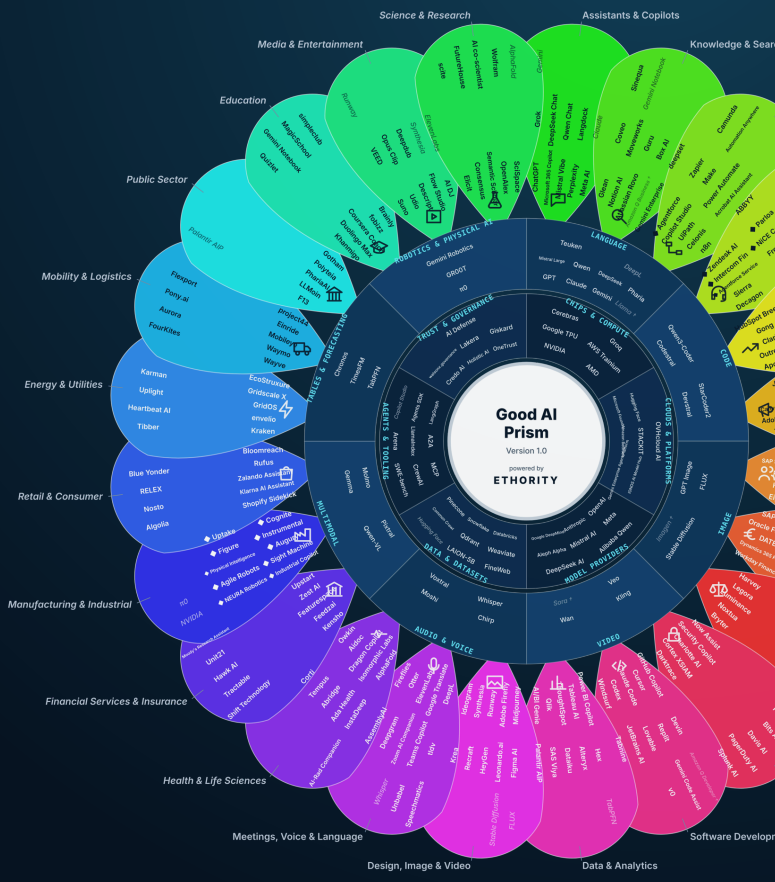
ETHORITY
AI BUSINESS OPERATING SYSTEM



GOOD AI PRISM · STUDY 2026/27 · US EDITION · FOR GOVERNMENTS, PAYERS AND CARE PROVIDERS

AI for care in an ageing America

How US hospitals, home care and long-term care can use AI and robotics to give time back to care, what China, Japan, the Nordics and Germany are doing, and what it means for Medicare, Medicaid and families.

63m
family caregivers in the US, nearly one adult in four (AARP/NAC, 2025)

600,000+
people on Medicaid home-care waiting lists in 41 states; average wait 32 months (KFF, 2025)

2.2×
growth of the US population aged 80+ by 2050: 14.8 to 32.9 million (UN WPP 2024)

Created by Sten Franke with a people and governance lens by Severin L. Wilson · October 2026

AT A GLANCE

America’s care gap is a family, budget and workforce question at once

The US is ageing more slowly than Japan, Germany or China, but its care system leans on unpaid family carers, a stretched direct-care workforce and Medicaid budgets. AI and robotics will not replace carers; used well, they give carers time back, help people stay at home and make care budgets go further.

This edition combines UN population projections with federal statistics (Census Bureau, CMS, BLS, ASTP/ONC), association surveys and programme data, and compares the United States with China, Japan, the Nordics and Germany. It maps 34 vendors in clinical AI and care technology, shows where the evidence is strong and where it is still thin, and sets out an agenda for federal and state governments, payers and providers.

61.2m
Americans aged 65+ in 2024, 18.0% of the population and up 13.0% since 2020 (Census Bureau)

11
states where people aged 65+ outnumber children, up from 3 in 2020 (Census Bureau, 2024)

7.4m
Americans aged 65+ living with Alzheimer’s disease in 2026 (Alzheimer’s Association)

$1.01trn
yearly value of unpaid family care: 49.5 billion hours at $20.41 (AARP, 2026)

760,500
openings a year for home health and personal care aides to 2035 (BLS)

71%
of US hospitals use predictive AI built into their health record (ASTP/ONC, 2024 data)

About this study

Population figures are UN World Population Prospects 2024, medium variant, calculated from the UN data package; US Census figures are cited where named. Care, cost and programme figures name their source and date; association and industry surveys are labelled as such. Vendor facts come from vendor or public sources. Not legal or medical advice.

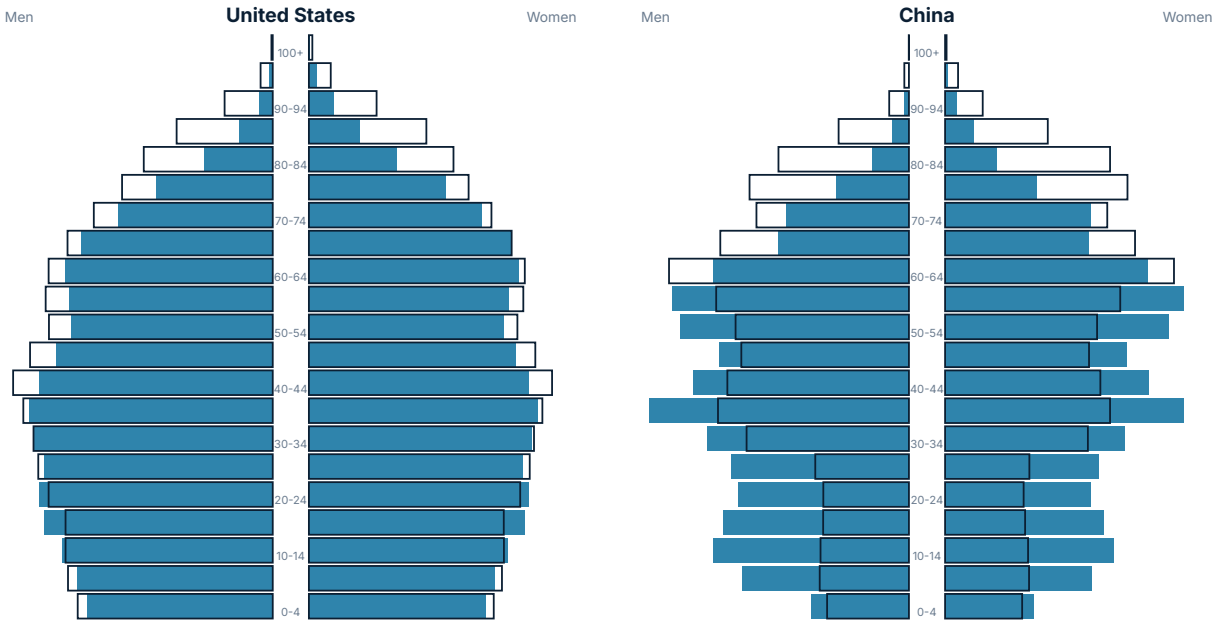
THE DEMOGRAPHIC TURN

Two pyramids: America ages, China ages faster

The US population keeps growing to 2050, yet its oldest groups grow fastest. The share aged 65+ rises from 18.6% to 23.2%, and the number aged 80+ more than doubles from 14.8 to 32.9 million. China starts younger and ends older: its 65+ share doubles from 15.0% to 31.2% and its 80+ population grows from 37.6 to 135.1 million. Both countries face the same question: who cares for the oldest old.

Exhibit 1 · Population by age and sex, 2025 and 2050

Bars: 2025 · outline: 2050 · men left, women right · scaled per country



UN World Population Prospects 2024, medium variant, 1 July; ETHORITY calculation from the UN data package

TEN PLACES COMPARED

The US ages later than Asia and Europe

The old-age dependency ratio counts people aged 65+ per 100 people aged 20–64. South Korea and Japan reach about 80 by 2050, Italy 76 and Germany 58. The United States reaches 42, close to Canada and the United Kingdom. That gives the US time, and lets it learn from countries that are already where it will be.

Exhibit 2 · Ageing in nine countries and the world, 2025 and 2050

COUNTRY	65+ 2025	65+ 2050	80+ 2025	80+ 2050	RATIO 2025	RATIO 2050
South Korea	20.9%	39.9%	5.0%	16.4%	32.3	80.7
Japan	30.1%	37.5%	10.7%	15.8%	55.6	79.2
Italy	25.4%	36.9%	8.0%	15.6%	43.6	76.1
Germany	24.0%	30.3%	7.4%	13.1%	41.7	58.2
China	**15.0%**	**31.2%**	**2.7%**	**10.8%**	**23.5**	**56.2**
Canada	20.5%	25.7%	5.1%	10.2%	34.7	45.9
United Kingdom	19.8%	24.8%	5.5%	9.2%	34.6	44.9
United States	**18.6%**	**23.2%**	**4.3%**	**8.6%**	**32.2**	**41.7**
Mexico	8.7%	17.1%	1.6%	4.5%	14.7	28.9
World	10.5%	16.4%	2.1%	4.7%	18.4	29.1

UN World Population Prospects 2024, medium variant; ETHORITY calculation

THE COST OF CARE

Federal, state and family budgets carry the load

CMS actuaries project national health spending to rise from $5.3 trillion in 2024 to $9.0 trillion in 2034, from 18.0% to 20.6% of GDP, with Medicare growing 7.7% a year. Medicare's hospital trust fund is projected to run out in 2033. Medicaid spent $228.6 billion on long-term services and supports in 2023, 64% of it on home and community care, yet more than 600,000 people wait for home-care waivers. Families carry the rest: unpaid care is worth about $1 trillion a year.

$9.0trn
projected US health spending in 2034, 20.6% of GDP, up from 18.0% in 2024 (CMS Office of the Actuary, Jun 2026)

2033
projected depletion of Medicare's hospital insurance trust fund (Medicare Trustees, 2026)

$228.6bn
Medicaid spending on long-term services and supports in 2023; 64% for home and community care (CMS)

32 months
average wait for Medicaid home-care waiver services; more than 600,000 people waiting (KFF, 2025)

$129,575
median yearly cost of a private nursing-home room; in-home care $35 an hour (CareScout, 2025)

$409bn
total cost of dementia care in 2026, $263bn of it paid by Medicare and Medicaid (Alzheimer's Association)

THE WORKFORCE GAP

Not enough hands, and many of them family

The shortage of carers is the hardest constraint. Home health and personal care aides held 4.68 million jobs in 2025, and BLS expects 18% growth and about 760,500 openings a year to 2035, at a median wage of $17.21 an hour. A third of home care workers are immigrants, which ties care capacity to immigration policy. Behind the paid workforce stand 63 million family caregivers, six in ten of them in paid jobs themselves.

Home care aides	**4.68 million**	jobs in 2025, +18% to 2035; median pay $17.21 an hour (BLS)
Openings	**760,500 a year**	for home health and personal care aides, 2025–35 (BLS)
Direct care	**9.7 million**	job openings to fill across all direct care settings, 2024–34 (PHI, 2025)
Immigrant share	**33%**	of home care workers; 24% of residential care aides (PHI, 2025)
Family carers	**63 million**	unpaid caregivers; nearly 1 in 4 give 40+ hours a week (AARP/NAC, 2025)

AI IN CLINICS

US hospitals adopt AI at scale; China plans it nationally

AI is now routine in US care delivery. 71% of hospitals used predictive AI built into their health record in 2024, and most of them check it for accuracy and bias. Physicians' use of AI more than doubled from 38% in 2023 to 81% in 2026. Ambient documentation spreads fastest: by mid-2025 it ran in 62.6% of hospitals on the leading health-record platform.

China plans the same shift top-down: a national plan of November 2025 aims for AI-assisted diagnosis in all primary care by 2030, and its regulator had approved 154 AI medical devices by mid-2025. Denmark shows the value of careful evaluation, with AI breast-cancer screening that cut the number of screening reads by a third while finding more cancers (Radiology, Jun 2024).

Exhibit 3 · AI adoption in US care, latest data

Three measures from three sources; not directly comparable

Hospitals with predictive AI in the health record	Physicians using AI	Hospitals with ambient AI (leading platform)
71%	**81%**	**62.6%**

ASTP/ONC Data Brief 80 (2024 data); AMA physician survey, Mar 2026; Yang & Graetz, AJMC, Jan 2026 (Jun 2025 data, peer-reviewed)

82%
of hospitals using predictive AI evaluate it for accuracy, 74% for bias (ASTP/ONC, 2024)

6 states
in CMS's AI-assisted prior authorisation model for traditional Medicare, 2026–31; a clinician reviews every non-approval

33
health-AI laws enacted in 22 states in 2026 to July (Manatt Health)

2030
target year for AI-assisted diagnosis in all Chinese primary care (NHC, Nov 2025)

AI IN LONG-TERM CARE

Where AI gives time back to carers

In long-term and home care, AI works in the background: it writes the care record from speech, watches over residents at night, dispenses medicines, calls patients and keeps older people company. The independent evidence is still thin. The table shows what has been measured and who measured it.

USE	EXAMPLE	MEASURED RESULT	EVIDENCE
Speech documentation in nursing homes	voize, Germany	−15 minutes per morning shift (−28%), 44 nurses in 14 homes	Pre-post study, vendor-affiliated author (JMIR, 2026)
Fall detection with smart lights	Nobi, in 79 care homes in England	32% fewer falls	Independent evaluation (Lancaster University, NHS)
Medication robot at home	Evondos, Finland	Home visits −89% to −92%; doses taken on time 97.7–99.0%	Non-randomised trial (BMC HSR, 2023); Finnish HTA (2019)
Companion robot	ElliQ, New York State Office for the Aging, 800+ older adults	95% reduction in loneliness reported	State agency report, self-reported (NYSOFA, 2023)
Patient-facing AI agents	Hippocratic AI, United States	More than 115 million clinical patient interactions; 50+ clients	Company-reported (Nov 2025); outcome studies pending
Care robots and jobs	Japanese nursing homes	More monitoring robots linked to more caregivers and lower turnover	Peer-reviewed (Labour Economics, 2025)

FIVE COUNTRY MODELS

Five ways to put AI into care

United States	PAYER AND MARKET	Medicare Advantage covers 55% of eligible beneficiaries; AI-assisted prior authorisation model in six states (2026–31); new remote-monitoring codes (2026); hospital-at-home under a Medicare waiver; ambient documentation and AI nurse agents at scale.
China	STATE-LED SCALE	National AI plan for health (Nov 2025), elder-care robot pilot 2025–27 with 32 projects, long-term care insurance for 308.5 million people, silver-economy policy (2024).
Japan	PAY FOR PRODUCTIVITY	Fee bonus per resident for homes using monitoring, intercoms and digital records (2024); ¥9.7bn subsidy for care technology (FY2025).
Nordics	MUNICIPAL WELFARE TECHNOLOGY	Sweden 82% night supervision, Norway 78% of municipalities with welfare technology, Finland medication robots, Denmark a legal basis for AI in elder care (proposed from Jul 2026).
Germany	INSURANCE-LED CATCH-UP	Hospital digitisation fund (€4.3bn), care digitalisation subsidy (40%, up to €12,000 per provider), law to cap care documentation (Nov 2025).

THE VENDOR MAP

34 vendors across clinical AI and care technology

The vendor landscape follows the country models: US companies grow with venture capital and payers and lead in ambient documentation and patient-facing agents; Chinese platform and robotics companies grow with state programmes, Nordic vendors with municipal procurement, Japanese industrial groups with subsidies.

Clinical AI and large models · 6

DeepSeek CN · Epic US · iFlytek Healthcare CN · Ping An Good Doctor CN · ScreenPoint Medical NL · Tencent Hunyuan CN

Documentation for doctors and nurses · 5

Abridge US · Dragon Copilot (Microsoft) US · Gosta Labs FI · Tandem Health SE · voize DE

Patient-facing agents and triage · 2

Corti DK · Hippocratic AI US

Monitoring, fall detection and telecare · 7

Careium SE · Kepler Vision NL · Nobi BE · Paramount Bed JP · Sensio NO · Tunstall UK · Vayyar IL

Medication robots · 1

Evondos FI

Companion and therapy robots · 2

ElliQ (Intuition Robotics) IL · PARO JP

Care, rehab and service robotics · 10

AgiBot CN · Cyberdyne JP · Fourier CN · FUJI (Hug) JP · Keenon Robotics CN · Panasonic (Resyone) JP · RobotGym CN · Siasun CN · Toyota (HSR) JP · UBTech CN

Home-care operations · 1

AlayaCare CA

Research pack, 22 Oct 2026 · vendor and public sources · names alphabetical within segment, not a ranking · extension research set for this study, not admitted to the Wave 1 market snapshot; overlaps with other maps, counts not additive

THE RULES

Rules that shape AI in US care

Federal: coverage	Medicare Advantage plans may use algorithms to assist coverage decisions but must decide on the individual patient (CMS, Feb 2024). The WISeR model tests AI-assisted prior authorisation in traditional Medicare in six states, with clinician review of every non-approval.
Federal: AI policy	Executive Order 14365 (Dec 2025) seeks a national AI policy framework and federal pre-emption of state AI laws; a DOJ task force reviews state rules.
California	AB 3030 (2025): AI-generated patient messages need a disclaimer and a route to a human clinician. AB 489 (Oct 2025): AI may not imply licensed oversight such as “R.N.” or “M.D.”.
Texas	SB 1188 (Sep 2025): practitioners must review AI-generated records and recommendations and remain responsible for decisions.
Illinois	HB 1806 (Aug 2025): bans AI-delivered therapy and therapeutic decisions; up to $10,000 per violation.
Nursing homes	CMS repealed the 2024 minimum staffing standards by interim final rule (Dec 2025); facility assessments remain required.
For comparison	EU AI Act: eligibility for public assistance and health services high-risk from Dec 2027; China: AI may not replace physicians in diagnosis.

What the rules mean for a project

Across jurisdictions the direction is the same: AI may support care and coverage decisions, but a person decides, residents and patients are informed, and data stays protected. Projects that build this in from the first pilot avoid rework later.

CONCLUSIONS

What the evidence adds up to

Ageing societies will not find enough carers. AI and robotics can give time back to care, if they are chosen on evidence, governed well and measured in hours returned. Six conclusions for decisions now.

1 **Treat AI in care as workforce policy**

Evidence. The US expects about 760,500 openings a year for home health and personal care aides to 2035; 63 million family caregivers carry much of the load.

What to do. Set targets in hours returned to aides, nurses and family carers, and plan every project with them. · The workforce gap

2 **Start where time is lost**

Evidence. Speech documentation saved 15 minutes per morning shift in German nursing homes; 82% of Swedish municipalities supervise nights digitally; smart lights cut falls by 32% in English care homes.

What to do. Measure a baseline, then pilot documentation and night supervision first. · AI in long-term care

3 **Ask for independent evidence**

Evidence. Much of the evidence in long-term care is vendor-linked or self-reported; Denmark and Sweden show what public evaluation looks like.

What to do. Fund evaluation with every purchase and publish the results. · AI in clinics; AI in long-term care

4 **Pay for productivity**

Evidence. Japan rewards care homes that use monitoring and digital records with a fee bonus; China scales through state programmes; the Nordics through municipalities.

What to do. Link payment to documented productivity and outcomes, not to the purchase of technology. · Five country models

5 **Keep a human decision**

Evidence. CMS requires Medicare Advantage plans to decide on the individual patient; the AI prior-authorisation model requires clinician review of every non-approval; 33 state health-AI laws passed in 2026.

What to do. Keep a clinician accountable for every coverage, care-level and treatment decision. · The rules

6 **Use AI to protect care budgets and families**

Evidence. Health spending is projected to reach 20.6% of GDP by 2034; more than 600,000 people wait for Medicaid home care; unpaid family care is worth about $1 trillion a year.

What to do. Target AI at what keeps people at home and shortens waiting lists, where budgets and families gain most. · The cost of care

THE PROBLEM

Care is not short of technology. It is short of time, hands and decisions that hold.

Providers, payers and governments face the same question: which AI gives carers time back, which is safe for residents and patients, and how to prove it to boards, regulators and families.

THE PROBLEM	WHAT WE SEE IN THE EVIDENCE	WHAT IT COSTS
Not enough hands	Home care needs about 760,500 new aides a year at a median wage of $17.21 an hour; a third of home care workers are immigrants.	**Care not delivered, waiting lists, burnout.**
Paperwork eats care time	Documentation, rostering and reporting take hours from every shift.	**Less time with residents and patients.**
Thin, vendor-linked evidence	Few independent studies; results often self-reported or vendor-affiliated.	**Purchases that do not deliver; lost trust.**
Fragmented funding and procurement	Subsidies, insurers, municipalities and providers each pay for parts of a solution.	**Pilots that never scale.**
Rules and trust	AI Act, data protection, residents' rights and staff participation apply together.	**Delays, resistance and rework.**

The question behind every project

What should improve, which options are credible, what evidence is missing, what implementation requires, and who owns the outcome?

HOW ETHORITY HELPS

From AI ambition to care time you can measure

ETHORITY helps care providers, payers and public bodies choose, govern and prove AI: from independent market evidence to decisions that can be defended and outcomes that can be measured in hours returned to care.

01
Discover
Find and qualify the opportunity: options, evidence, constraints and rules.

02
Create
Design and build the solution with your data, systems and people.

03
Run
Operate it responsibly, with owners, controls and support.

04
Improve
Measure against the objective and adjust.

05
Grow
Turn what was learned into new capability and value.

WHERE A PROJECT CAN BEGIN

AI opportunity case
One use, such as documentation, night supervision or rostering, assessed against evidence, cost and rules. It ends in a clear decision: pilot, redesign, expand or stop.

Vendor and evidence due diligence
Good AI Prism research profiles and comparisons, including the 34 vendors in this study, with a structured check of claims and evidence.

AI estate audit
An inventory of AI and care technology across sites and services, with owners, risks, costs and overlaps.

Governance and readiness
Each use mapped to the AI Act, data protection, residents' rights and staff participation, with proportionate controls.

AI literacy for carers and managers
Role-based training for nurses, aides and managers, with named overseers for alerts and decisions.

From pilot to operation
A pilot charter with baseline, threshold and stop conditions, then building and running the solution on ETHORITY's AI Business Operating System.

Who we work with

Health systems and hospital-at-home programmes, home-care agencies and nursing homes, Medicare Advantage and Medicaid plans, state agencies, care technology vendors and investors.

Start with one question. Talk to us: sten@ethority.ai · severin@ethority.ai · ethority.ai/ai-prism-study

THE AGENDA

What US governments, payers and providers can do now

Federal and state governments

- Treat AI in care as workforce policy: measure hours returned to care and to family carers.
- Use AI to shorten Medicaid home-care waiting lists, not only to cut cost.
- Fund independent evaluation and publish results, as Sweden and Denmark do.

Payers

- Pay for outcomes that matter: safer nights, fewer falls, longer life at home.
- Keep a clinician's decision on every denial, as CMS requires.
- Cover proven remote monitoring and support tools for family carers.

Care providers

- Start where staff lose most time: documentation, scheduling and night supervision.
- Involve aides, nurses, residents and families from day one; name accountable overseers.
- Count saved time only when it flows back into care and better pay.

WORKFORCE LENS

When agendas change quickly, the people side breaks first: half-adopted tools, skills that lag the system, employees who were not involved, and decisions no one owns. Plan adoption, training, employee participation and accountable oversight as part of every staged commitment, not after it.

Severin L. Wilson, workforce lens in the Good AI Prism Market Study 2026/27

PRACTICAL APPENDIX

Seven questions before AI enters a care home or a home-care round

Use these questions with providers, staff, residents and families before a pilot starts.

QUESTION	WHAT TO ASK	EVIDENCE TO REQUEST
Purpose	Which task loses most time today, and what should improve?	Baseline of time, quality and incidents
Evidence	Who measured the result, in which setting, and was it independent?	Study or evaluation report
Residents' rights	How are consent, dignity and privacy protected, including at night?	Information and consent process
Staff	Were carers involved, trained and, where required, the works council consulted?	Participation record, training plan
Data	Which data is collected, where is it stored, and who can see it?	Data protection impact assessment, contract terms
Oversight	Who acts on alerts and suggestions, and who decides?	Named roles, escalation rules
Measurement	How will hours returned, falls, quality and satisfaction be counted?	Measurement plan, review dates

PILOT CHARTER: AGREE IT BEFORE THE PILOT STARTS

Scope and duration
Process, users, volume and weeks

Success threshold
The result that justifies scaling

Quality controls
Who reviews what, how errors are recorded

Budget ceiling
Total spend, including integration and review

Stop conditions
Results or incidents that end it early

Decision date and owner
When go or stop is decided, and by whom

A pilot without a threshold and a stop condition cannot fail, and so cannot prove anything. ETHORITY recommendation, derived from the evidence in this publication.

ABOUT ETHORITY

From understanding markets to building AI capability

ETHORITY connects market intelligence, research and practical delivery to help organisations put AI to work. It is built as an AI1st organisation: humans and AI agents work on one AI Business Operating System, with the research, engineering and operations to build and run AI after the pilot. Its roots lie in the digital intelligence business Sten Franke founded in 2005, which combined monitoring, research and advisory work to help organisations understand changing markets.

The Good AI Prism is the entry point: research profiles, documented relationships and comparisons help users investigate their options. Advisory, governance and transformation work connect those options with an organisation's objectives, data, systems, people and operating conditions.

SELECTED REFERENCES AND PARTNERS SINCE 2005

Bosch · Bayer · BMW · Siemens · Mercedes-Benz · Coca-Cola · Deutsche Bank · T-Mobile · Telefónica o2 · DHL · EDEKA · AIDA Cruises

Selected historical references and partners from the group's market-intelligence and advisory heritage, in projects or through former group companies.

METHOD

Population data: UN World Population Prospects 2024, medium variant, calculated by ETHORITY from the UN data package; US Census Bureau figures where named. Care, cost, workforce and programme figures from CMS, BLS, ASTP/ONC, KFF, AARP, PHI, the Alzheimer's Association and peer-reviewed studies as cited; industry figures are labelled. Vendor set: 34 vendors from public and vendor sources, extending the Good AI Prism 2026/27 dataset. Not legal or medical advice.

MAIN SOURCES

- UN World Population Prospects 2024 (data package); US Census Bureau, Vintage 2024 and 2023 projections
- CMS Office of the Actuary, NHE projections 2025–34 (Jun 2026); 2026 Medicare Trustees Report (via KFF, CRS)
- CMS / Mathematica, Medicaid LTSS rebalancing brief 2023; KFF, HCBS waiting lists 2025; KFF, Medicare Advantage 2026
- BLS Occupational Outlook Handbook; PHI, Direct care workers key facts 2025
- AARP/NAC, Caregiving in the U.S. 2025; AARP, Valuing the Invaluable 2026; Alzheimer's Association, Facts & Figures 2026
- CareScout (Genworth), Cost of Care Survey 2025
- ASTP/ONC Data Brief 80; AMA physician AI survey, Mar 2026; Yang & Graetz, AJMC 2026
- CMS WISeR model FAQ; CMS MA FAQ Feb 2024; EO 14365; Manatt Health Q2 2026; state statutes (CA, TX, IL)
- NYSOFA ElliQ report; Lauritzen et al., Radiology 2024; Kajander-Unkuri et al., BMC HSR 2023; Schwabe et al., JMIR 2026
- NHSA, NHC and MIIT/MCA (China); MHLW (Japan); Socialstyrelsen, Meld. St. 11 (Nordics)

ETHORITY
AI BUSINESS OPERATING SYSTEM



FROM BUSINESS AMBITION TO AI THAT WORKS

Put AI to work, with evidence.

ETHORITY helps organisations choose, govern and prove AI: from independent market evidence to decisions that can be defended and outcomes that can be measured.

CONTACT



Sten Franke
Founder, Principal Architect & Lead Creator
sten@ethority.ai
linkedin.com/in/stenfranke



Severin L. Wilson
Chief Business & Transformation Officer
severin@ethority.ai
linkedin.com/in/severinwilson

STUDY REPOSITORY AND UPDATES

ethority.ai/ai-prism-study

ethority.ai

THE ETHORITY STUDY SUITE

01	**Put AI to Work: The Good AI Prism Global Market Study 2026/27** Global edition · EN and DE	
02	**Put AI to Work: The Good AI Prism Market Study 2026/27** Germany–US focus · EN and DE	
03	**Good AI Prism sector briefs 2026/27** HR & Workforce · Health & Life Sciences · Financial Services & Insurance · Public Sector · Education · Energy & Utilities · Mobility & Logistics · Global EN and DE	
04	**AI for Care in Ageing Societies** Study 2026/27 · EN, DE, US and Global editions	YOU ARE READING
05	**AI in Pharma, Biotech and Longevity** Study 2026/27 · Global EN and DE	
06	**The Social Media Prisma 2009–2025** Historic paper · EN and DE	

© 2026 ETHORITY & STEN.AI LLC · San Francisco HQ · European operations: Hamburg, Germany · ethority.ai
AI for Care in Ageing Societies · US edition · Good AI Prism study 2026/27 · Edition 1.2, 22 October 2026 · All rights reserved. Exhibits may be quoted with source attribution.