF+ and ERDF's PO4 ("a more social Europe") rather than new funding lines. Where relevant, Digital Europe should also support the deployment of digital care and health services, recognising that many public authorities remain unaware that digital care infrastructure can be financed through this programme. Calls should be designed with greater complementarity across programmes, reducing fragmentation between ESF+, ERDF, EU4Health, Digital Europe and other



relevant instruments while allowing different funds to support complementarity aspects of the same transformation. Interreg programmes with an existing health focus should also be considered here: several already fund cross-border health cooperation, and could work in sync with the piloting.

- **Pilot results should be tracked against the indicators already established** in the EU's 2025 monitoring framework on long-term care, so that evidence accumulates within an existing reporting structure. That framework, however, measures service coverage rather than the other foundational care resource. As such, new, minimal set of evidence-based indicators should be developed alongside it, covering aspects such as time use, caregiver strain, service pressure, and their distribution across gender, age, and migrant status, as set out in section 2.2. These should be applied consistently across all pilots so that mid-term decisions can be made on evidence the 2025 framework does not yet capture.

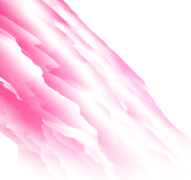
6.1.2 Mid-term: Commit to instruments already under discussion

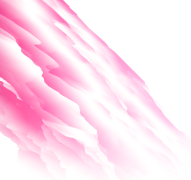
This horizon depends on commitment to instruments already on the table, principally the Care Deal due in 2027.

- **The task force should become a standing coordinating body within the Care Deal's** architecture, responsible for aligning the Care Strategy, ESF+, ERDF and EU4Health on an ongoing basis. Two of the three deficits named in section 5.2 should close directly here: successor instruments to the Recovery and Resilience Facility and the Social Climate Fund **should carry a minimum care-expenditure share**, as climate and digital spending already do. Where sectoral objectives remain fixed, eligibility criteria should explicitly prioritise households and settings where care is given or received, so that energy poverty, building renovation, and clean mobility investments double as preventative care measures (falls prevented, health maintained, strain on carers eased), rather than reaching those outcomes only incidentally.
- **Long-term care should get numerical targets comparable to the Barcelona childcare targets**, replacing the indicator-only monitoring introduced in 2025. The pilot indicators from 6.1 **should become a standing European Care Observatory**, and work should begin on a European Carers' Statute so that time-for-care credits (section 3.2) are portable across employers and borders.

6.1.3 Long-term: Build the coordinating architecture

This horizon requires sustained political commitment and should be understood as the destination the short- and mid-term steps are building toward and aims to close the third deficit from section 5.2.

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- **The standing coordinating body should become permanent**, paired with the binding long-term care framework directive Parliament has already called for. **A dedicated care funding instrument**, structurally comparable to the Just Transition Fund, should be established within the EU's multiannual financial framework, replacing reliance on general funds. It should follow the National and Regional Partnership Plan model proposed for the 2028–2034 MFF, complementing the Commission's own push to give member states more discretion over EU resources, and respecting care's status as a national competence, while still guaranteeing funding at EU level and closing the earmarking deficit from section 5.2.
 - **The Carers' Statute should become binding law**, the Commission should use European Semester country-specific recommendations to press remaining member states toward ratifying the ILO domestic workers convention, and the Care Observatory's indicators should be published as a standing EU Care Barometer, completing the shift named in section 5.1 from "care economy" metrics to "care society" standing.



About the project

The Care Contract: How to unlock European resources for the need of care

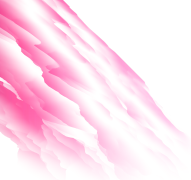
The project is funded by the Calouste Gulbenkian Foundation.

Europe is currently navigating a decade defined by overlapping crises and political polarisation, making the renewal of its social contract essential for maintaining social cohesion and democratic resilience. In this context, the realities of an ageing population have turned care into a point of systemic "lock-in" and crisis, driven by historical path dependencies. The project posits that if European societies fail to adequately care for citizens in need, trust in public institutions will dramatically erode. Therefore, care is identified as the critical area and leverage where European cohesion is either sustained or fractured.

The primary aim of the project is to recentre and reposition care as a fundamental dimension of a renewed European social contract. It seeks to shift the overarching narrative of care from a "crisis" to a "transition" and strengthen the understanding that care requires a societal shift comparable in scope to digitalisation or decarbonisation. Specifically, the project aims to:

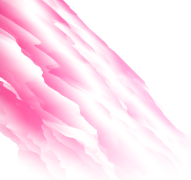
- Reposition care as a fundamental dimension of a renewed European social contract, shifting the prevailing narrative from one of crisis to one of transition.
- Reorganise the core resources that sustain care, time, relationships and individual capabilities, so that they are allocated systematically, through collective tools and institutions, rather than left unequally distributed, with the burden falling disproportionately and invisibly.
- Identify and develop concrete mechanisms, and the institutional pathways needed to realise them, at the meso-level where formal services and private households meet. Identify and target the specific failure modes in systems that put social cohesion at risk, rather than addressing surface symptoms.
- Contribute to a social contract grounded in inclusivity, peace, and resilience against disruptive pressures.

The project's scope bridges conceptual design and practical, policy-oriented application. It draws on desk research, policy analysis, and interviews. In practice this



included the following during Spring 2026:

1. Literature review: The project drew on academic literature across the ethics of care, dependency and vulnerability theory, welfare-state research, feminist political economy, caring-democracy scholarship, and social contract theory, alongside EU policy documents, to build the report's conceptual framework and standard of care justice
2. Policy observatories: The proposed mechanisms underwent a co-design and validation process within two policy observatories. Participants included policymakers, researchers and experts, with the aim of co-developing, sharpening and validating the proposed mechanisms. The first one was held online in April 2026, the second one was held at the Creative Bureaucracy Festival in Berlin in June 2026.
3. Multi-method research: The project applied a multimethod approach that combined existing secondary datasets, semi-structured interviews, and an analysis of European Parliamentary debates on care.



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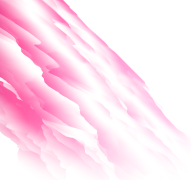
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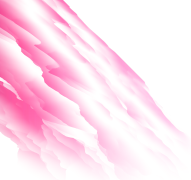
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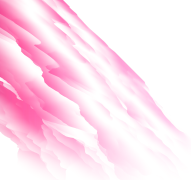
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