Re:State

BEYOND CARING

A new funding model for later-life social care

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ABOUT RE:STATE

Re:State is established as the leading Westminster think tank for public service reform. We believe that the State has a fundamental role to play in enabling individuals, families, and communities to thrive. But our vision is one in which the State delivers only the services that it is best placed to deliver, within sound public finances, and where both decision-making and delivery is devolved to the most appropriate level. We are committed to driving systemic change that will deliver better outcomes for all.

We are determinedly independent and strictly non-party in our approach. This is reflected in our cross-party Advisory Board and our events programme which seeks to convene likeminded reformers from across the political spectrum.

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ABOUT RE:IMAGINING THE STATE

After a decade of disruption, the country faces a moment of national reflection. For too long, Britain has been papering over the cracks in an outdated social and economic model, but while this may bring temporary respite, it doesn't fix the foundations. In 1942 Beveridge stated: "a revolutionary moment in the world's history is a time for revolutions, not for patching." 80 years on, and in the wake of a devastating national crisis, that statement once again rings true. Now is the time to fix Britain's foundations.

Re:State's programme, 'Re:Imagining the State', puts forward a bold new vision for the role and shape of the State. One that can create the conditions for strong, confident communities, dynamic, innovative markets, and transformative, sustainable public services.

'Re:Imagining Health' and 'Re:Imagining the Local State' are two of the major work streams within this programme.

ABOUT RE:IMAGINING HEALTH

This paper is part of the 'Re:Imagining Health' work stream. While the National Health Service was once visionary, as demand rises and outcomes deteriorate, a fundamental rethink is needed. The current model no longer works for patients, who too often struggle to access high-quality timely care; for medical staff, who feel disempowered, stressed, and burnt out; or for taxpayers, who foot an increasing bill for a service which is struggling to cope. Simultaneously, social care, always the junior partner, remains woefully underfunded, with deep geographical disparities, vast unmet need, and a workforce that is underpaid, undervalued, and suffering from excessive vacancies. In short, the structures and institutions designed to meet the challenges of the post-war world are not equipped to deal with our current and future health and care challenges.

'Re:Imagining Health' seeks to explore how to transform England's approach to health and care. It will consider how to move from a treatment-oriented model to one geared towards health creation, the changes necessary in healthcare to facilitate this, and how to build a fair and sustainable approach to funding across health and care.

ABOUT RE:IMAGINING THE LOCAL STATE

This paper is also part of the 'Re:Imagining the Local State' work stream. English local and regional government stands at a turning point. There are signal opportunities for local innovation, close community engagement, and ambitious devolution of powers and responsibilities from the centre. There are also unprecedented challenges, driven by years of fiscal retrenchment, rocketing service demand, and a growing democratic deficit. This programme will develop policy ideas for the future of devolution, the role of communities, and the structures, practices, and leadership of local government itself. This report sets out an alternative model for the future of Adult Social Care for older people.

Re:Imagining the Local State Advisory Group

Re:State is grateful to the expert members of the 'Re:Imagining the Local State' Advisory Group who provide invaluable insight and advise on the programme. Their involvement does not equal endorsement of every argument or recommendation put forward.

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- Professor Yvonne Birks, Professor of Applied Social Care Research, University of York
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The arguments and any errors that remain are the authors' and the authors' alone.

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Recommendations

Recommendation 1: England's adult social care funding model should distinguish between working-age (adults pre-retirement age) and later-life (retirement age or older) adult social care need, with separate funding models for each.

Recommendation 2: A social insurance scheme, where individuals contribute to a pooled, privately-managed and invested Later Life Care Fund, should be introduced to fund state-funded later-life social care, ultimately replacing the funding of adult social care through council tax and general taxation. This would be a mandatory scheme in which 34-year-olds are required to contribute 1.8 per cent of their pre-tax income (above a minimum income threshold of £6,240, the lower earnings threshold for pensions auto-enrolment) to the national-level Fund, every year until they retire. This Fund would be invested over time, with an explicit mandate to maximise returns, then used to fund state-funded later-life social care for the contributing cohort.

Recommendation 3: Within the new system, when someone over retirement age has a social care need, they should undergo a needs assessment, carried out by their local authority, to determine the support they require. This needs assessment should be based on national standards. Anyone who has met the contributory requirements during their working life and is assessed to have a social care need should be eligible for state support, funded by the Later Life Care Fund.

Recommendation 4: Local authority means assessments should determine the total value of someone's savings, investments, income, and property. If someone owns property, this should be included in their means assessment, even if they or a spouse are and will continue living in the property. Based on individuals' wealth, they should be subject to co-payments for their later-life care needs.

Recommendation 5: Local authorities should be supported to carry out assessments of individuals' wealth through a standardised, consented data-sharing and verification framework, enabling them to avoid relying on onerous manual evidence collection alone. This framework should incorporate digital property ownership data from HM Land Registry services; streamlined access to HMRC income data; and information from other relevant departments and public bodies.

Recommendation 6: The prefunded social insurance scheme should be independently reviewed every five years, with its structure adjusted to target at least a 10 per cent sustainability buffer in the Fund based on latest usage, population, and demographic projections. This duty to review should be placed on a statutory footing and carried out by an independent review body. The model's components – including contribution rates, co-payment levels, eligibility thresholds and the protected capital floor – should be inflation adjusted each year, ensuring the sustainability and fairness of the model.

Recommendation 7: Government should progressively phase out, and ultimately abolish, the Social Care Precept as a funding mechanism for later-life care. As a new contributory regime is introduced, the later-life care element of the precept should be withdrawn for cohorts within that regime, with remaining legacy liabilities instead met through more equitable transition-funding measures.

Recommendation 8: This system should be arranged with a protective safeguard in place. This should take the form of a protected asset 'floor'. Contributing individuals with assets valued below £75,000 should not have to then also contribute towards their care costs at the point of usage, meaning they would have a co-payment rate of 0 per cent: the 'floor'.

Recommendation 9: If it becomes necessary to access the value of someone's home to pay for their or their spouse's later-life care needs, there should be a range of ways to unlock the equity without them having to move out of their home. This should include an expansion of the current Deferred Payment Agreement scheme, with resourcing available to local authorities to meet the costs of administration.

Recommendation 10: There should be an annual co-payment-free 'personal care allowance' for those of retirement age or older, pegged at 60 per cent of the full new State Pension level. Individuals would be entitled to care services costing up to this threshold entirely state-funded, without co-payments.

Recommendation 11: Individuals who cannot consistently work or who move to the UK later than the age of 34 should have pathways to eligibility for the full state-funded later-life care deal, including ways to 'buy in' to the system and to qualify for a substitute 'credit' if they can demonstrate inability to contribute.

Recommendation 12: Anyone aged 34 years or younger when contributions into the Later Life Care Fund begin being made should be required to contribute 1.8 per cent of their income (above the pension auto-enrolment threshold) to the national-level Fund during the contribution period (from ages 34 to 68), even if they will be unable to meet their overall contributory requirements.

Recommendation 13: For those who fail to meet the contributory requirements to access the full deal available through the proposed prefunded social insurance model, there should be a safety net offer in place. This safety net offer should be: a protected asset 'floor' that is equivalent in value to one fifth of the full deal, which would currently be £15,000; a flat co-payment rate of 70 per cent (until the individual reaches the asset floor); and no annual co-payment-free 'personal care allowance'.

Recommendation 14: To fund the transition period, Government should develop a package of transition-funding levies or tax changes, including the expansion of personal National Insurance contributions to the incomes of pensioners, and/or the creation of a high-value property levy to ensure greater contributions by the wealthiest homeowners and incentivise more down-sizing among older people.

1. Introduction

It is no secret that England's adult social care system is in crisis. Chronic underfunding, regional disparities, and distributive unfairness plague the system, undermining the accessibility and quality of care services. This crisis is only accelerating in the face of an ageing population and the growing cost of delivering care. Given such enormous complexity, this is a model in need of foundational transformation, not the tweaking of past decades.

In England's current model, access to state funding for care services is premised on demonstrating an individual's need for social care first, then a financial means assessment, with only low-wealth individuals eligible for support. The basic intention is that those who can afford to pay for their care should do so, with state support reserved for those who cannot.

In practice, however, the system functions very differently. Public expectation remains that such care, like healthcare, should be free at the point of use; wealth accumulated in later life, particularly housing, is difficult to unlock; and many people just above the means-test thresholds face catastrophic costs without protection. The result is a system widely seen as unfair and unsustainable, both for individuals and for the councils that must deliver it.

Individuals, families, local authorities and care providers are all facing increasing financial pressures due to an unsustainable funding model. Local authority spending on care provision has soared, in absolute terms and as a proportion of their expenditure on services: a significant cause of increasing numbers of local authorities declaring 'bankruptcy' in recent years.[1] At the same time, providers are struggling to maintain adequate staffing levels and service quality, due to the rising costs of delivering care.

The current model of funding has significant, unfair structural consequences. Local authority budgets, highly dependent on each council's revenue-raising abilities, largely dictate funding availability, leading to significant geographic disparities in access and quality of provision. Individuals are not being protected from catastrophic personal costs, resulting in many having to drain their savings, assets and sell their home in order to fund care. Local authorities are facing increasing fiscal pressures to deliver their statutory social care responsibilities as a result of demographic and cost of care trends, harming the other services they provide. All the while, unmet need for social care keeps growing.

At every point in the system and for many involved, the funding model is failing. A new approach is desperately needed, one that is sustainable and fair. Addressing these challenges and transforming the funding of adult social care is not only a policy challenge; it is a moral imperative to ensure adequate support and dignity for those requiring care, as well as preventing further erosion of the legitimacy of the social contract between citizen and state.

The current Government has pledged to deliver a National Care Service, one of its flagship manifesto commitments, and the Independent Casey Commission, tasked with delivering this National Care Service and making recommendations to deliver a sustainable long-term model, is now well underway.

Yet successive governments have made similar promises of action, only to underdeliver or backtrack in the face of political and fiscal pressures. As the severity and visibility of the

[1] The Chartered Institute of Public Finance and Accountancy; Infoshare+, *CIPFA Infoshare+ Financial Resilience Index 2025* (2026).

system's failures has continued to grow, the perceived cost of reform has continued to outweigh the cost of inaction. This must change.

The adult social care system is on the brink of collapse. Meanwhile, the burden of its provision contributes to wider, unmanageable costs borne by the NHS, in avoidable hospital admissions and delayed discharges, and by local authorities, struggling to afford to provide other statutory local services. In this context, the case for urgent, transformational reform has become all but undeniable.

In order to outline what such reforms should look like, this paper begins by outlining the current model and its consequences, exploring previous attempts at reform, and analysing international approaches. This brings into question the fact that working-age and later-life care are funded via a single model, under the umbrella of 'adult social care', despite the significant distinctions between the two types of need.

In 2024-25, there were 344,535 working-age recipients of state-supported social care,[2] representing less than 30 per cent of the total number of people receiving state-funded adult social care, but accounting for 48 per cent of the total spend.[3] For working-age versus later-life care, there are fundamental differences in: the nature of care needs arising, the inefficiencies and problems plaguing the current system, and best practice.

Recognising this, *Re:State* recommends wholly distinct funding models for working-age and later-life social care, distinguishing between these two areas of public service in much the same way as it is normalised to differentiate children's social care services. With this as the starting point, this paper outlines a new funding model for later-life social care.

Inspired by systems used in other countries, this paper argues that the new model for funding later-life social care should be a type of social insurance. In this model, working-age adults should make mandatory contributions to a Later Life Care Fund from the age of 34. This Fund will be privately managed, then used to fund their own cohort's care needs in later life.

The fairness of this social insurance model is underpinned by the predictability of some degree of social care need in later life. As many as four in five 65-year-olds may ultimately need some amount of social care.[4] It is reasonable that working-age adults should prepare for and contribute to meeting the cost of their own likely future later-life care needs.

The Fund constructed by these contributions should not be used to pay for the care of current service users, known as pay-as-you-go models, as is the case with so many systems. Instead, this Fund should be operated as a privately managed and administrated investment pot, delivering value for money by benefiting from the aggregate growth of the private market over long-run investments.[5]

Recognising that individuals will have contributed towards their potential later-life care needs through their working life, the vast majority of later-life care costs that arise should be funded via the social insurance scheme – this is vital for the legitimacy of the proposed model.[6] Similarly, in recognition of the contributions individuals will have already made, and promoting

[2] Department of Health and Social Care, *Adult Social Care Activity Report, England: 2024 to 2025* (GOV.UK, 2025).
[3] Ibid.
[4] House of Commons Health and Social Care Select Committee, *Adult Social Care Reform: The Cost of Inaction; Second Report of Session 2024-25*, HC 368 (2025).
[5] Reform Think Tank, *Social Care: A Prefunded Solution* (2017).
[6] Ibid.

the deliverability of the proposed model, meaningful protections of some personal assets and the sustainable mitigation of catastrophic care costs should be part of the new funding model.

The time for incrementalism has long passed. This paper proposes a fair, sustainable and deliverable new model for funding later-life care. At its core, this would be a new social contract: one in which individuals contribute fairly to a system that will support them in later life.

2. Adult social care funding models

2.1 Defining social care

Adult social care, distinct from healthcare, refers to a wide range of services which are provided to support individuals to live independently and safely. Users of adult social care services are those who have difficulties with daily living, likely to be people who are older or who are living with frailty, a disability or an illness. This sort of support is provided to both working-age and later-life adults – working-age being adults pre-retirement age and later-life meaning those of retirement age (currently 66) or older.

The main types of adult social care services are:

- domiciliary care – provided in people's homes or place of residence (including prisons, for example);
- community care – provided in a community location which individuals travel to;
- residential care – provided in residential care and nursing homes;
- reablement services – helps people regain independence and capabilities, hopefully reducing their long-term care needs;
- information and advice; and
- support for carers – support for those providing care to a family member or loved one.

The type of care provided depends on the severity and type of needs of the individual, from personal care assistance such as washing and dressing, to intensive 24/7 residential home care.

Figure 1: Different types of care services

Domiciliary Care (home)	Community Care	Residential Care
Personal care, such as help washing, dressing and getting out of bed	Support in community day centres	Long-term care provided in a residential nursing or care home
Home adaptations and equipment aids, such as handrails or stair lifts	Transportation services	Short-term or 'respite' care provided in a nursing or care home
Meal delivery services	Support to access work, training, education or voluntary opportunities	Supported living accomodation
Provision of information and advice, often over the phone	Services for carers	

Source: King's Fund, *Key facts and figures about adult social care*, 2025; National Audit Office, *Adult social care at a glance*, 2018.

In England, social care services are primarily delivered by a highly fragmented market of private and charitable organisations which are commissioned by both the State and individual service users.

2.2 Goals of an adult social care funding model

The funding model for state-funded adult social care determines: the total funding available for the State to provide adult social care; who ultimately foots the bill for this funding; who is eligible for state-supported social care; and, for those eligible, how much care they are entitled to receive funded by the State. The consequences of a country's chosen funding model are therefore far-reaching – from the redistribution of wealth across regions, socioeconomic groups and generations, to the country's 'acceptable' level of unmet social care need.

Different countries, with their differing priorities, and differing political and economic contexts, therefore have highly varied funding models.

Goals of a funding model could include:

- avoiding, as far as possible, unmet social care need;
- protecting individuals against catastrophic personal care costs;
- providing a safety net for those unable to fund their own care;
- promoting equity in care provision;
- encouraging individuals to take personal responsibility for funding their own care needs; and/or
- ensuring a low tax burden.

Japan introduced a long-term care insurance system in 2000 which provides comprehensive care to those with care needs aged over-65 and to disabled individuals aged between 40 and 65 with care needs.[7] The introduction of this funding model, offering near universal care to those who need it, occurred alongside a commitment to create a positive view of ageing among the population.[8] This ageing population, widespread concerns about those with unmet social care needs extensively using health services (when social care services would be more appropriate and cheaper), and recognition of the informal care burden preventing especially women joining the workforce led to strong popular support for a new approach.[9]

In Germany, the introduction of a mandatory social insurance model to fund adult social care was politically and logistically deliverable because their health system was already a mandatory social insurance model.[10] As such, the population's views of the role of the State, social obligations and tax burdens aligned with the new funding model for adult social care.

2.3 Working-age and later-life social care need

Considering fair responsibilities for funding adult social care highlights key differences between social care needs in working-age adults (18 to retirement age) versus later-life adults (retirement age or older, currently over-65s).

A high proportion of working-age adults who will require state-funded care are born with a severe disability or health condition. These adults are unlikely to be able, nor is it reasonable to expect them to, contribute towards the cost of their social care needs. For those who enter adulthood without a social care need, such a need arising during their working-age life is highly unlikely and nearly always unpredictable. It is therefore unreasonable to expect individuals to

[7] Natasha Curry et al., *What Can England Learn from the Long-Term Care System in Japan?* (Nuffield Trust, 2018).
[8] Ibid.
[9] Ibid.
[10] Deutsche Sozialversicherung Europavertretung, *History of Social Insurance*, 2023.

save or be prepared for such a need arising. As a result, it is appropriate working-age social care needs are funded by the State.

On the contrary, some degree of social care need arising in later life is known to be very likely – four in five 65-year-olds will need social care before the end of their life.[11] Even though the intensity and duration of these care needs is varied and unpredictable, the high likelihood of some need makes it reasonable to expect working-age adults, if they are financially able, to save for and contribute to their likely later-life care needs.

Given this key distinction in the predictability of social care needs arising, as well as a host of differences in the type of need and issues facing the current system for working-age and later-life care, a 'fair' funding model for these two groups is different. The funding models for these two groups should therefore be separate.

An argument against separating the funding models for working-age and later-life adult social care is the 'cliff-edge' problem raised by the Dilnot Commission.[12] If eligibility for state support is different in the two models, it is likely some individuals with the same care needs for the same reasons will receive different levels of state support, just because one of them is working-age and the other later-life. Similarly, people receiving state support as working-age adults could see their support reduce when they enter the later-life model.

Previous *Re:State* work highlights this issue is entirely resolvable.[13] This previous work explains that welfare policy necessarily requires a network of rules, which can appear somewhat arbitrary, but this is the nature of welfare policy and the important part is ensuring these rules are as rational as possible.

One rationalisation – proposed by *Re:State* in 2017 – to resolve this cliff edge problem is separating the funding models based on the nature of the need, instead of an arbitrary age cutoff.[14] This could mean the later-life model is for those with age-related conditions, while the working-age model is for those with non-age-related conditions.

Alternatively, there could be a rule ensuring nobody will have their state support reduced when they 'age out' of the working-age model into the later-life model. This would protect those with a lifelong disability or condition who would be at risk of facing the cliff edge problem.

Recommendation 1: England's adult social care funding model should distinguish between working-age (adults pre-retirement age) and later-life (retirement age or older) adult social care need, with separate funding models for each.

[11] House of Commons Health and Social Care Select Committee, *Adult Social Care Reform: The Cost of Inaction; Second Report of Session 2024-25*.
[12] Reform Think Tank, *Social Care: A Prefunded Solution*.
[13] Ibid.
[14] Ibid.

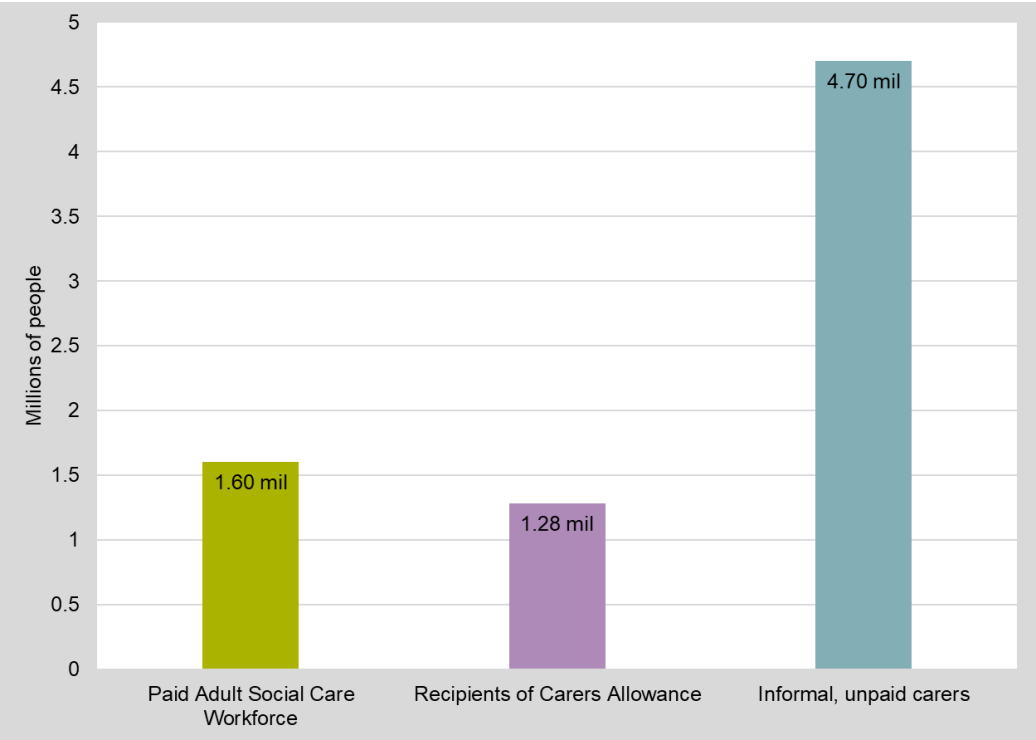
2.4 Different funding models for adult social care

2.4.1 England's model

2.4.1.1 Provision of care

The majority of social care in England is provided informally by family, friends and neighbours. However, where this is not available and/or when care needs are too extensive, formal care can be provided by the paid care workforce. Paid care may be personally funded or, in certain circumstances, may be fully or partially state-funded. As care needs become increasingly complex and intensive, individuals may need to move into residential care.

Figure 2: Those involved in delivering adult social care in England, 2024-25



Source: Skills for Care, *The state of the adult social care sector and workforce in England 2025,* 2025; Department for Work and Pensions, *DWP benefit statistics: August 2025,* 2025; Carers UK, *Facts about carers (last updated March 2025),* 2025.

Someone can only qualify for state-funded social care if they satisfy assessments of both needs and means. It is the responsibility of local authorities to carry out these assessments, as well as to arrange and fund care services for those who qualify.

The needs test determines the nature and extent of formal care someone requires. The means test determines how much of an individual's care will be funded by the State and how much they will be required to self-fund. The stringency of both tests has increased in recent years, meaning fewer individuals are eligible for support.[15]

[15] Antonella Bancalari and Ben Zaranko, *Adult Social Care in England: What Next?* (Institute for Fiscal Studies, 2024).

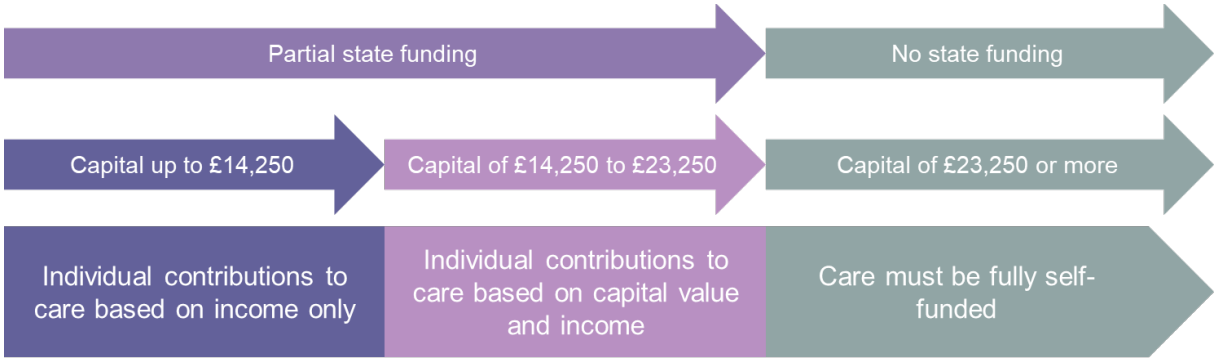
The means test assesses both capital (wealth) and income. The capital assessment includes the value of someone's savings and any property they own. If someone will need to continue living in the home they own while receiving care, or a spouse/partner will be living there, the value of their residential property is not included in the capital assessment.

If someone's capital is valued over £23,250, they must fund the full cost of their care. If someone's capital is valued between £14,250 and £23,250, their local authority will fund part of their care costs, and the individual must fund part of their care based on their income plus a 'tariff income' of £1 per week for every £250 of assets above £14,250. If someone's capital is valued under £14,250, their capital is ignored for means-testing purposes, but income is still considered. This means their local authority will fund part of their care and the individual must fund part of their care from their income.

The income assessment includes an individual's pensions, any earnings, and most benefits.[16] Individuals are required to contribute all of their income towards their care costs, until their remaining income reaches the protected minimum. If someone is receiving care in a care home, this protected minimum income is £30.65 per week for 2025-26 – known as the Personal Expenses Allowance.[17] If someone is receiving care other than in a care home, this protected minimum income is between £89.15 and £232.60 (based on age and circumstances) – known as the Minimum Income Guarantee.[18]

Both the lower capital threshold, £14,250, and the upper one, £23,250, have remained frozen at their 2010-11 levels, meaning they are increasingly less 'generous'.[19] In November 2025, these thresholds would be £21,259 and £34,686, if the original thresholds were inflation-adjusted.[20]

Figure 3: Means test thresholds to access state-funded adult social care



The *Care Act 2014* requires local authorities to assess someone's care needs against nationally set eligibility criteria.[21] Nevertheless, local authorities appear to interpret and implement this national criteria quite differently.[22]

[16] NHS, 'Financial Assessment (Means Test) for Social Care', Web Page, 4 July 2025.
[17] Department of Health and Social Care, *Social Care - Charging for Care and Support 2025 to 2026: Local Authority Circular* (GOV.UK, 2025).
[18] Ibid.
[19] David Foster, *Adult Social Care: Means-Test Parameters since 1997* (House of Commons Library, 2021).
[20] Using the Bank of England 'Inflation calculator' to calculate
[21] Department of Health & Social Care, 'Care Act Factsheets', Web Page, GOV.UK, 19 April 2016.
[22] Bancalari and Zaranko, *Adult Social Care in England: What Next?*

The proportion of self-funded and state-funded care varies between working-age adults and later-life adults. Among the former, most care recipients receive state support. This is because these individuals are likely to have had a disability or long-term condition their entire lives, limiting their ability to work, earn and save. For instance, 93 per cent of working-age adults who receive community care are state-funded, and 98 per cent of those in a care home for younger adults are state-funded.[23]

For later-life adults, the State funds a substantially smaller proportion of social care. Only around half (51 per cent) of these individuals in care homes receive state support, and 72 per cent of later-life adults who receive community care services are funded by the State.[24]

2.4.1.2 Funding sources

The state-funded adult social care system in England operates through a complex 'pay-as-you-go' (PAYG) funding model. Current working-age taxpayers fund the provision of state-funded adult social care today, both through council taxes and national taxation. In 2024-25, total expenditure on state-funded adult social care was £34.5 billion.[25]

Adult social care in England is chronically underfunded, and the costs of care are growing fast. The current model does not, and will not, meet existing need, even with increasingly stringent eligibility criteria. With a growing tax burden on working-age adults, such underfunding and unmet need erodes the legitimacy of both the funding model and the social contract it is understood to create between citizen and state.

[23] Office for National Statistics, *Estimating the Size of the Self-Funding Population in the Community, England: 2022 to 2023* (2023); Office for National Statistics, *Care Homes and Estimating the Self-Funding Population, England: 2022 to 2023* (2023).
[24] Office for National Statistics, *Care Homes and Estimating the Self-Funding Population, England: 2022 to 2023*; Office for National Statistics, *Estimating the Size of the Self-Funding Population in the Community, England: 2022 to 2023*.
[25] Department of Health and Social Care, *Adult Social Care Finance Report, England: 2024 to 2025*.

Figure 4: Estimated annual funding requirements for state-funded adult social care in different care provision scenarios, and the projected funding gaps (2024-25 prices)

Adult social care provision scenario	Estimated annual funding required
Meet future demand: meet the expected growth in demand from an ageing population and provide funding to local authorities to meet increased costs resulting from increased employer National Insurance contributions and National Living Wage	2025-26, £29.1bn *Forecast funding gap: £0.7bn*
	2029-30, £32.7bn *Forecast funding gap: £4.3bn*
	2034-35, £37.5 *Forecast funding gap: £9.1bn*
Meet future demand and improve access: meet expected future demand and increased costs (as above), and increase local authority budgets by 10 per cent to expand access to care	2025-26, £31.9bn *Forecast funding gap: £3.5bn*
	2029-30, £35.8bn *Forecast funding gap: £7.4bn*
	2034-35, £41.1bn *Forecast funding gap: £12.7bn*
Meet future demand, improve access and improve pay: meet expected future demand, increased costs and improve access (as above), and provide local authorities with additional funding to improve pay for care workers and improve the financial sustainability of the market	2025-26, £34.0bn *Forecast funding gap: £5.6bn*
	2029-30, £38.2bn *Forecast funding gap: £9.8bn*
	2034-35, £43.8bn *Forecast funding gap: £15.4bn*

Source: George Stevenson, Jack Elliott, Laurie Rachet-Jacquet, Lucinda Allen, and Hiba Sameen, *Adult social care funding pressures: 2023-35*, (The Health Foundation, 2025).

In England's PAYG system, local authorities are responsible for organising and funding the vast majority of state-funded adult social care. They receive central government grants earmarked for specific purposes, as well as using their revenue-raising capabilities. State-funded adult social care is also sometimes provided via national funding initiatives aimed at integration with the NHS or by the NHS themselves.

Local authorities

English upper-tier local authorities – County Councils, London Boroughs, Metropolitan Districts and Unitary Authorities – bear statutory responsibility for the provision of adult social care services.[26] These are primarily resourced through a combination of Council Tax and centrally allocated grants, as well as mandatory NHS contributions.

In 2024-25, English local authorities' total spending on adult social care reached £29.4 billion.[27] This accounted for around 20 per cent of all local authority spending on service delivery in 2024-25.[28] This is a substantial, growing and unsustainable financial burden (see section 3.1.1).

[26] Care Act 2014 (Part 1 Care and support).
[27] Department of Health and Social Care, *Adult Social Care Finance Report, England: 2024 to 2025*.
[28] Ministry of Housing, Communities and Local Government, *Local Authority Revenue Expenditure and Financing England: 2024 to 2025 – Second Release* (GOV.UK, 2025).

NHS

While the Department for Health and Social Care's budget is large and growing, most of its spending is consumed by NHS services. For instance, in the *Autumn Budget 2024*, social care was allocated an additional £600 million of grant funding for the next year, compared to £22.6 billion of additional annual funding granted to the NHS by 2025-26.[29]

This additional £22.6 billion for the NHS – adding to the running cost for just *one financial year* for the NHS – far exceeds the amount needed to reach even the most generous estimation of adult social care costings, as illustrated in Figure 4. To meet social care needs above and beyond what is done today – increasing local authority budgets by 10 per cent to improve access to care, and increasing budgets to cover better pay for care workers and shore up the care market's sustainability – would cost an estimated additional £5.6 billion in 2025-26.[30]

Better Care Fund

In order to improve integration between adult social care services and the NHS, as well as bolster support for local authorities, central government established the Better Care Fund (BCF) in 2013.[31] The BCF's purpose is fostering integration between health and social care, through pooled budgets between local authorities and the NHS, with a specific focus on reducing hospital discharge delays. The BCF helps local authorities in providing adult social care as a byproduct, but it is not designed for this specific purpose.

It initially provided £3.8 billon to support local health and social care services, although much of this was not new money and was largely drawn from existing CCG allocations.[32] For the 2025-26 period, the NHS must contribute a minimum of £5.6 billion to the BCF and local authorities must contribute the Local Authority Better Care Grant to the fund, a minimum of £2.6 billion.[33]

The BCF has helped to formalise joint working between health and social care, but its overall impact has been underwhelming. Some areas have seen improvements in discharge delays and emergency admissions, but these benefits have been inconsistent and localised with no lasting national reductions.

The underlying financial, geographical and cultural barriers, which have made historic collaboration between health and social care services difficult, persist. These include fragmented funding, and the differing boundaries of local authorities and Integrated Care Boards (ICBs).[34] Many BCF negotiations are therefore fraught, requiring external mediation

[29] HM Treasury, *Autumn Budget 2024* (2024).
[30] George Stevenson et al., *Adult Social Care Funding Pressures: 2023–35* (The Health Foundation, 2025).
[31] Department of Health; Department for Communities and Local Government, *Better Care Fund: Policy Framework* (2014).
[32] Richard Humphries, 'Reviewing the Better Care Fund: Time to Be Bold?', *The King's Fund*, 5 October 2018.
[33] Department of Health & Social Care; Ministry of Housing, Communities & Local Government, *Better Care Fund Policy Framework 2025 to 2026* (2025).
[34] Dan Peters, 'Councils and NHS Row over Better Care Fund Use', *The MJ*, 18 June 2024.

between the local authority and ICB.[35] Meanwhile, delayed discharges continue to be a systemic problem.[36]

NHS Continuing Healthcare

Under NHS Continuing Healthcare (CHC), introduced in 2007, the NHS is responsible for fully funding and coordinating any social care needs of individuals assessed as having a 'primary health need'.[37] A primary health need means the individual's health needs are the main reason for the social care they require.

Someone is likely to qualify for CHC if they primarily have needs of a medical nature requiring medical interventions, these needs are severe requiring significant support, a high level of skill is required to adequately manage this individual's care, and the individual's needs are at least somewhat unpredictable.

In 2024-25, 164,737 people were assessed as eligible for CHC, across both Standard and Fast Track referrals.[38] This is just under 15 per cent of the total number of recipients of state-funded adult social care services. In 2023-24, NHS spending on CHC totalled £6.5 billion – just over 4 per cent of the total NHS budget.[39]

Interviewees for this paper emphasised that applying for CHC is a complex, long and intimidating process and that many are unaware CHC exists. It is therefore likely that many who need CHC struggle to access it.[40]

It is very difficult to qualify for CHC. For example, less than a fifth of people assessed for Standard CHC were found eligible in October to December 2024.[41] Additionally, the numbers of discounted or rejected referrals have increased over the past decade.[42] The result is that many people with extensive health needs are found ineligible.

There's also variation in eligibility rates across England, which aren't fully explained by demographic factors or levels of deprivation in an area.[43] This suggests unfair access disparities, which interviewees for this paper raised as a problem. For example, 7.3 per cent of Standard CHC applicants are assessed as eligible in Gloucestershire ICB, compared to 42.5 per cent assessed as eligible in Leicester, Leicestershire and Rutland ICB.[44]

[35] Director of Strategy and commissioning Adult Social Care, *Better Care Fund 2024-25 Update* (London Borough of Camden, 2024).
[36] QualityWatch, *Delayed Discharges from Hospital* (Nuffield Trust, 2025).
[37] Department of Health & Social Care, *National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care* (2022).
[38] NHS England, *Continuing Healthcare and NHS-Funded Nursing Care – Quarterly Data* (2025).
[39] Elliot Bridges, *NHS Funding and Expenditure* (House of Commons Library, 2026).
[40] Rachel Hutchings et al., *All or Nothing? Access and Variation in NHS Continuing Health Care* (Nuffield Trust, 2025).
[41] Ibid.
[42] Ibid.
[43] Ibid.
[44] Rachel Hutchings et al., *Falling through the Gaps? A Closer Look at NHS Continuing Healthcare* (Nuffield Trust, 2024).

NHS-funded Nursing Care

NHS-funded Nursing Care (FNC) is a weekly contribution from the NHS, paid directly to a care home, to cover the cost of registered nursing care.[45] FNC is for those living in residential care who don't qualify for CHC.[46] Someone is only eligible for FNC if it is determined their needs would be most appropriately met in a care home with nursing.[47]

In 2024-25,123,339 people were assessed to be eligible for FNC.[48] The budget for FNC comes directly out of ICB budgets, and is not separately accounted for, making it challenging to assess the efficacy and value for money of FNC. This spending would typically be counted as part of broader spending categories, such as 'community services' or 'non-CHC adult social care'.

Central government grants

Nearly half of local authority expenditure on adult social care is financed by central government grants.[49] These grants include:

1. *Social Care Grant – £5.9 billion in 2025-26* [50]

   This grant is for both the provision of adult and children's social care services. It is entirely at the discretion of each local authority to determine the division of this grant between adult's and children's services. In 2024-25, approximately 60 per cent of the total grant was spent on adult social care.

   In the *Autumn Budget 2024*, the Government increased the Social Care Grant by £880 million, bringing the total to approximately £5.9 billion for 2025-26.

2. *Local Authority Better Care Grant – £2.6 billion in 2025-26* [51]

   This grant is a central government allocation to local authorities which they must contribute to the pooled budget of the Better Care Fund.[52]

3. *Market Sustainability and Improvement Fund Grant – £1.05 billion in 2025-26* [53]

   This grant is to be used by local authorities to build capacity in, and improve the market sustainability of, the adult social care sector.[54]

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[45] Department of Health & Social Care, *NHS-Funded Nursing Care Practice Guidance* (GOV.UK, 2022).
[46] Ibid.
[47] Ibid.
[48] NHS England, *Continuing Healthcare and NHS-Funded Nursing Care – Quarterly Data*.
[49] Ministry of Housing, Communities and Local Government, *Local Authority Revenue Expenditure and Financing England: 2024 to 2025 – Second Release*.
[50] Ministry of Housing, Communities & Local Government, *Social Care Grant Determination 2025 to 2026* (2025).
[51] Department of Health & Social Care; Ministry of Housing, Communities & Local Government, *Better Care Fund Policy Framework 2025 to 2026*.
[52] Ibid.
[53] Ministry of Housing, Communities & Local Government, *Market Sustainability and Improvement Fund Grant Determination 2025 to 2026* (2025).
[54] Department of Health & Social Care, *Market Sustainability and Improvement Fund 2024 to 2025* (2024).

The funds within this grant are a combination of the funding allocated directly to the Market Sustainability and Improvement Fund, and leftover funds from both the Market Sustainability and Fair Cost of Care Fund and the MSIF - Workforce Fund.[55]

4. *Disabled Facilities Grant – £711 million in 2025-26* [56]

This grant is to help local authorities fund home adaptations required by disabled individuals.

5. *Accelerating Reform Fund – allocated £42.6 million across 2023-25* [57]

This fund supports local authorities with projects that scale innovations in adult social care and improve services for unpaid carers.[58] Although the scheme was set up for two years, some funding is still available.[59]

6. *International Recruitment Regional Fund – £12.5 million in 2025-26* [60]

This grant is for regional partnerships, to help tackle unethical international recruitment and employment practices in the adult social care sector. Regional partnerships work with both impacted adult social care employees and with adult social care providers.

In November 2025, *The Fair Funding Review 2.0* confirmed a simplification of local government funding. This includes consolidating the majority of grants and funding flows from central to local government into one grant, the Revenue Support Grant (RSG).[61] Consequently, the Market Sustainability and Improvement Fund (3 above), Local Authority Better Care Grant (2 above), and the Social Care Grant (1 above) will be consolidated into the RSG for 2026-27.[62]

Given local authorities will (mostly) no longer be receiving funding which is hypothecated for adult social care, a new accountability mechanism will be introduced: for each local authority, an adult social care 'notional allocation' will be published alongside each annual Settlement Funding Assessment.[63] This 'notional allocation' will set out how much the government expects each local authority to spend on adult social care.[64]

Individual contributions

Individuals who do not qualify for state-supported care (Figure 3) have to privately fund their care needs, often placing individuals under intense financial pressure. There is no cap on the

[55] Ibid.
[56] Department of Health & Social Care; Ministry of Housing, Communities & Local Government, *Better Care Fund Policy Framework 2025 to 2026*.
[57] Department of Health and Social Care, *Evaluation of the Accelerating Reform Fund: Summary Report* (GOV.UK, 2026).
[58] Department of Health & Social Care, *Accelerating Reform Fund 2024 to 2025: Grant Determination No 31/7516* (2024).
[59] Social Care Institute for Excellence, *Accelerating Reform Fund* (2025).
[60] Department of Health & Social Care, *International Recruitment Regional Fund for the Adult Social Care Sector 2025 to 2026: Guidance for Regional Partnerships* (2025).
[61] Ministry of Housing, Communities & Local Government, *Consultation Outcome: The Fair Funding Review 2.0* (GOV.UK, 2025).
[62] Ministry of Housing, Communities & Local Government, *Consultation Outcome: The Fair Funding Review 2.0*.
[63] Ibid.
[64] Ibid.

amount individuals may ultimately be required to directly contribute toward their own care needs.

2.4.2 Alternative models

Internationally, there are a wide range of funding models for adult social care. These different models have distinct consequences. England's current funding model is quite unique, though has similarities with Medicaid in the United States.[65]

[65] Medicaid.gov, 'Eligibility Policy', Web Page, 2025.

Figure 5: Different types of funding model for social care

Funding model	Revenue raising mechanism	Separates demand types	Eligibility for state support	Examples	Pros	Cons
England's current model	National taxation (central government grants and NHS spending) and local (council revenue)	No, one funding model for working-age and later-life care	Based on both a needs and means assessment, otherwise self-funded	England	• The most in need are eligible for state support • Some public safety net in care provision	• Failure to pool risk leaving people vulnerable to facing catastrophic costs • Financially unsustainable • Vast and growing unmet need • Regional disparities in access and quality • Intergenerationally unfair
Pay-as-you-go social insurance model	Contributions from working-age or income-earning adults; funds current later-life care needs	Yes, separate funding models working-age and later-life care	Near universal provision of later-life care, often with (means-tested) co-payments	Japan Germany	• Effective societal risk pooling • Reasonably financially sustainable • Low unmet need, equity in care provision, and promotes a strong care market • A transparent and comprehensible model	• Increasingly financially unsustainable • Intergenerationally unfair • Individuals may still face catastrophic costs (albeit more slowly) • High transition costs
Universal model	National, regional or local taxation	No, one funding model for working-age and later-life care	Based on need, regardless of means, like the NHS	Sweden Denmark	• Effective societal risk pooling • Low unmet need, equity in care provision, and promotes a strong care market • A simple and comprehensible model	• Often financially unsustainability • Requires high taxation levels • Intergenerationally unfair
Partially universal model	National, regional or local taxation	Sometimes	Some care services are universally provided, and others are self-funded	Scotland	• Partial societal risk pooling • Reduces unmet need • Promotes equity in care provision for universally available care	• Often financially unsustainable • Requires high taxation levels • Intergenerationally unfair • Individuals still face catastrophic costs • Risk of inequity for non-universal services
Mixed social insurance and other model	Social insurance contributions, plus national, regional or local taxation	Yes, separate funding models working-age and later-life care	Eligibility combines elements of social insurance models and other models	Netherlands	• Effective societal risk pooling • Reduces unmet need • Promotes equity in care provision for universally available care	• Risks financial unsustainability • High taxation levels typically required • Intergenerationally unfair • Administratively complex
Private	Individuals must pay for their own care via private means	No, one funding model for working-age and later-life care	Incredibly limited state-supported care	United States	• Low tax burden • Encourages personal responsibility	• Lack of societal risk pooling • Substantial unmet need and inequities
Care cost cap	National taxation	No, one funding model for working-age and later-life care	Individuals self-fund their adult social care needs up to a set limit, after which care is state-funded	Proposed in England in various forms, never implemented	• Effective societal risk pooling • Protects individuals against catastrophic costs	• Often financially unsustainable • Unmet need below care cost cap level • The cap is universal, not progressive • Many who fund its provision (including those who end up with care needs) won't benefit from the cap's implementation
Prefunded social insurance model	Revenue raised as in a pay-as-you-go social insurance model; but funds are pooled for each cohort and privately managed, to then fund each cohort's later-life care	Yes, separate funding models working-age and later-life care	Near universal provision of later-life care needs, with co-payments based on ability to pay	Proposed in this paper	• Effective societal risk pooling • Strong financial sustainability • Low unmet need, equity in care provision, and promotes a strong care market • Most fair model across all measures • A transparent and comprehensible model	• Transitioning to this model will be politically and economically difficult • A double burden – meaning some will contribute to funding the old model and the new model or to funding the transition and the new model – is unavoidable • Individuals, with the financial means, may be exposed to significant care costs over time

2.4.2.1 Deep dive: Japan's model

Japan's long-term care insurance system, introduced in 2000, is a PAYG social insurance model. It offers comprehensive care to those with social care needs who are over-65 or who have a disability and are aged between 40 and 65.[66] Eligibility is based on need, with supplementary means-tested co-payments. Eligible individuals receiving care are required to make co-payments of 10, 20 or 30 per cent of the cost of their care services, with the rate dependent on a person's income.[67]

This system is funded through general taxation (approximately half of funding); mandatory contributions, known as premiums, for those 40 years and older; and co-payments by those receiving care. For those aged 65 and over, premiums are set and collected automatically from pensions by municipalities.[68] For 40- to 64-year-olds, premiums are set and collected nationally, typically at around 1.5 per cent of income, split between individuals and employers.[69] Funds are held at municipality level, with nationally collected funds allocated to the municipalities based on their proportion of over-65s.[70]

Japan's long-term care insurance model is reviewed by the Japanese government every three years to adjust national levers and ensure the system's longevity. Yet Japan's model has still struggled with fiscal sustainability. Consequently, in 2005, residential care was removed from universal entitlement. Service users must now self-fund residential care, paying a means-tested rate.[71] Co-payment rates, initially 10 per cent for all, were made progressive.[72] Insurance premiums have been increased at every review.[73]

Funds are not set aside in a dedicated investment 'pot', they are used to fund current service users.[74] This is therefore a PAYG social insurance model, not a prefunded one. Potential cost efficiencies and generational fairness (deliverable if premiums were set aside and privately invested) therefore fail to be capitalised on.[75]

2.4.2.2 Deep dive: Germany's model

In 1995, Germany introduced a mandatory long-term care insurance system, known as Pflegeversicherung.[76] This model is also a type of PAYG social insurance model. Germany funds universal basic long-term care, meaning the State only provides partial coverage for basic care needs. Individuals are expected to self-fund additional services to top-up provision, or apply for welfare if additional financial support is needed.[77] Provision for eligible individuals

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[66] Curry et al., *What Can England Learn from the Long-Term Care System in Japan?*
[67] Julien Forder and José-Luis Fernandez, *What Works Abroad? Evaluating the Funding of Long-Term Care: International Perspectives* (The London School of Economics and Political Science, 2011).
[68] PwC Worldwide Tax Summaries, 'Japan: Individual - Other Taxes', Web Page, PwC, 2 July 2025.
[69] Curry et al., *What Can England Learn from the Long-Term Care System in Japan?*
[70] Ibid.
[71] Ibid.
[72] Ibid.
[73] Ibid.
[74] Ministry of Health, Labour and Welfare, 'Long-Term Care Insurance in Japan', Web Page, 2002.
[75] Reform Think Tank, *Social Care: A Prefunded Solution*.
[76] Feather Insurance, 'What Is Long-Term Care Insurance (Pflegeversicherung)?', Web Page, 22 August 2024.
[77] Incisive Health, *An International Comparison of Long-Term Care Funding and Outcomes: Insights for the Social Care Green Paper* (Age UK, 2018).

is therefore far less generous than in Japan's system, indicating a different societal view of the role of the State and personal responsibility.

Germany's model also has far higher contribution rates than Japan's. All income-earning adults, including pensioners and under-40s, are required to make long-term care insurance contributions.[78] For employed individuals, their contribution will be between 2.6 and 4.2 per cent of their gross salary, up to a maximum income of €66,150, split with their employer.[79] Childless employees over 23 must pay a surcharge, on the basis that childless people are likely to require more formal care as a result of not having children to provide informal care.[80] Self-employed people and pensioners must make a contribution of 3.4 per cent, up to a maximum income of €62,100.

Germany has also struggled to ensure the fiscal sustainability of its model, with contribution rates frequently having to be raised, alongside an increasing financial demand on service users.[81] Demographic shifts are putting additional strain on the system making it difficult to maintain current levels of provision, despite an already less generous system than in Japan.[82]

As in Japan, Germany's model is a PAYG model with mandatory long-term care contributions being used to fund the current provision of social care, not a prefunded model. Again, this undermines the cost effectiveness and sustainability of the model, as well as resulting in a sense of intergenerational unfairness.[83]

[78] Feather Insurance, 'What Is Long-Term Care Insurance (Pflegeversicherung)?'
[79] Ibid.
[80] Ibid.
[81] Ricarda Milstein et al., *Germany's Difficult Balancing Act – Universality, Beneficiary Choice and Quality for Older Persons* (World Health Organization, 2025), https://doi.org/10.2471/b09373.
[82] World Health Organization, *Germany: Country Case Study on the Integrated Delivery of Long-Term Care* (2020).
[83] Reform Think Tank, *Social Care: A Prefunded Solution*.

3. Symptoms and challenges

3.1 Symptoms of England's funding model

England's funding model for adult social care is characterised by a number of problematic structural consequences. Some undermine the provision of both working-age and later-life social care, while others uniquely impact later-life care. Given already underway demographic shifts, these issues will only become more acute.

3.1.1 Impacting both working-age and later-life social care

3.1.1.1 Unmet need

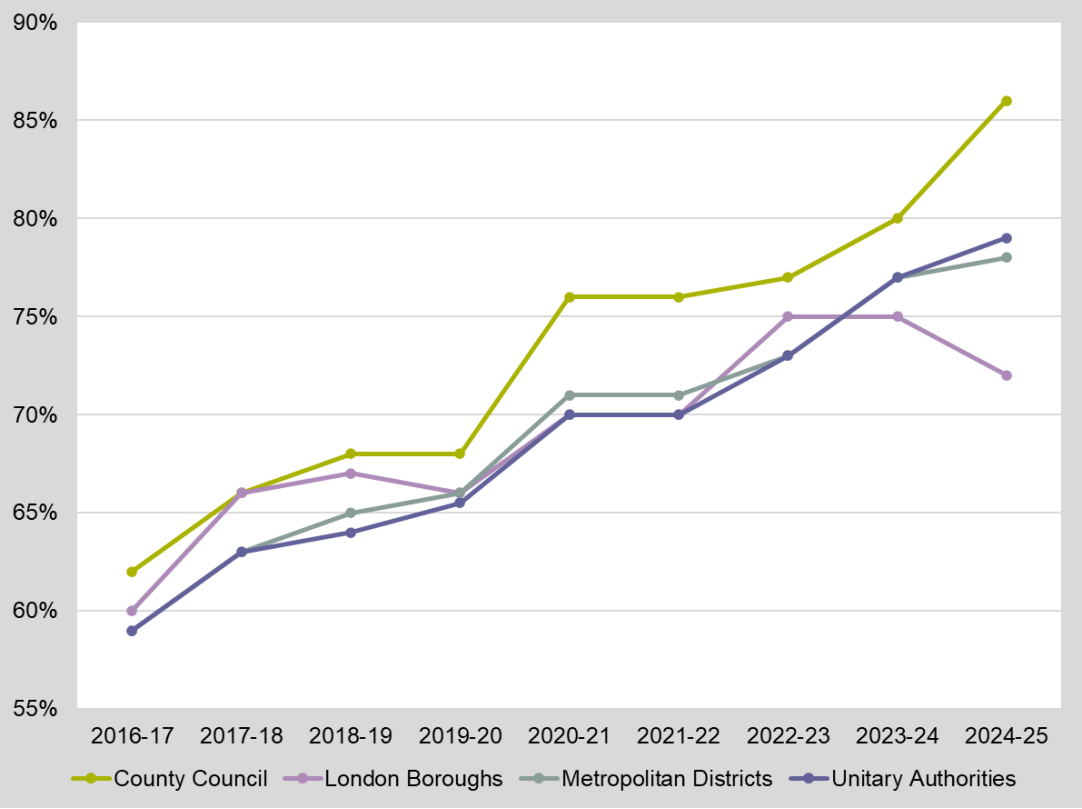
An ageing population, increasing need for adult social care across age groups, and increasingly stringent means and needs assessments has resulted in growing levels of unmet social care need. Here, when 'unmet need' is discussed, this refers to social care needs that are entirely unmet, under-met and wrongly met.

It is estimated over 2 million later-life and 1.5 million working-age adults are not accessing the social care they need.[84] Between 2017-18 and 2022-23, the number of new requests for state-supported social care services that did not result in a service being provided increased by 27 per cent.[85] This strongly indicates increasing levels of unmet need.

This unmet need is primarily the result of chronic underfunding in the system. This is true despite local authorities spending increasing amounts on adult social care provision, especially as a proportion of their revenue spending (spending on day-to-day service provision, rather than capital spending). Spending on social care provision is growing to an unsustainable point. In 2016-17, this accounted for just over 60 per cent of local authority net revenue spending, but reaching on average 78 per cent in 2024-25.[86]

[84] House of Commons Health and Social Care Select Committee, *Adult Social Care Reform: The Cost of Inaction; Second Report of Session 2024-25*.
[85] Care Quality Commission, *The State of Health Care and Adult Social Care in England 2023/24*, HC 274 (2024).
[86] The Chartered Institute of Public Finance and Accountancy; Infoshare+, *CIPFA Infoshare+ Financial Resilience Index 2025*.

Figure 6: The proportion of local authority Net Revenue Expenditure on social care provision (children's and adult) by authority type



Source: The Chartered Institute of Public Finance and Accountancy and Infoshare+, *CIPFA Infoshare+ Financial Resilience Index 2025*, 2026.

Increased spending on social care provision has been a significant factor in several councils entering 'bankruptcy' in recent years, as well as being the primary driver of ever-growing unmet care needs in England.[87]

Additionally, poor quality care services are far too common in England, implying inadequately met need throughout the system. The Care Quality Commission (CQC) – the regulator responsible for inspecting and rating the quality of care services – found one in six adult social care services fall below acceptable standards.[88] Chronic underfunding of state-funded adult social care, coupled with rising operational costs for providers, has squeezed profit margins, undermining service quality across the country.

3.1.1.2 Regional disparities

There is significant variation in access to state-supported care across England. Some of this is driven by factors which create appropriate differences in access. For example, an area with higher levels of deprivation is likely to have higher rates of later-life adults accessing state-supported care, due to a greater proportion of people who are likely to qualify for state-funded care based on the means assessments and higher levels of need in their area.[89] Similarly, an

[87] Dr Simon Kaye et al., *Back from the Brink: Radical Ideas for Sustainable Local Finances* (Reform Think Tank, 2024); Mark Sandford and Philip Brien, *Why Are Local Authorities Going 'Bankrupt'?* (House of Commons Library, 2024).
[88] The King's Fund, 'Social Care 360: Access', Web Page, 21 May 2025.
[89] Stuart Hoddinott, *Adult Social Care across England* (Institute for Government; Nuffield Foundation, 2025).

area with higher rates of self-reported disability is likely to have higher rates of access to state-funded social care.[90]

However, accounting for factors which appropriately drive differences in access to state-funded later-life care, geographical access disparities persist.[91] In local authorities with a higher proportion of their population which is over 65, later-life adults are less likely to receive state-funded care, even when factors which appropriately impact access are controlled for.[92] Highlighting this, the South West has the highest proportion of over-65s, 28 per cent, and the lowest rates of access to care for over-65s, 2.8 per cent.[93] In comparison, England's average rate of access to state-supported care for later-life adults is 3.6 per cent.[94]

This indicates local authorities are rationing care due to greater demand and there is local variation in the stringency of needs and means assessments. This postcode lottery is unfair and unacceptable.

Areas in England with higher levels of income deprivation see higher rates of many health conditions, indicating greater social care needs too.[95] Simultaneously, local authorities of areas with greater deprivation have a lower potential amount per head to raise from council taxes, including the social care precept.[96] For example, raising council tax by 1 per cent in Somerset and Bristol would return £2 million compared to £14-15 million in Hampshire.[97]

The consequences can be stark. The North East region has the fewest homecare services per 100,00 population of older people.[98] This is not the result of lack of demand. The North East had the highest proportion of delayed discharges from acute hospitals due to waiting for home-based care for nearly all of 2023-24.[99] Care England describes this access gap as a "structurally violent North-South divide".[100]

Self-funders pay significantly more for adult social care services than if those same care services are state-funded. This means running services is less profitable in areas where there are fewer self-funders, i.e. in areas of greater deprivation. There is evidence this can cause care providers to withdraw from these areas, as running a care service is not viable.[101] This contributes to insufficient availability of care services in areas with fewer self-funders, found to be "entrenching inequalities of provision and a north-south divide".[102]

This reality creates regional disparities in the quality of care services, as well as in access to care services. Only 2.3 per cent of care homes are rated outstanding by the CQC in the West

[90] Ibid.
[91] Ibid.
[92] Ibid.
[93] Ibid.
[94] Ibid.
[95] Carl Baker, *Health Inequalities: Income Deprivation and North/South Divides* (House of Commons Library, 2019).
[96] David Foster, *Adult Social Care Funding in England* (House of Commons Library, 2025).
[97] House of Commons Health and Social Care Select Committee, *Adult Social Care Reform: The Cost of Inaction; Second Report of Session 2024-25*.
[98] Care Quality Commission, *The State of Health Care and Adult Social Care in England 2023/24*.
[99] Ibid.
[100] Care England, *Bridging the Gap: Tackling Inequalities in England's Social Care Sector and Beyond* (2023).
[101] House of Lords Economic Affairs Select Committee, *Social Care Funding: Time to End a National Scandal; 7th Report of Session 2017-19*, HL Paper 392, page 22, 2019.
[102] Ibid.

Midlands, compared to 6.1 per cent of care homes in the Southwest.[103] And in the East Midlands, less than 70 per cent of care homes are rated good or outstanding, compared to nearly 86 per cent in the Southwest.[104]

Since council tax, one of the main funding sources for adult social care, produces a disproportionate tax burden in the North and areas of deprivation, the sense of injustice caused by these regional inequalities is deepened.[105]

'Equalisation' measures have therefore become a part of the Social Care Grant. This means local authorities with high social care needs and low revenue-raising ability receive a higher proportion of equalisation funding than those with low need and strong tax bases.[106] However, this equalisation mechanism is insufficient to resolve the structural inequalities and negative outcomes of the funding model, especially given chronic underfunding of the adult social care system.

Inequalities in accessing state-funded care seem to exist beyond regional disparities. Those less able to advocate for themselves, typically the most vulnerable in society, are often less able to access such services. Applying for state-funded care is a complex and bureaucratic process, and local authorities are facing significant waiting lists to access their different 'pots' of funding. Consequently, those most able to advocate for themselves, or with loved ones who can advocate on their behalf, are therefore usually better able to access state-funded care.

Interviewees for this paper highlighted this reality, and explained that it is an especially common issue for accessing NHS funding, such as NHS Continuing Healthcare. A fair funding model should have funding allocated based on need, not ability to navigate a complex system.

3.1.2 Uniquely impacting later-life social care

3.1.2.1 An insurance problem

Later-life social care provision is an insurance problem the private market is unable to solve.

While the high likelihood of having a social care need in later-life is predictable, the extent of these care needs is very unpredictable, with very high care costs reasonably frequent. It is estimated one in seven older people will have care costs over £100,000.[107] What's more, care needs are frequently long-term in nature, further extending the potential costs. These features of need make later-life care largely unsuitable for private insurance.

If available, individuals would purchase insurance to protect themselves decades down the line. As such, the policy landscape, extent of population need, costs of care services, and more could change substantially between an insurance product being purchased and a claim being made. This complexity and long-run nature of the risk is unappealing for potential insurers.

In 2021, an 'In Focus' report published by the House of Lords Library similarly found private insurers are adverse to providing such products due to "the difficulty of predicting future

[103] Fulcrum Care Consulting, *CQC Data Reveals Postcode Lottery for Outstanding Care*, 13 June 2025.
[104] Ibid.
[105] Martyn Brown, 'Unfair Council Tax Means North Pays 80% More than the South, Says Report', *The Express*, 24 February 2021.
[106] Department of Health & Social Care; National Audit Office, *Reforming Adult Social Care in England*, HC 184 (2023).
[107] House of Commons Health and Social Care Select Committee, *Adult Social Care Reform: The Cost of Inaction; Second Report of Session 2024-25*.

costs".[108] This report also identified the problem of adverse selection – meaning those with a higher risk of requiring social care are more likely to purchase private insurance – as a reason the private sector doesn't widely provide social care insurance.[109]

Additionally, interviewees for this paper consistently highlighted that individuals vastly underestimate the chance that they will have social care needs in the future. One interviewee explained this was even true for individuals recently diagnosed with degenerative conditions, such as Alzheimer's. Coupled with a lack of financial preparedness – the Department of Health found in 2015 that 71 per cent of adults had made hardly any or no preparations for the potential future need to pay for social care – this indicates there could also be very little demand for private insurance products.[110]

Some might argue that financial incentives, such as tax breaks, could be used to encourage take-up of private insurance products, making a private market viable. Analysis of pensions – a similar market with similar products and financial incentives, also impacted by under-preparedness – indicates financial incentives are often not effective enough. Recent research found about half of UK adults don't have a plan for their finances in retirement and just over 15 per cent are too confused or busy to even think about their pension.[111]

Given public awareness of the need to save for retirement is, though low, greater than awareness of the need to save for social care needs, it seems likely financial incentives to encourage take-up of private insurance for later-life care needs would be equally or less effective. It is plausible such products would primarily be taken up by wealthier, money-savvy individuals, who likely already have enough wealth to self-fund their later-life care needs. The case for private insurance, even if supported by tax breaks or other financial incentives to encourage uptake, as a solution is therefore weak.

All this means that later-life social care presents a market failure problem, not just a savings problem, and is therefore one only the State is in a position to solve.

3.1.2.2 Intergenerational unfairness

Younger (and future) generations face a disproportionate and growing financial burden, fuelled by demographic changes: an ageing population, increasing life expectancy but with proportionally fewer healthy years, and increasing working-age need for social care. The result is a shrinking taxpayer population responsible for growing state-funded social care need.

Simultaneously, England's care funding model tends to protect pensioner wealth at the expense of working-age adults, inadvertently deepening the relative impact on working-age adults. The end result is significant and growing intergenerational unfairness.

It is a fair social contract for current working-age taxpayers to fund the provision of care for current working-age adults with social care needs. Each cohort is responsible for funding this need among their own cohort.

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[108] Russell Taylor, *Social Care Funding: Improving the Availability of Private Sector Insurance Products* (House of Lords Library, 2021).
[109] Ibid.
[110] Ipsos MORI, *Public Perceptions of the NHS and Social Care: An Ongoing Tracking Study for the Department of Health, Winter 2014 Wave* (2015).
[111] '10.7 Million UK Adults Are Too Busy or Confused to Think about Their Pension', *Money and Pensions Service*, 5 November 2025; Demography team, *Population Estimates for the UK, England, Wales, Scotland and Northern Ireland: Mid-2024* (Office for National Statistics, 2025).

However working-age taxpayers are also responsible for funding state-funded later-life care, with the aforementioned redistributive consequences. As the number of later-life adults who require care grows and the length of time they are likely to require care for extends, the number of working-age taxpayers sustaining the system is in decline. This means a shrinking group of working-age adults have to shoulder an increasing financial burden, and for a later-life population who bore a much less disproportionate burden.

The different economic context current younger generations face, compared to current later-life adults, only exacerbates this unfairness. Millennials, born between 1981 and 1996, are the first generation to be worse off economically than their parents.[112] Only 40 per cent of those born in the early 1980s were homeowners by the age of 30, compared to 60 per cent of 1950s and 1960s cohorts.[113] Younger generations are also facing stagnant pay growth compared to previous generations, as well as weak personal pay progression.[114]

Meanwhile, one in four pensioners is a millionaire.[115] And pensioner incomes are forecast to exceed working-age incomes across the income distribution.[116]

The fairness of younger generations shouldering the expense of an unwieldy social care system is increasingly questionable.

3.1.2.3 Catastrophic costs

Many individuals fund the entirety of their social care needs, as well as many funding part of their care. This can create intense financial pressures. Some are required to spend down their assets over time in order to pay for their care. There is no cap on the amount individuals may be required to contribute to their care needs, and so people are susceptible to facing catastrophic costs.

Individuals will have contributed to funding state-funded later-life social care their entire working lives, many believing that if such needs arise for them, the State will support them. In reality, this expectation often goes unmet.

Further, self-funding individuals face higher care costs compared to those funded by local authorities. For instance, average weekly costs for self-funders in residential care are approximately £1,278, whereas local authorities pay around £908 for similar services; and the Competition and Markets Authority found that self-funders pay, on average, 41 per cent more than local authorities for care home places.[117] Such disparity paints a worrying picture in terms of the fairness and financial burden facing individuals requiring care.

Unless individuals have very limited assets, under the thresholds of the means test (Figure 3), or run their assets down to these thresholds, they have no option but to privately fund their care. Private insurance products, as discussed above, are not widely available.

Further, there seems to be a widespread lack of awareness and preparedness among adults in England for their potential future care costs. A recent survey conducted by YouGov found

[112] Molly Broome et al., *An Intergenerational Audit for the UK: 2023* (Resolution Foundation, 2023).
[113] Jonathan Cribb et al., *The Economic Circumstances of Different Generations: The Latest Picture* (Institute for Fiscal Studies, 2016).
[114] Broome et al., *An Intergenerational Audit for the UK: 2023*.
[115] Jessica Beard, 'One in Four British Pensioners Is Now a Millionaire', *The Telegraph*, 29 June 2022.
[116] Broome et al., *An Intergenerational Audit for the UK: 2023*.
[117] Department of Health & Social Care; National Audit Office, *Reforming Adult Social Care in England*.

that 57 per cent of adults in the UK have limited or no understanding of the social care system, and 77 per cent have taken no steps to prepare for long-term care needs.[118]

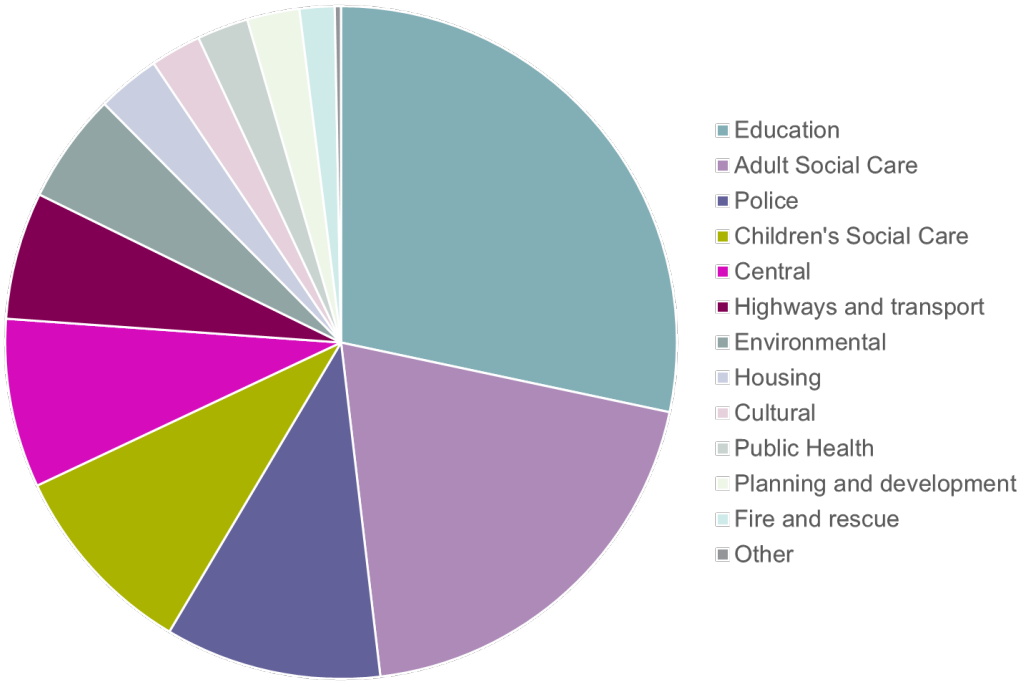
3.1.3 Other impacts

Local authorities are buckling under the costs of providing adult social care. ADASS (a membership organisation for local authority Directors responsible for state-supported adult social care services) found that 81 per cent of councils were on course to overspend their adult social care budget in 2024-25, up from 72 per cent in 2023-24 and 63 per cent in 2022-23.[119] ADASS findings also indicate that on current trends, all local authority adult social care budgets would be overspent within two years.[120]

These financial pressures risk local authorities being forced to deliver care in a slimmed down way. Recent data from ADASS reveals 74 per cent of Directors of Adult Social Care in local authorities have only partial or no confidence their budgets are sufficient to meet their legal duties relating to prevention and wellbeing within adult social care in 2025-26.[121] And local authority spending on adult social care prevention has dropped year-on-year since the pandemic, indicating this aspect of care is being delivered in a slimmed down way.[122]

The financial pressures also risk harming the delivery of other local government services, such as education, policing, roads, children's social care, housing, public health, and more.

Figure 7: Breakdown of local authority gross service expenditure, 2024-25



Source: Ministry of Housing, Communities and Local Government, *Accredited Official Statistics: Local Authority Revenue Expenditure and Financing England: 2024 to 2025 – Second Release*, 2025.

[118] Institute and Faculty of Actuaries, *Who Cares? Exploring Attitudes toward Social Care in the UK, 2025 Survey* (2025).
[119] ADASS, *2024 Autumn Survey* (2024).
[120] Ibid.
[121] ADASS, *2025 Spring Survey* (2025).
[122] ADASS, *2025 Autumn Survey* (2025).

Last year, the Health and Social Care Committee found that, due to the financial pressures being faced, many councils are being forced to provide "only the bare minimum" in other services.[123]

This means that citizens are contributing more in council taxes – often 5 per cent more each year – while getting less out of council-provided services.[124] This is frustrating and confusing, for some contributing to an erosion of faith in the social contract between themselves and the State, sometimes referred to as a 'democratic deficit'.[125]

3.2 Political context

Given all of the challenges discussed so far in this report, it may be surprising that this funding model is still in place.

3.2.1 The difficulty of reform

Despite widespread consensus the current model isn't working, and repeated promises to deliver change, no recent government has successfully transformed England's adult social care system. Recent governments' efforts have been characterised by numerous independent commissions; election pledges that end up diluted, delayed or cancelled; and public U-turns.

Accusations of 'kicking the can down the road' on adult social care reform have been levelled at many governments, including this Government. Despite their election pledge to create a 'National Care Service', their subsequent action has been the launch of the Casey Commission, set to report by 2028.

There are a number of reasons social care reform is frequently delayed.

Firstly, the system is chronically underfunded, meaning reform must be accompanied by a substantial funding boost to meaningfully transform the system. This necessarily requires increasing taxes, increasing borrowing or spending cuts, all of which would be politically painful. The widespread consensus that adult social care desperately needs more funding doesn't change the political difficulty of sourcing this funding.

This challenge was exemplified in 2022, when Boris Johnson's Government introduced a National Insurance increase of 1.25 per cent, to fund the commitments of the *People at the Heart of Care: adult social care reform white paper*.[126] This measure was reversed and scrapped only five months later by his own party under Liz Truss (Figure 8).

Yet overcoming the challenge of boosting funding for social care is only the first step. Spending alone won't solve the problems facing the system. Addressing the negative structural consequences of the funding model requires radical reform to the system.

The political difficulty of adult social care reform shouldn't be underestimated. Even when there is consensus around a specific problem of the system, this in no way translates to consensus around the solution. Any solution will require trade-offs and these are nearly always difficult

[123] House of Commons Health and Social Care Select Committee, *Adult Social Care Reform: The Cost of Inaction; Second Report of Session 2024-25*.
[124] Ibid.
[125] Ibid.
[126] People at the Heart of Care: Adult Social Care Reform White Paper (2021).

ones. Everyone agrees adult social care is underfunded, but disagree on how to increase its funding. Many have argued that uncapped care costs are unfair, resulting in some people depleting nearly all their assets to fund their care. Nonetheless, repeated attempts to introduce a lifetime cap on care costs have failed.

Investing in a better-funded adult social care system or in reforming the model can also be hard to justify in the difficult economic context facing the country. Justifying investing in adult social care, instead of investing in other public services or reducing taxes, is very difficult, despite the scale of crisis in adult social care.

Partly this is because only a small number of individuals are, at any one time, benefitting from state-funded care or have loved ones who are. Those benefiting from state-funded care are also not particularly visible, often worn down by the challenges of their or their loved one's care needs and the difficulty of accessing state-funded care.

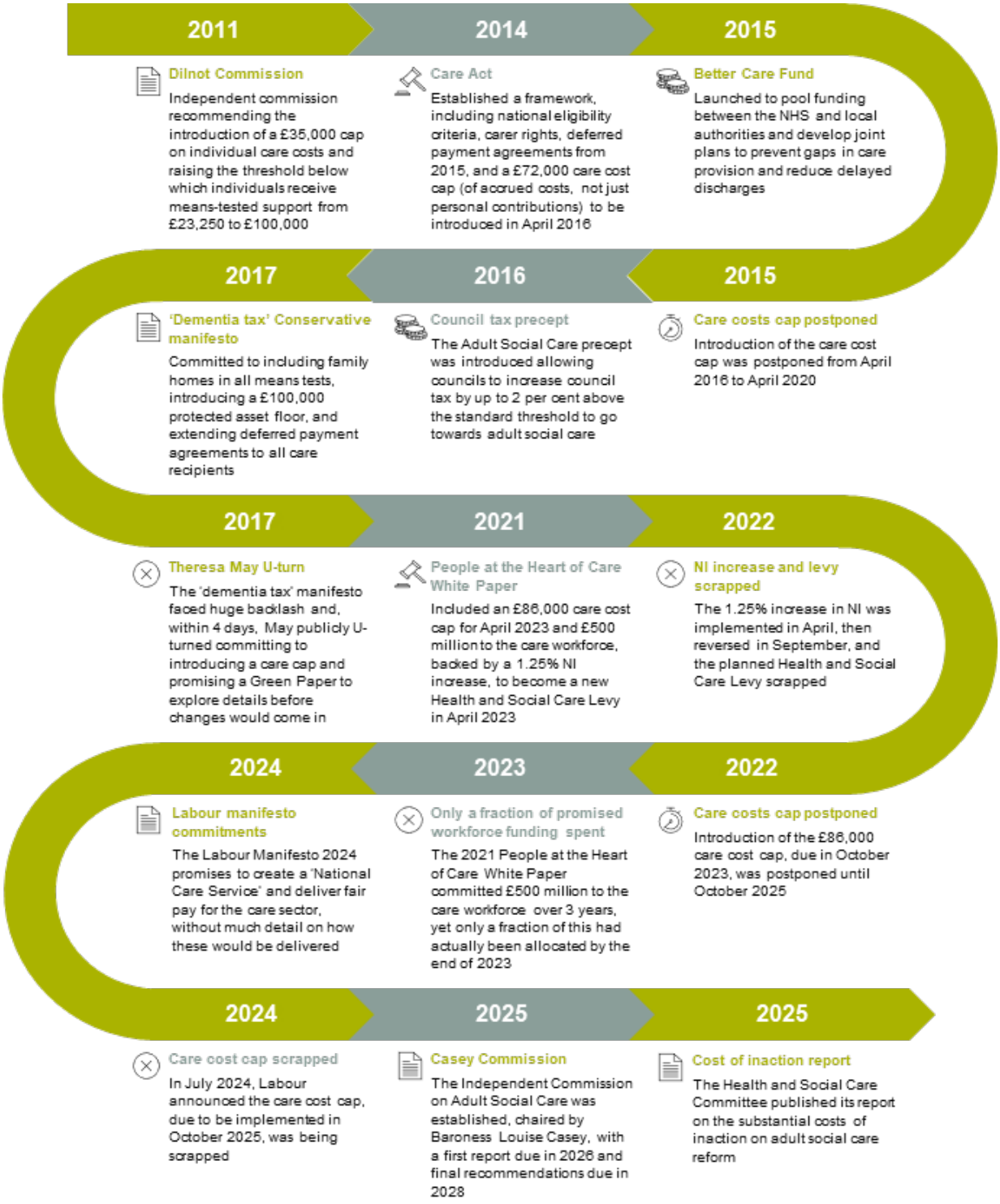
Successfully implementing adult social care reform is often a long-term endeavour, adding to the difficulty of doing so. Sometimes policymakers underestimate how long a transition will take. It is highly likely cross-party consensus will be needed for adult social care reforms to be successfully implemented, but achieving such cross-party support is not straightforward. Instead, policymakers sometimes rush to ensure reforms are enacted during their time in position.

Reforms have also failed because plans simply aren't good enough. This might apply to the policy itself or to the plan to implement the policy. Adult social care is an incredibly complex policy issue, making it hard to find a 'good' solution or reform. Inadequate policies can also be the result of policymakers underestimating the problem(s) or not understanding the full effects of their proposed reforms. A disconnect between on-the-ground local experiences and idealised central government perceptions of experiences contributes to this.

Lastly, insufficient capacity often contributes to the political difficulty of reforms. Insufficient capacity to build cross-party consensus to achieve lasting impact. Insufficient capacity to stress test proposed reforms adequately. Insufficient local authority capacity to implement new reforms.

Figure 8 demonstrates how difficult it is to deliver substantial reforms for adult social care, detailing repeated failed attempts. This is perhaps most evident in the repeated delays in implementing a cap on personal care costs – committed to in 2014 to be introduced in 2016, then delayed to 2020, then 2023, then 2025, and ultimately scrapped in July 2024.

Figure 8: Timeline of key actions to reform adult social care in England



There has often been a strong backlash to proposed reforms of adult social care funding, exemplified in 2017 when Theresa May's manifesto pledge was dubbed the 'dementia tax' and swiftly followed by a public U-turn (Figure 8). The belief that the public usually reacts negatively to proposed reforms of adult social care funding only adds to a lack of political

appetite for such action.

3.2.2 Current political context

The current Government committed in their 2024 manifesto to establish a Fair Pay Agreement in adult social care, without specific details or clarity on how this would be funded.[127] In September 2025, the Government announced a £500 million investment in the fair pay agreement.[128] Since then, the *Employment Rights Act 2025* established the power to create a national Social Care Negotiating Body which will be responsible for setting legally enforceable minimum standards for pay and working conditions.[129]

The Government also made a manifesto commitment to create a sustainable National Care Service.[130] There has been little detail on what this National Care Service will look like, beyond the manifesto claims it will be "underpinned by national standards, delivering consistency of care across the country" and services will be locally-delivered.[131] The Government has tasked the Independent Commission into Adult Social Care, chaired by Baroness Louise Casey, with determining a plan to implement this National Care Service. The Casey Commission is due to report these plans this year, 2026.[132]

The second phase of the Casey Commission will make longer-term recommendations to transform adult social care, including the funding model. Considering demographic changes, frontline service organisation, and alternative models, the commission will report by 2028 and make recommendations to "deliver a fair and affordable adult care system".[133]

Since 2023, the CQC have been carrying out assessments of how well local authorities are carrying out their adult social care responsibilities, per the *Care Act 2014*.[134] Once concluded, these assessments will shed public light on the quality of care provision across each local authority.

In June 2025, the Government's implemented their first policy change to the adult social care model. *The Fair Funding Review 2.0* stipulated central government grants to local authorities for adult social care will now be accompanied by a published 'notional allocation' detailing how much each local authority is expected to spend on adult social care.[135] It is hoped this, alongside future reforms, will improve local authority accountability in their delivery of adult social care.

3.2.3 Public opinion

In Japan and Germany, widespread public support for social care reform, recognising the system was in crisis, was crucial for the implementation of new funding models for later-life

[127] Labour Party, *Change: Labour Party Manifesto 2024* (2024).
[128] Department of Health and Social Care, '£500 Million for First Ever Fair Pay Agreement for Care Workers', Press Release, 30 September 2025.
[129] Employment Rights Act 2025.
[130] Labour Party, *Change: Labour Party Manifesto 2024*.
[131] Ibid.
[132] Department of Health and Social Care, *Independent Commission into Adult Social Care: Terms of Reference* (2025).
[133] Ibid.
[134] Care Quality Commission, *Assessment Framework for Local Authority Assurance* (2025).
[135] Ministry of Housing, Communities & Local Government, *Consultation Outcome: The Fair Funding Review 2.0*.

social care.[136] Polling at the start of 2025 indicated that over three-quarters of people in England are unaware of Labour's manifesto promise to create a National Care Service.[137] The lack of public awareness around Labour's commitments makes the sort of widespread public support seen in Japan or Germany ahead of reform highly unlikely. This will make delivering substantial reforms more difficult.

3.3 Fundamental principles for a new model

It is clear England's funding model for later-life social care is unfair, unsustainable and unfit for purpose, beyond being chronically underfunded. Radical transformation of the system will be difficult, but it is clear a new funding model is desperately needed.

The new model should deliver on four key principles: risk pooling, sustainability, fairness, and deliverability.

3.3.1 Risk pooling

Later-life social care need is an insurance problem that only the State is in a position to address (as explained in subsection 3.1.2.1). Despite the likelihood of individuals having some later-life care needs being predictable, the nature and severity of these needs are not. Such later-life care needs are also not infrequently catastrophic and highly unequally distributed.

This is precisely the kind of risk that collective pooling is designed to address. The funding model should spread this risk across the population and over time, allowing the system to operate efficiently and equitably. Such a 'risk pool' would enable the predictability of contributions and guarantee a baseline level of support.

3.3.2 Sustainability

A viable model must be able to meet both current and future need for later-life care services. That means building a system resilient to demographic change and capable of adjusting over time as life expectancy, dependency ratios and patterns of need evolve.

A financially sustainable model must be able to plan for rising costs in a rational, pre-emptive way, rather than through crisis-driven emergency funding or repeated retrenchment. Sustainability also requires long-term institutional credibility. People must believe the system will be there when they need it, and will ultimately be capable of self-correction over time.

3.3.3 Fairness

The model must be fair across socioeconomic groups, across regions, and across generations. It should avoid entrenching the structural inequalities currently seen in care access and quality, particularly in more deprived local authorities. It should ensure that care entitlements do not vary according to geography or the generation someone happens to be born into, as is currently the case.

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[136] Feather Insurance, 'What Is Long-Term Care Insurance (Pflegeversicherung)?'; Deutsche Sozialversicherung Europavertretung, *History of Social Insurance*.
[137] Lucinda Allen and Genevieve Cameron, 'The Government's Approach to Social Care Reform: What Do the Public Think?', *The Health Foundation*, 24 January 2025.

‘Fairness’ is a complex concept, and one where different definitions may be in tension with each other. In this paper, fairness is defined by public perception. A transparent, clear and credible model which feels justifiable and reasonable to contributors, balancing consistent, needs-based access to state-funded social care in later-life, with contributions to its cost according to ability to pay (including wealth, not just income). In such a ‘fair’ system, those with similar needs should be treated similarly, regardless of where they live or how effectively they can navigate the system, and every generation should have access to a comparable deal.

Everyone will have contributed into the system through their working life. It is therefore vital the proposed model ensures a comfortable level of provision for later-life care needs as needed by any contributor. This (near) universal entitlement will enable the model to have legitimacy, positively rebuilding the social contract that’s currently under strain.

Some depletion of personal assets will have to remain part of the system, to maintain socioeconomic fairness, intergenerational fairness, and ensure a financially sustainable model. But the model must incorporate asset depletion transparently and with clear, comprehensible and fair personal protections. As will be recommended, a far more generous minimum asset floor, below which no one is asked to contribute, would help to strike a balance between fairness, affordability and legitimacy.

3.3.4 Deliverability

Any serious reform must be as politically practicable as possible. Past proposals have repeatedly failed not just because of cost, but because they proved impossible to explain, build consensus around or defend under public scrutiny. The ultimate model must be comprehensible, stable over time, and grounded in principles that resonate with voters, particularly contributory fairness and personal protection.

Cross-party support for a new model is likely to be essential for its success, given the length of time required to implement a new funding model. Baroness Casey recently stressed this point.[138] To garner the necessary cross-party support, the Independent Commission which Baroness Casey chairs should be used as a rallying focus.

The model may achieve greater public legitimacy by building from familiar ideas in existing systems, such as tax and pensions. Legitimacy may also be built through a more transparent and comprehensible system in which people understand the ‘deal’ they will have access to, if needed, as a result of their contributions into the system. Meanwhile, by setting out clear limits to personal costs, fears of personal exposure may also be mitigated.

A review mechanism would allow for course correction without wholesale redesign, ensuring the sustainability and survivability of the model.

[138] Alison Holt, ‘Trying to Get Social Care Can Be “Horrendous”, Baroness Casey Tells BBC’, *BBC News*, 5 March 2026.

4. An alternative model

This chapter outlines in detail a prefunded social insurance model, explained through the four fundamental principles that a new funding model should deliver (subsection 3.3).

One economist's critique of prefunded social insurance is that, where contributions are compulsory and the state ultimately stands behind entitlements, such a scheme may not differ greatly from PAYG models: in both cases, the real resource cost of care is part defined by future economic conditions, and these costs are effectively met from the output of the future economy.

However, the case for prefunding is primarily about governance, credibility and distributional fairness. A ring-fenced fund with routine actuarial valuation, explicit adjustment levers, and a transparent link between contributions, co-payments and entitlements can create a durable financing discipline that the current discretionary, tax-funded model lacks. It also makes the intergenerational settlement explicit: each cohort builds an identifiable claim on resources to meet its own expected liabilities, rather than relying on repeated future tax rises or ad hoc bailouts.

4.1 The model in brief

For an individual whose met the contributory requirements (explained in subsection 4.2), the core components of the proposed model are:

- mandatory 1.8 per cent contributions on income from the age of 34;
- state funding provided towards later-life care needs;
- a requirement to contribute towards later-life care services, via co-payments based on wealth;
- protection of assets worth £75,000 or less, meaning that at this wealth level and below, care recipients will not be required to contribute towards their care costs; and
- an annual co-payment-free 'personal care allowance', pegged at 60 per cent of the value of the full new State Pension (currently just over £7,000).

Structurally, the core components of the proposed model are:

- mandatory contributions which go to a national-level, pooled, privately-managed Later Life Care Fund;
- that this Fund is invested over time, then used to resource the contributing cohort's later-life care needs;
- wealth assessments to determine later-life care users' co-payment rates, carried out by local authorities and always including the value of property;[139] and
- independent reviews of the model every five years, to ensure the model's financial sustainability and longevity, maintaining a buffer against unanticipated additional demand or other costs.

In implementation terms, the new contributory regime would apply prospectively to cohorts who have not yet passed the entry age when it begins, while older cohorts remain within a legacy settlement funded through transitional arrangements. At the end of that transition, this

[139] These means tests would be periodically re-evaluated, and changes attributed to significant capital divestment would be treated as "deprivation of assets" in relevant cases.

prefunded approach would replace the current funding of adult social care via council and national taxation.

4.2 The model in detail

4.2.1 Risk pooling

Later-life social care involves unpredictable, sometimes catastrophic costs. It is unreasonable to expect every individual to meet these costs alone. A contributory social insurance model pools this risk fairly across society.

In this model, adults will contribute to a Later Life Care Fund from 34-years-old until they reach retirement age. In later life, most will have modest care needs, some none, and a minority will require high-cost care. Pooling resources ensures that the latter are protected, while everyone benefits from a more predictable system. Unlike the PAYG social insurance models seen in Germany and Japan, this would be a prefunded model, with individuals' contributions privately invested, then used to fund their cohort's later-life care needs. This prefunded model would deliver better value for money, capitalising on the opportunities of the private market. Prefunding would deliver intergenerational fairness more effectively than seen in any current international model, with each cohort funding the provision of their own cohort's care needs.

In order to capitalise on the benefits of prefunding, contributions need to be collected early enough in each person's working life. However, introducing this contributory requirement as soon as adults are working, like in Germany, when people often have lower and more volatile earnings, seems likely to have a negative net economic impact, limiting young adults ability to afford living costs, save, and improve their financial security. Japan requires contributions from the age of 40 as this is when most adults will see the benefits of the system for their ageing parents.[140] Balancing these considerations, and the need for sustainability, contributory requirements should begin at 34.

Introducing this mandatory contribution will, of course, be politically difficult. As laid out in section 3.2.1, 'fixing' adult social care requires a significant increase to its funding, as well as reform of the funding model. Both are incredibly challenging to deliver, made clear by consecutive governments failing to achieve these aims (Figure 8). Yet this difficulty does not change the reality: an ever more urgent need for a properly funded and reformed model of adult social care.

Given adult social care in England is desperately underfunded, a sustainable solution to raise the necessary revenue must be found. The best solution is one that is as sustainable, comprehensible and fair as possible. A contributory social insurance model, with working-age adults contributing from age 34 until retirement to a Fund which will then be used to pay for their cohort's later-life care needs, is this best solution.

The point of income at which contributions become mandatory should be pegged to the 'lower earnings limit' for pensions auto-enrolment (currently £6,240). Also like auto-enrolment, contributions will be on pre-tax income – in effect ensuring the State co-funds the scheme by giving tax relief on the contribution. This reduces the take-home cost for individuals and will help to ensure that the Fund builds up without a large new call on day-to-day public spending.

[140] Curry et al., *What Can England Learn from the Long-Term Care System in Japan?*

Recommendation 2: A social insurance scheme, where individuals contribute to a pooled, privately-managed and invested Later Life Care Fund, should be introduced to fund state-funded later-life social care, ultimately replacing the funding of adult social care through council tax and general taxation. This would be a mandatory scheme in which 34-year-olds are required to contribute 1.8 per cent of their pre-tax income (above a minimum income threshold of £6,240, the lower earnings threshold for pensions auto-enrolment) to the national-level Fund, every year until they retire. This Fund would be invested over time, with an explicit mandate to maximise returns, then used to fund state-funded later-life social care for the contributing cohort.

Recommendation 3: Within the new system, when someone over retirement age has a social care need, they should undergo a needs assessment, carried out by their local authority, to determine the support they require. This needs assessment should be based on national standards. Anyone who has met the contributory requirements during their working life and is assessed to have a social care need should be eligible for state support, funded by the Later Life Care Fund.

4.2.2 Sustainability

This model should be self-sustaining, meaning funding must match the long-term costs. Funds would come from: mandatory contributions on income for adults from the age of 34; returns on investment of the Later Life Care Fund; and co-payments.

In this model, individuals would contribute 1.8 per cent of gross income into the Later Life Care Fund, from age 34 onwards. These contributions would be privately invested with an explicit mandate for those managing the Fund to maximise returns (Recommendation 2), and returns would grow the Fund over time, delivering better value for money than if later-life care needs were funded at the point of need.[141] Lastly, co-payments – requiring care service users to fund a set percentage of their care costs – will be a component of this model.

Co-payments help to protect against moral hazard. Individuals being required to contribute towards their later-life care needs incentivises individuals to maintain responsibility for looking after their health and wellbeing. It also disincentivises unnecessary overuse of care services.

More importantly though, co-payments are necessary for the financial sustainability of the proposed model. Co-payments should be progressive, dependent on the care recipients' wealth including income. This enables a financially sustainable model, with costs shared fairly across the population. The following section, 4.2.3, explains why progressive co-payments should be implemented.

Recommendation 4: Local authority means assessments should determine the total value of someone's savings, investments, income, and property. If someone owns property, this should be included in their means assessment, even if they or a spouse are and will continue living in the property. Based on individuals' wealth, they should be subject to co-payments for their later-life care needs.

[141] Reform Think Tank, *Social Care: A Prefunded Solution*.

Recommendation 5: Local authorities should be supported to carry out assessments of individuals' wealth through a standardised, consented data-sharing and verification framework, enabling them to avoid relying on onerous manual evidence collection alone. This framework should incorporate digital property ownership data from HM Land Registry services; streamlined access to HMRC income data; and information from other relevant departments and public bodies.

It is vital this model is financially self-sustaining. This requires it adequately accounts for factors that impact how much delivering care will cost, including need volume, need complexity, the social care market, the wider economic context and any other factors that could undermine its financial footing. The model must also be able to adjust and respond if any of these factors change.

Care inflation

Care inflation – the cost of providing care – is one such factor which could undermine the financial sustainability of the model. If recent trends continue, care inflation is likely to be higher than general inflation.

Between 2015-16 and 2023-24, the average weekly fee paid by councils for later-life residential and nursing care increased by 33 per cent above inflation.[142] In the same time period, the average hourly rate for domiciliary care (provided in the home) increased by 18 per cent above inflation, calculated across both later-life and working-age care recipients.[143]

Care worker pay growth has been the primary cause of this above-inflation increase in care costs. This has been the result of the introduction of, and increases to, the National Living Wage. Staffing costs account for about 60 per cent of care home providers' costs and 70 per cent of domiciliary care providers' costs.[144]

In more recent years, growing operational costs, underpinned by steep increases to energy prices, have exacerbated care inflation.[145]

The increasing complexity of care recipients' needs is another key cause of increasing costs in providing care. People are living longer and are living longer with long-term conditions, frailty, disabilities and illnesses, as a result the average complexity of an adult's care needs is increasing. Short-term factors, such as patients being discharged from hospital more quickly and long waits for NHS services causing deterioration, are also contributing to care recipients having more complex needs.[146]

Indeed, in ADASS's *2024 Spring Survey*, directors of adult social services (DASSs) ranked "increased complexity of needs as the greatest concern in relation to budgetary pressures".[147] And in their *2025 Spring Survey*, 89 per cent of DASSs were concerned about increased costs

[142] The King's Fund, 'Social Care 360: Expenditure', Web Page, 3 March 2025. Some of this inflation is driven by the rise in residential costs.
[143] Ibid.
[144] Ibid.
[145] Megan Thomas, 'Care Home Fees Soar amid Cost of Living Crisis', *Which?*, 10 September 2023.
[146] ADASS, *2024 Spring Survey* (2024).
[147] Ibid.

due to increased complexity of needs in older people.[148] These concerns are evidence-backed. The average size of care packages have increased in many council areas, across types of care packages including for those discharged from hospital, those accessing community-based support, and homecare packages.[149]

These pressures, driving above-inflation increases in the cost of providing care, may indeed continue, which could undermine the sustainability of the proposed model if not properly accounted for.

Technology does offer significant efficiency and cost savings, and is currently severely underutilised.[150] For example, Reading Borough Council's use of non-intrusive monitoring technology for homecare has saved 25 per cent of care costs per service user, and Medway Council saved £1.25 million in their first year using the same type of technology.[151] Similar savings are possible by utilising technology for administrative tasks too. For example, the Priory Group, since implementing digital social care records in all their care homes, saved an equivalent of £1.1 million in saved staff time in 2024.[152]

Nonetheless, likely care inflation must be a key consideration in the implementation of the proposed prefunded social insurance model, to ensure the Later Life Care Fund is self-sustaining. In part, inflationary pressures must be compensated by shifts in practice and incentives within the care system that a refreshed funding model pays for. Implementation of new approaches to help prevent some proportion of the occurrence of the most costly kinds of care need, and more consistent market stewardship of care provision should all be objectives of an updated delivery model.

For this paper, ensuring a sufficiently generous sustainability 'margin' or 'buffer' within the proposed funding model is key. Under core assumptions (set out below, and including conservative assessments of the growth potential of the invested Fund), the target buffer for the model is set at 10 per cent – a margin that will allow for coverage of all administrative costs and unexpected variation in need or market conditions.

Beyond this, sustainability of this model will depend upon flexibility. The model must be able to respond dynamically to highly changeable variables. There must, therefore, be a regular review mechanism in place which provides scope to adjust contributions and entitlements, if this were to end up being necessary, and which oversees the routine uprating of the system in line with changing and inflating costs. The design of this independent review and update function could incorporate polling, participatory, or consultative processes to clarify public appetite and establish a clear mandate over some of the trade-offs which may be the result of decisions for the model.

[148] ADASS, *2025 Spring Survey* (2025).
[149] Ibid.
[150] Florence Conway and Rosie Beacon, *Innovating for Independence: A Win-Win for Health and Social Care* (Reform Think Tank, 2025).
[151] Ibid.
[152] Ibid.

Recommendation 6: The prefunded social insurance scheme should be independently reviewed every five years, with its structure adjusted to target at least a 10 per cent sustainability buffer in the Fund based on latest usage, population, and demographic projections. This duty to review should be placed on a statutory footing and carried out by an independent review body. The model's components – including contribution rates, co-payment levels, eligibility thresholds and the protected capital floor – should be inflation adjusted each year, ensuring the sustainability and fairness of the model.

4.2.3 Fairness

Council tax

The current system's reliance on council tax is unfair across regions and households. Property values have diverged significantly since the 1991 banding, and high-need areas are correlated with weaker tax bases.[153]

Consequently, the dedicated Social Care Precept should be abolished as soon as possible. And once costs of providing later-life social care are absorbed by the Fund, council tax receipts previously used to provide care will no longer be needed. Councils should have the fiscal autonomy to therefore either reduce council taxes further or justify to residents the reallocation of receipts to other priorities.

In the long term, funding of state-funded later-life social care will be delivered through the prefunded social insurance model proposed, no longer relying on council or national taxation.

During the transition from the current model to the proposed one, for later-life care, current later-life care needs will still need to be funded. Given how regressive and unfair council tax is, it should be a shrinking component of funding later-life care during the transition. The details of how this could be achieved will be outlined in the next chapter.

Recommendation 7: Government should progressively phase out, and ultimately abolish, the Social Care Precept as a funding mechanism for later-life care. As a new contributory regime is introduced, the later-life care element of the precept should be withdrawn for cohorts within that regime, with remaining legacy liabilities instead met through more equitable transition-funding measures.

Co-payments

Per Recommendation 4, co-payments should be a part of the model, mitigating some risks of moral hazard and securing the financial sustainability of the model. Co-payment rates should be progressive, based on the care recipients wealth at the time of need.

[153] Foster, *Adult Social Care Funding in England*.

There should be four co-payment rates:

- 10 per cent for lower wealth individuals (total assessed wealth between £75,001 and £100,000), comprising an estimated 6 per cent of the retirement-age cohort;
- 20 per cent for middle wealth individuals (total wealth between £100,001 and £600,000), comprising 40 per cent of the cohort;
- 40 per cent for higher wealth individuals (total wealth between £600,001 and £2 million), comprising 41 per cent of the cohort; and
- 45 per cent for ultra wealthy individuals (total wealth over £2 million), comprising 4 per cent of the cohort.[154]

The contributory rate for adults aged 34 and older is a fixed rate of 1.8 per cent. Given most wealth, especially unearned wealth, exists in property and other non-income sources, a progressive contribution rate based on income alone would not be the fairest way to ensure those who are able to contribute more do so. Instead, progressive co-payment rates (based on wealth, including income) should be implemented.

Capital floor

Fairness also requires some depletion of personal assets. Protecting the assets of the wealthiest individuals, partially funded by the contributions of less wealthy individuals, is plainly unfair and therefore should be avoided wherever possible. The main mechanism to prevent this becoming a reality is a model without a cap on lifetime co-payment contributions. Progressive co-payment rates also help to prevent this.

If a cap on co-payment contributions were to be put in place – similar to the cap on lifetime contributions proposed by the Johnson Conservative Government in 2021[155] – many lower to middle wealth individuals would drain all their wealth in co-payments, until they reached the protected asset floor (below which all social care needs are state-funded). Meanwhile, wealthy individuals could spend a proportionally very small amount of their wealth on their care needs, before then reaching the cap and having all their care needs state-funded. This is clearly unfair, in a resource-limited reality.

Attempting to avoid this issue, the Dilnot Commission recommended a cap on total care costs rather than on an individual's contributions, in conjunction with increasing the upper threshold for means-tested state support to £100,000.[156] Such a cap is agnostic to whether the running total costs have been met by an individual or a local authority. In a scenario where a care recipient was partially self-funding (spending £20,000 total) while receiving some local authority funding (reaching £15,000 total), their lifetime contributions are £20,000 but their total care costs are £35,000. Under Dilnot's recommendations, with a £35,000 total cap, they would no longer be required to contribute to any future care costs.

The total cost cap, compared to the lifetime contributions cap, would help to mitigate the injustice outlined above. Yet, the wealthiest individuals would still only have to contribute up

[154] This estimated distribution would see 8 per cent of the retirement-age cohort making no co-payments because their assets fall below the £75,000 protected floor. Figures extrapolated and rounded for the purposes of modelling from *3 million pensioner millionaires* (Intergenerational Foundation, 2022).
[155] 2019 to 2022 Johnson Conservative government, *Build Back Better: Our Plan for Health and Social Care* (Prime Minister's Office 10 Downing Street; Cabinet Office; Department of Health and Social Care, 2024).
[156] Sir Andrew Dilnot CBE, *Fairer Care Funding: The Report of the Commission on Funding of Care and Support* (Department of Health, 2011).

to the total cap, protecting the vast majority of their wealth at the cost of the State. Meanwhile many lower to middle wealth individuals would drain a high proportion of their wealth. This is still unfair.

The proposed model therefore does not include a cap on lifetime contributions or total care costs. Instead each individual's co-payment rate would be solely determined by their wealth at the point of need. And individuals may, over time with asset depletion, move into a lower co-payment rate.

However, recognising that later-life care recipients will have contributed into this model for over three decades, it is absolutely essential, for both fairness and deliverability, that there are far more generous personal protections for individuals than in the current model.

The fairest personal protection, across socioeconomic groups, is a protected asset floor below which individuals are not required to contribute towards the cost of their care. Currently, no such floor exists, as even when an individual's wealth is not factored into their means assessment (when assets are worth £14,250 or less), they are still required to contribute towards their care from their income, including pensions. For those with assets above the value of £23,250, they aren't eligible for any state funding.

In the new model, a protected asset floor of £75,000 should be introduced. This new floor is approximately 25 per cent of the national average house price – a level which could become the basic benchmark for future revisions to the floor during the regular review process proposed in this report (Recommendation 6).

Recommendation 8: This system should be arranged with a protective safeguard in place. This should take the form of a protected asset 'floor'. Contributing individuals with assets valued below £75,000 should not have to then also contribute towards their care costs at the point of usage, meaning they would have a co-payment rate of 0 per cent: the 'floor'.

Housing wealth should be included in means assessments (Recommendation 4) and some asset depletion will remain part of the model in some cases (Recommendation 8), but no one should be forced to move out of their home to fund their or their spouse's later-life care. Deferred Payment Agreements, currently in place, and similar mechanisms should therefore be expanded to enable families to release equity fairly.

Recommendation 9: If it becomes necessary to access the value of someone's home to pay for their or their spouse's later-life care needs, there should be a range of ways to unlock the equity without them having to move out of their home. This should include an expansion of the current Deferred Payment Agreement scheme, with resourcing available to local authorities to meet the costs of administration.

A key failure of both England's current model and other PAYG models, like in Germany and Japan, is the structural intergenerational unfairness that results. Current working-age adults

are responsible for funding current later-life care provision, but demographic shifts and changing economic contexts make this a highly inequitable arrangement, as laid out in subsection 3.1.2.2.

The proposed prefunded model resolves this and delivers intergenerational fairness, with each cohort funding the later-life care provision for their own cohort, primarily during their own working-age lives. This is also achieved with greater value for money than in PAYG models, benefiting all.[157]

4.2.4 Deliverability

For the model to be politically deliverable, it must be a transparent, comprehensible and durable one. England's current system is the opposite. Many believe care will be free at the point of use, like the NHS, only to be confronted by steep self-funding requirements if care needs arise.[158] Meanwhile, growing obligations for taxpayers fuel frustration, central government is required to bail out local authority funding gaps year after year, and unmet need continues to grow.

The proposed contributory model presents a radical alternative, with a clear relationship between required contributions and the offer this delivers. In order for this model to be politically deliverable, it should also provide universal personal protections for those meeting contributory requirements through their working life. This is fair and transparent.

These significant and equitable personal protections are:

- a protected asset floor of £75,000, at or below which individuals will not be required to contribute towards their later-life care costs (Recommendation 8 above); and
- an annual co-payment-free 'personal care allowance' providing state-funded care, without a requirement for co-payments, pegged at 60 per cent of the full new State Pension level to avoid erosion of its value by fiscal drag.

These guarantees give clarity about how those who have contributed into the system will benefit from it, should later-life care needs arise, regardless of their financial position at the point of need. This makes contributions feel fair and worthwhile. Trust and understanding are central to making the system deliverable, and a clear link between contributions and entitlements is essential for delivering the new social contract.

Recommendation 10: There should be an annual co-payment-free 'personal care allowance' for those of retirement age or older, pegged at 60 per cent of the full new State Pension level. Individuals would be entitled to care services costing up to this threshold entirely state-funded, without co-payments.

[157] Reform Think Tank, *Social Care: A Prefunded Solution*.
[158] Ipsos MORI, *State of the State 2017-18: Austerity, Government Spending, Social Care and Data* (2017).

To ensure the model is deliverable, there are some practical challenges which may be addressed in the model's design. For example, a 'tapering' between co-payment bands could be included, which could otherwise produce significant 'cliff-edge' shifts between levels of co-payment and strongly incentivise individuals and households to 'game' the system.

Various mechanisms or approaches could be implemented to smooth this effect. While this paper sets out clear 'tiers' of co-payment for simplicity's sake, this system could be replaced by one that calculates the appropriate rate of co-payment with an equation, so that the co-payment rate is unique for each service user – this would remove cliff edges from the system altogether (at the cost of additional administrative steps). In the USA, percentage payment caps are used to smooth transitions on contributions to healthcare costs within some insurance schemes – though this entails a subsidy which would add costs to the system.

4.3 Eligibility

Another practical difficulty, vital for the model to be fair and deliverable, is specifying the contributory requirements in order for someone to be eligible for the deal provided by this prefunded social insurance model in later life. This subsection outlines this part of the model.

4.3.1 Contributory requirements

The proposed model is a contributory one, meaning access to the most generous version of the 'deal' is premised on having made sufficient contributions. For this model, there should be a number of different ways an individual can meet the contributory requirements, and the system should be agnostic about how the contributory requirements are met.

One aspect of the contributory requirements should be specifying the minimum number of years an individual must have made contributions into the Later Life Care Fund. Mirroring the state pension system, there could be different ways someone could achieve such a qualifying year, namely if an individual:[159]

- earned income and paid the mandatory 1.8 per cent fixed rate; or
- was awarded a Later Life Care Contribution credit (in line with requirements to be awarded a National Insurance credit);[160] or
- paid a voluntary Later Life Care Contribution lump sum (can be done at any point).

The contributory requirements need to take into account how long someone has been a citizen, resident, or otherwise lawfully living in the UK, to ensure fairness across different categories of contributors. It would not be fair for someone who moves to England at age 60 and contributes for 8 years to access the same offer in later-life as someone who has contributed for 34 years. On the other hand, there should be ways for late joiners to buy into the model, if they are able to and want to.

Contributory requirements for different groups could be arranged as follows:

1. **If you have been a citizen, resident, or otherwise lawfully living in England from at least 34-years old**

   These individuals must have contributed (or have a qualifying year) in every year from 34-years-old until retirement age.

[159] GOV.UK, 'The New State Pension', Web Page, 2025.
[160] GOV.UK, 'National Insurance Credits', Web Page, 2025.

2. **If you become a citizen, resident, or otherwise lawfully move to live in England within 34 years of retirement age**

   These individuals will be required to pay a fee based on how many years before retirement age they become a citizen, resident, or otherwise lawfully move to live in England. This fee can be calculated as an annual 'top up' to distribute through remaining working years, or paid one-off at any point prior to retirement. The specific sum – with a sum set for each of 0-years before, 1-year before, 2-years before, and so on – will be defined by the value of the median-average contribution for their cohort, at that point in contributory years. These specific sums will be defined by the statutory review process (Recommendation 6).

Recommendation 11: Individuals who cannot consistently work or who move to the UK later than the age of 34 should have pathways to eligibility for the full state-funded later-life care deal, including ways to 'buy in' to the system and to qualify for a substitute 'credit' if they can demonstrate inability to contribute.

If someone is unable to meet the contributory requirements for the group they fall into, they will not have access to the later-life deal as laid out in section 4.2. Instead, a basic 'safety net' version of the service will be provided, the details of which are laid out in the next subsection. This will ensure those who are entirely unable to fund their own care still have their care needs met. This is a moral and medical obligation for the State.

The basic safety net will be funded via the Later Life Care Fund, hence everyone will be required to contribute 1.8 per cent of their income over the threshold into the Fund, even if it is known they will not ultimately meet the contributory requirements to access the most generous version of the system. This additionally incentivises individuals to meet the contributory requirements, as there is no way to avoid the 1.8 per cent fixed rate on income over the threshold on UK-earned income.

Recommendation 12: Anyone aged 34 years or younger when contributions into the Later Life Care Fund begin being made should be required to contribute 1.8 per cent of their income (above the pension auto-enrolment threshold) to the national-level Fund during the contribution period (from ages 34 to 68), even if they will be unable to meet their overall contributory requirements.

4.3.2 The safety net model for non-eligible individuals

For those who don't meet the contributory requirements to access the full deal, there should be a far less generous offer in place. However, this still needs to be sufficient to ensure those with care needs in later-life, who are unable to self-fund, have their needs met.

The safety net model should mirror the proposed model in design, while being less generous. This helps ensure both models are well understood by the public and makes clear the benefits of meeting the contributory requirements to access the full deal.

The components of the safety net model should be:

- a protected asset 'floor' of £15,000 for all social care users, below which users are not required to contribute towards their care costs;
- a flat co-payment rate of 70 per cent (until the individual reaches the asset floor); and
- no co-payment-free annual allowance.

This model acts as a safety net for those who don't qualify for the full deal but are unable to fund their care needs. Simultaneously, this model is sufficiently less generous than the full deal to ensure those who do meet the contributory requirements to access the full deal feel they have gained something worthwhile from doing so – vital for fairness and deliverability.

Recommendation 13: For those who fail to meet the contributory requirements to access the full deal available through the proposed prefunded social insurance model, there should be a safety net offer in place. This safety net offer should be: a protected asset 'floor' that is equivalent in value to one fifth of the full deal, which would currently be £15,000; a flat co-payment rate of 70 per cent (until the individual reaches the asset floor); and no annual co-payment-free 'personal care allowance'.

4.4 Stress testing the model

This chapter has proposed a new prefunded social insurance model to fund later-life social care. The credibility of any such model depends on whether it can demonstrate long-term viability. In the case of later-life care, this challenge is heightened: a near-universal entitlement would not simply increase funding flows but fundamentally reshape how care is accessed and delivered.

The model presented will be impacted by a range of pressures that an alternative system would not need to withstand: changes in need patterns, a likely shift from informal to formal provision, the incentives created for earlier intervention, and the difficult-to-predict fiscal and demographic forces that will define the coming decades. None of these dynamics can be treated in isolation.

This subsection sets out the rationale and assumptions behind a proof-of-concept of the financial viability of this model, and a set of 'stress test' scenarios. These are designed to explore how resilient the scheme would be in different situations, and whether it could, assuming sufficient updates in response to shifting circumstances, provide a fair and sustainable foundation for later-life social care over the long term.

The proposed model relies on a pooled Fund built through mandatory contributions over time and must therefore be tested against different plausible future need and cost scenarios, factoring in the likelihood of above-inflation increases to the cost of care.

Moreover, implementing a clear, near-universal entitlement may shift the shape and size of demand. Currently, significant unmet need suppresses demand artificially. A more legitimate and visible system could:

- bring forward more users, especially at low to moderate levels of need;

- shift more informal care into formal care settings; and
- encourage earlier intervention, potentially preventing more costly crises later, because the threshold for access to care is easier.

These possible effects are anticipated through the design of the proposals in this report, including five-yearly reviews of key parameters (including compensating for care inflation and demand levels through changes to the contribution rate, co-payment levels, eligibility thresholds, and the 'floor' level), and clear boundaries on core entitlement.

It is impossible to fully model all possible eventualities for a policy which would have implications for decades to come. Until a new policy is implemented, it is unclear what all the consequences of the change would be. Given in the current model, people typically under-save for retirement and broadly do not prepare for potential later-life care costs whatsoever, changes in retirement savings behaviour could be very small. Earlier interventions could increase social care costs and be cost saving at a system-wide level, through reduced hospital admissions and healthcare usage. Similarly, a reduced reliance on informal care could enable those who would provide informal care to remain in employment, with positive broader economic impacts.

It is therefore difficult to set out stress tests for the sustainability of the new system – but it is also important to note that there could be significant unpredicted implications for overall system usage and cost distribution.

4.4.1 Key assumptions for the stress tests

At the heart of these stress tests is a series of core assumptions that define the Later Life Care Fund's income, its expected liabilities, and the policy levers used to balance the two. This enables the production of a proof-of-concept for the proposed system's affordability. In this subsection, the assumptions underpinning the 'baseline' scenario in this proof-of-concept are explained. More detail on the underpinning calculations are provided in the appendix to this report.

To generate a baseline, a number of assumptions about Fund contribution variables are made:

- Contribution period: 34 years (from age 34 to 68)[161]
- Contribution rate: 1.8 per cent of gross income over a floor pegged to the pension auto-enrolment lower earnings limit
- Mean salary across age bands (start of contributing period): £46,202[162]
- Investment return: 4 per cent annual compound growth[163]

The baseline start age is chosen to be late enough to avoid front-loading burdens on the earliest career years, but early enough to allow meaningful accumulation. Stress tests then

[161] This defined period reflects the practical reality that individuals in their 20s often have lower and more volatile earnings (including time in education), so contributions are set to begin at 34. A sensitivity model has also been run to show the impact of starting contributions at age 30, which strengthens the Fund by producing higher average pots.
[162] This is a mean average based on average earnings across a working 34-68 cohort (and is thus higher than the national average salary).
[163] Real terms returns. This rate is modelled as a relatively 'conservative' starting point for a privately managed investment fund with moderate risk appetite. Higher and lower return rates are separately modelled.

vary the start age (for example, showing scenarios where contributions are started earlier) to show the effect on the Fund.

In comparative terms, a 1.8 per cent contribution rate is well within the bounds of practice in other countries. For example, Germany's statutory long-term care insurance contribution rate is around 3.6 per cent of gross pay (and higher for childless adults), typically split between employee and employer.[164]

This model also uses an explicit assumption for earnings growth over time rather than holding earnings constant at the current mean for the relevant age cohort, since the scheme's sustainability depends on how contribution inflows change over decades. The baseline earnings growth rate is set at 0.7 per cent to represent modest long-run real wage growth, recognising uncertainty and the possibility of prolonged weak productivity growth.

For the investment return calculation, the plausible average annual rate of return is set conservatively, reflecting the fact that the model is intended to test viability under prudent assumptions rather than relying on optimistic market outcomes. Scenarios within the stress tests then show the implications of other rates of return.

These returns are more realistic if the managers of the Fund invest it with a mandate to maximise return on investment (Recommendation 2), but they become unrealistic if the Fund is managed with other mandates – e.g. particular policy objectives related to the objectives of the Government of the day. Because the long-term viability of the Fund is crucial, the Fund should be invested with the sole objective of maximising returns.

Care need variables

This model estimates the demand placed on the Fund by combining: i) the share of the cohort expected to draw on formal later-life care, with ii) an assumed average cost per care user, expressed in today's prices and then grown forward to reflect above-inflation care cost pressures. The starting point is established national evidence on lifetime care risk and the skewed distribution of lifetime costs: a large majority of individuals are expected to require some formal care over later life (a lifetime "ever-use" rate), while average lifetime costs among users are materially higher than the median because a minority incur very high costs.

The stress tests translate these lifetime parameters into an expected burden on the Fund by: a) converting lifetime usage and lifetime cost assumptions into an expected per-capita gross liability for a representative cohort, and b) increasing care costs so that the model reflects the likelihood that the real unit cost of care rises faster than general inflation over the decades between contribution and drawdown.

The baseline assumption is that real care costs grow by 1 per cent per year above inflation, applied over 34 years from contribution start to drawdown; this implies real costs are around 36 per cent higher at the point of drawdown (for example, a £45,000 average lifetime care cost becomes approximately £61,000 in today's prices). This produces a baseline gross cost to be funded (before co-payments), which is then combined with the co-payment design (including the protected wealth floor, the co-payment-free personal allowance, and banded co-payment rates) to estimate the net demand placed on the Fund.

[164] OECD, *Tax and Benefit Policy Descriptions for Germany 2025* (2025).

Because the model explicitly assumes 1 per cent average annual real growth in care costs, the implied per-user and per-capita costs in the stress tests are not intended to match today's average spend per user. They represent a plausible future cost burden for the cohort at the point of drawdown, given sustained real cost pressures and the fact that mean lifetime costs are driven by a relatively small number of very high-cost cases.

The model assumes a lifetime incidence of 75 per cent for older adults who will face some formal care costs, consistent with DHSC estimates used in charging reform analysis.[165] The stress tests also show the implications of a higher 'usage rate', consistent with the higher estimates of, for example, the Health and Social Care Committee.[166]

Co-payment levels

The model is part-funded by a co-payment scheme. To ensure simplicity and fairness, co-payment thresholds are based on an assessment of total net wealth in retirement. The assessment of wealth should include:

- property (net of mortgage);
- savings and investments (ISAs, shares, etc.);
- pensions (in drawdown or, potentially, in accumulation);
- other kinds of income;
- business or trust assets; and
- valuable possessions above a threshold to be determined by the five yearly review.

These thresholds allow the model to align more closely with the real distribution of ability to pay for care, ensuring the model is fair across socioeconomic groups:

- 10 per cent co-payments for lower wealth (total wealth assessed between £75,001 and £100,000)
- 20 per cent for middle wealth (between £100,001 and £600,000)
- 40 per cent for higher wealth (between £600,001 and £2 million)
- 45 per cent for ultra wealthy (those with wealth over £2 million)

These wealth categorisation brackets should be subject to updates over time, compensating for shifting need profiles and compensating for inflation. They could also be designed with 'smoothing' or 'tapering' mechanisms in place to avoid incentive-shaping 'cliff edges', as discussed in subsection 4.2.4.

This model uses a simplified segmentation of the later-life population into these wealth bands, with each band assigned a share of the eligible population (see appendix). The purpose is to capture, in a transparent way, the fact that capacity to contribute via co-payments varies sharply with wealth. The baseline band shares are set to approximate the broad shape of UK retirement-age wealth including private pension wealth, as well as housing and other assets.

To calculate the value of the co-payment regime as a supplement to the Fund, the model uses average effective co-payment rates in each band which represent the net proportion of gross costs expected to be recovered in each band after the relevant protections are applied. This

[165] Department of Health and Social Care, *Social Care Charging Reform Impact Assessment* (2022).
[166] House of Commons Health and Social Care Select Committee, *Adult Social Care Reform: The Cost of Inaction; Second Report of Session 2024-25*.

approach captures the interaction between wealth, floors and co-payment design without requiring individual-level simulation.

Personal protections

Public confidence in the system will be improved by the use of the following visible safeguards:

1. an annual co-payment-free 'personal allowance': individuals are entitled to co-payment-free care up to an amount pegged as 60 per cent of the full new State Pension (currently around £7,000), meaning the 'lightest' users of social care services may never be required to contribute a co-payment;[167] and
2. the 'floor': no one pays from the last £75,000 of their assets, so that assets can never be wholly depleted by social care costs and some funds will always be reserved for funeral, housing, and legacy purposes.

The £75,000 floor is a central policy parameter: raising it strengthens perceived fairness and reduces the risk of catastrophic asset depletion, but also reduces co-payment receipts and increases net demand on the Fund. The baseline floor is set as a policy judgement balancing protection against sustainability.

4.4.2 Stress testing

A series of scenarios can be used to test whether the pooled Fund is sufficient under a range of pressures for a notional population of 100,000 contributors. This is a round, intelligible cohort that is large enough to make the proposed mechanics meaningful while keeping the modelling transparent. Across stress tests, cohort size is held constant so that scenario comparisons isolate the effects of the key behavioural and economic variables rather than demographic volume.

The stress tests include:

- higher overall usage rates (more people requiring care);
- higher per-user costs (longer care periods, rising prices); and
- lower returns on investments.

The table also incorporates more optimistic scenarios to show their implications for the Fund, given the generally conservative assumptions that underpin the baseline case.

Provisos and limitations

It is important to note three limitations within this proof-of-concept modelling.

First, this model does not explicitly model the separate safety-net pathway (the safety net offer for those outside, or only partially within, the full scheme) set out in section 4.2 above. The modelling does incorporate a reduced-contribution element to reflect that some contributors pay less than the headline rate or may have non-contributing years, but it does not offset this by modelling that some individuals who appear as full-scheme users (at full cost to the Fund) in the proof-of-concept may, in practice, receive a less costly safety net package or a different

[167] For example, this is roughly equivalent to 300 to 320 hours of homecare each year, or a one-hour home visit by a care professional six days per week, in today's prices.

entitlement structure. The likely direction of bias produced by this limitation is conservative: by not crediting the model with reduced cost demand from the safety-net pathway, the stress tests probably overstate net demand on the Fund in scenarios where safety net coverage meaningfully substitutes for full-scheme claims.

Second, dynamic movement between co-payment bands (spend-down) is not modelled. This model cannot accurately simulate how individuals might move between co-payment bands over time as co-payments reduce their assets. In reality, some individuals who begin in higher co-payment bands may transition into lower bands – or fall below the protected floor – thereby reducing co-payment receipts later. The banded approach approximates co-payments using effective band-level rates, but it does not capture this dynamic spend-down process explicitly. The likely direction of bias is that a static band model may overstate the persistence of co-payment revenue over time, though the expectation is that this movement – particularly movement into the 'floor' of asset value, therefore removing the participant from co-payments altogether – would have only a small impact on the model.

Finally, this model does not directly incorporate administrative costs. In a proof-of-concept built around a stylised 100,000-person population, applying a fixed percentage uplift to represent administration risks misrepresenting what a scaled national Fund could achieve through economies of scale. Instead, administrative overhead is treated as one of several reasons for seeking a clear buffer between the size of the Fund and the modelled demand upon it: in practice, administrative costs could be paid from that margin without undermining the Fund's ability to meet care liabilities. This keeps the stress test focused on the primary structural question: whether the contribution and investment mechanism can plausibly cover net care costs.

What the 'stress tests' show

The table below (Figure 9) presents a small set of summary outputs that together provide a stress test picture: the implied Fund size at drawdown, total gross cost, co-payment receipts, net demand on the Fund, and a sustainability ratio (Fund size divided by net demand). These outputs are chosen because they expose the scheme's core mechanics and allow readers to see which stresses threaten viability without requiring a full actuarial projection.

Figure 9: Stress testing the sustainability of the proposed model in different scenarios

	Usage rate (of later-life population)	Average user care costs	Investment return	Fund size	Total cost after co-payments	Buffer (£bn)	Sustainability ratio
Base case	75 per cent	£61,872	4 per cent	£4.24 billion	£3.82 billion	+0.42	1.11
Higher usage	80 per cent	£61,872	4 per cent	£4.24 billion	£4.07 billion	+0.17	1.04
Higher user cost	75 per cent	£66,872	4 per cent	£4.24 billion	£4.19 billion	+0.05	1.01
Higher usage and user cost	80 per cent	£66,872	4 per cent	£4.24 billion	£4.47 billion	-0.23	0.95
Lower return (3 per cent)	75 per cent	£61,872	3 per cent	£3.53 billion	£3.82 billion	-0.29	0.92
Contributions from 30	75 per cent	£61,872	4 per cent	£5.54 billion	£3.82 billion	+1.73	1.45
Higher return (4.5 per cent)	75 per cent	£61,872	4.5 per cent	£4.66 billion	£3.82 billion	+0.84	1.22

It is possible to draw some important conclusions from Figure 9:

- The model provides a substantial buffer under the baseline assumptions outlined above.
- The model more than breaks even in higher usage rate and higher average user cost scenarios, but the buffer falls below the desired 10 per cent threshold.
- This model falls short in a scenario with lower returns on investment of the Fund. This suggests that significantly lower investment returns or drastically higher costs would ultimately require a longer contribution period, an increased rate of contribution, or another shift to system design.
- Small changes to the contribution starting age (or retirement age) would be a powerful way to boost the sustainability of the system, if needed.
- The investment returns used in the base case are conservative. Higher annual returns could justify reduced co-payment rates or additional investment into the system.

The stress tests highlight the importance of a defined entitlement to manage demand, the commitment to invest the Fund in such a way as to maximise returns, and a reviewable system design to make adjustments over time.

4.4.3 A viable model

The modelling shows that the proposed prefunded system provides a strong sustainability buffer under baseline assumptions and, with tweaks, would continue to meet the target 10 per cent buffer even under more challenging conditions, such as higher user costs and higher service usage rates. This would represent a drastic improvement in systemic resilience compared to England's current approach, while also creating a better-funded system which will accommodate currently unmet need and likely increases in system and workforce costs.

By ruling out any ceiling on lifetime costs, the model ensures that wealthier cohorts continue contributing throughout their care journeys, while protection is delivered instead through the more generous asset floor and progressive co-payment structure. The system therefore remains broadly break-even across a range of plausible stress tests, though significantly lower

investment returns or sharply rising costs would require either an extension of the contribution period or other parameter adjustments.

The model's design is intended to balance sustainability with fairness. Those who contribute fully receive a comprehensive package with asset protection and a personal allowance, while late joiners or partial contributors access a significantly more limited, but still protective, basic offer. This helps to incentivise participation while ensuring no one is left without support. Compared with international PAYG systems, this prefunded approach offers much greater intergenerational fairness by ensuring each cohort funds its own care needs. Taken together, the results indicate that a prefunded, contribution-based model is financially viable, provided there is strong governance of the Fund and careful management of the transition.

5. Transitioning to the new model

Moving from the current PAYG system to a prefunded social insurance model requires managing a period where some contributors will face an effective ‘double burden’: paying both for today’s care and significantly contributing to their own later-life care. This transition must be made as fair and palatable as possible.

Under the core model proposed here, those already older than 34 when the new regime begins would remain within a legacy settlement, while those 34 and under would enter the new contributory model over time. Transitioning to a prefunded model will be expensive, politically painful, or likely both. As such, navigating the transition and delivering the proposed new model will not be easy, and will require strong political leadership, upfront investment, and public engagement. It is, however, essential for putting social care on a sustainable and equitable footing.

5.1 Shortening the transition period?

Even once the first full-contributor cohort reaches retirement age, a substantial legacy population would remain outside the new Fund. The transition is therefore not simply a matter of waiting for the first fully funded cohort to retire, but of sustaining the legacy system over several further decades.

If the Government wishes to include cohorts older than 34 into the new model at the point the new contribution regime begins, rather than their remaining within the legacy model, it would need to require them to contribute at rates higher than the baseline 1.8 per cent. This is because later entrants would otherwise miss not only some of the contributions made by those who started at 34, but also the investment growth those earlier contributions would have generated by retirement. Given the model set out in this paper, with a 34-year contribution window from age 34 to 68, and real investment returns of 4 per cent, relatively modest uplifts would not be sufficient to create anything close to equivalent prefunding by retirement.

If this approach were pursued, it would therefore need to take the form of a mandatory age-banded ‘catch-up’ schedule. Under such an approach, the baseline 1.8 per cent rate would continue to apply to those entering at age 34, but those entering later would face progressively higher mandatory rates, designed to reflect both missed contribution years and foregone investment growth.

On an indicative basis, this could imply rates in the following ranges:

- ages 35-38: roughly 2 to 2.4 per cent contributions
- ages 39-42: roughly 2.5 to 3.1 per cent
- ages 43-46: roughly 3.2 to 3.8 per cent

These figures are illustrative rather than definitive, and any final schedule would need to be set through detailed actuarial analysis and periodic review. But they demonstrate that if government genuinely wished to shorten the transition by bringing older working-age cohorts into the new Fund on terms close to those who began contributing at 34, this would require mandatory contribution rates that rise quickly with age.

Even within this relatively narrow age range, however, the political and economic challenges are obvious. People in their mid 30s to early 40s are often carrying particularly heavy financial

commitments, including childcare, housing costs, and the wider pressures associated with peak working-age family life. Requiring them to make materially higher mandatory contributions to prefund their own later-life care would therefore be likely to prove politically unpopular and practically difficult, despite the far more generous state-supported later-life care offer it would enable access to. For somewhat older age groups, the required rates would rise further still, becoming increasingly hard to justify and more likely to create undesirable knock-on effects such as reduced disposable income, weaker consumption, and lower wider economic activity.

For this reason, while mandatory catch-up rates for older cohorts remain a conceivable design option, they are unlikely to offer the most deliverable route to reform. In practice, the more plausible approach is not to attempt to shorten the transition period by forcing substantially higher contributions from those older than 34 when the new regime begins.

Instead, the priority should be to develop a broader package of measures to keep existing later-life care arrangements affordable and sustainable for those older cohorts while the new Fund gradually matures for younger ones. This is likely to be both more politically realistic and more economically prudent than trying to accelerate transition through sharply higher mandatory contribution rates on age groups already facing significant financial pressure.

5.2 Transition funding options

If the question is not principally how to bring older cohorts into the new Fund, but how to finance the legacy system fairly and sustainably while the prefunded model matures for younger cohorts, then new ways will be needed to shore up that system.

Raising revenue to fund the current provision of state-funded later-life care, until the prefunded model reaches maturity, could involve cutting spending elsewhere, raising taxes, borrowing, or a combination of these.[168]

Fundamentally, this is a question about who in society bears the costs of funding current later-life state-funded care until the new model reaches maturity. This is a difficult, but unavoidable, cost of moving to a prefunded model.

Current and soon-to-be later-life adults have, as working-age adults, funded older cohorts' state-funded later-life care needs. It may therefore appear that they have accrued rights for their state-funded later-life care to be funded by working-age adults.

The reality is different. Older cohorts had to fund far fewer later-life adults' state-funded care needs, divided amongst far more of them (compared to current working-age adults), and the later-life care needs older cohorts funded were less complex and thus less costly. This means current older cohorts did not pay enough into the system to have accrued the right for their later-life care needs to be funded by current or future working-age adults.

Importantly, current older cohorts have also benefited from prosperous economic circumstances that are starkly different to those currently faced by working-age adults. Older cohorts benefited from sustained real pay growth,[169] strong personal pay progression,[170] and

[168] Reform Think Tank, *Social Care: A Prefunded Solution*.
[169] Phil Tinline, 'Why Has It Taken so Long for Stagnant Pay to Become Central to UK Politics?', *Economics Observatory*, 11 October 2023.
[170] Stephen Machin, 'Real Wages and Living Standards: The Latest UK Evidence', *LSE British Politics*, 6 April 2015.

a prolonged period of exceptionally strong asset inflation – particularly in housing – which far outpaced income growth.[171] Additionally, supportive welfare policies have generally protected older cohorts in recent years. This result is that one in four pensioners are now millionaires,[172] and pensioner incomes are forecast to exceed working-age incomes across the income distribution.[173]

These factors – substantially lesser requirements on current older cohorts when they were working-age adults and being the beneficiaries of an unprecedented prosperous economic context – mean it is most fair that this cohort primarily funds the legacy system, by taking on more direct responsibility for their own likely social care costs within the terms of the current system.

Some options for supplementing the existing funding model for current later-life care users and cohorts older than 34 at the time that the new contributions regime begins are set out below. These will become more important over time as the council tax precept 'base' for supporting current care users diminishes, with an ever-growing cohort established on the prefunded model set out in this paper.

5.2.1 Expansion of deferred payment agreements

Deferred Payment Agreements could be significantly expanded so that those approaching retirement contribute to the system more deeply. This would ensure that older cohorts have several effective routes to shoring up the sustainability of the system, first by continuing to support the existing care regime through their tax contributions, and second by pre-agreeing that their own costs should be met, should need arise, from the value of their home, to be settled from their estate.

The expansion of deferred payment agreements would also facilitate self-funding of later-life care needs without care recipients or their spouses having to move out of the home. This should be a permanent measure, though their use will likely decrease at the point that the proposed social insurance model reaches maturity.

5.2.2 Borrowing

One way to fund the legacy system throughout the transition would be borrowing. This would mean the double burden falls to younger and future working-age adults. They would be the ones responsible for servicing resulting debt, while also contributing into the Later Life Care Fund to fund their own potential later-life care needs.

The cost of borrowing is a strong argument against this approach, as well as the intergenerational unfairness of passing on this burden in an already debt-ridden country.[174] These compelling economic and moral arguments against funding the legacy system through significant borrowing rule out this option.

[171] David Miles and Victoria Monro, *Staff Working Paper No. 837: UK House Prices and Three Decades of Decline in the Risk-free Real Interest Rate* (Bank of England, 2019).
[172] Beard, 'One in Four British Pensioners Is Now a Millionaire'.
[173] Broome et al., *An Intergenerational Audit for the UK: 2023*.
[174] Ryan Bourne, *Written Evidence from The Institute of Economic Affairs (IGF0031)* (Institute for Economic Affairs, 2016).

5.2.3 Spending reallocation

There is limited scope for spending cuts in England. Consequently, this mechanism would be insufficient to fund the transition. However, it could play a small role.

Given a properly funded social care system could ultimately help to prevent or redirect significant demand from the health system, it may be appropriate to source the funding for the initial set-up of the Later Life Care Fund from the NHS budget. This could be done, for example, by redirecting 10 per cent of the additional NHS spending set out in the 2025 Budget and confirmed in 2026, which would be worth approximately £3 billion.

5.2.4 Taxation

Council tax

Continuing, or raising, council taxes would be a way for both working-age and later-life adults to fund the transition. This may instinctively be appealing through the lens of intergenerational fairness. It may also seem politically easier to not reduce council tax, than to introduce or increase taxes elsewhere.

However, council tax is regressive, outdated and unfair. The current funding model's reliance on council tax is a significant source of its structural unfairness, contributing to entrenched regional inequalities in access to and quality of care services. Its continued role to fund care needs should therefore be avoided.

Current working-age adults

The transition and legacy system could be funded by taxes on working-age adults, via (hypothecated) income tax or increased National Insurance contributions. This means the double burden would fall to working-age adults who, once they reach 34 years old, would be funding the current provision of state-funded later-life care and contributing to the Later Life Care Fund for their own cohort's later-life care needs simultaneously.

It would be administratively straightforward to raise funds via these mechanisms, given they are already in place. Despite this, given current working-age adults are facing far more difficult economic circumstances than older generations faced, and the tax burden is already high (and would be increasing with the introduction of mandatory contributions to the Later Life Care Fund from the age of 34), such policies are certainly unfair and likely to be deeply unpopular. This option would also represent a continuation of the structural intergenerational unfairness of the current model.

The double burden falling to working-age adults should therefore be minimised. This could be achieved through the implementation of taxes which are designed to primarily affect older groups, as the next section shall discuss.

Figure 10: Transition funding options for moving to a prefunded social insurance model of later-life care and funding the legacy system throughout the transition

Mechanism	Who the burden falls to	Pros	Cons
Borrowing	Future working-age cohorts	• Spreads costs over time • Avoids politically difficult immediate tax rises	• Adds to an already high national debt burden • Intergenerationally unfair • Vulnerable to interest rate shocks
Spending reallocation (especially from the NHS)	Shared (current taxpayers)	• Recognises interdependencies between well-funded social care and hospital demand • Politically feasible if limited and tied to integration between health and social care	• Scale of funding required far exceeds feasible reallocations • NHS and all public service budgets are already under strain
Council tax	All adults, disproportionately impacting regions with higher levels of deprivation	• Continues or extends an existing system, which is helpful for delivery • Shares the financial burden across generations	• A regressive, outdated and unfair tax • Continues entrenching regional inequalities • Counter to long-term objectives to abolish council tax
Working-age taxes (income tax and National Insurance)	Current working-age adults	• Administratively simple, making use of existing mechanisms • Public familiarity with mechanisms • Provides predictable revenue	• Double burden falls on younger cohorts already facing high living costs and a less prosperous economic context than older cohorts did • Politically difficult given already high tax levels
Later-life taxes (National Insurance on pension income, inheritance tax, property levy and expanded DPAs)	Current and soon-to-be later-life adults	• Progressively targets wealthier cohorts • Helps rebalance housing-wealth imbalances • Time-limited levies are easier to justify	• May be perceived as breaking the implicit contract, given older cohorts funded the PAYG system, but wouldn't fully benefit from it • Politically unpopular • Revenue from inheritance tax is prone to avoidance

5.3 A roadmap

With the options for funding the legacy system's provision of state-funded later-life care outlined, it is fairest for much of the costs to be absorbed primarily by wealthier current and soon-to-be older people. This would mean taxes levied on these cohorts in combination with mechanisms to unlock asset value to enable self-funding.

There are several plausible levers which could be temporarily used to raise additional revenue. To take two examples:

1. National Insurance contributions for pensioners, and
2. a high-value property levy, which would disproportionately impact homeowners in their late 30s and older (who tend to own more valuable properties).

Extending National Insurance to pensioners' earned and investment incomes would broaden the base in an ageing society, align contributions with longer working lives, and improve intergenerational fairness by reducing the tax advantage older cohorts have over working-age payers on the same cash income. Designed with a generous threshold and targeted reliefs, this could protect low-income retirees while raising predictable revenue without increasing headline rates on workers.

The expansion of the effective 'mansion tax' property levy proposed in the *Budget 2025* could also provide a useful source of funding during the transition period, and would primarily impact

the wealthiest in society. Current Government plans to add further bands to the top end of council tax could provide a template, ideally if organised alongside a much-needed re-basing of the council tax system.

Revenue raising potential

Recent analysis predicts that significant amounts could be raised by applying employee National Insurance contributions to pensioner income. Introducing NICs to those already drawing pensions would yield roughly £750 million for every 1 per cent of NICs charged, so that a notional NIC rate of 10 per cent could be worth around £7.5 billion per year (assuming no significant behavioural shifts).[175] The negative impact of such a policy could be minimised by introducing it by increments, though this could have the effect of encouraging defined contribution savers to draw their pensions earlier to reduce their tax liability, so a birth-cohort introduction may be preferable.

Introduction of a property levy – 1 per cent of the property value for properties valued over £2 million, but less than £3 million; and 2 per cent of the property value for properties valued over £3 million – has been estimated to be worth as much as £1.5 billion in 2026-27.[176]

Likely implementation challenges

The main challenge for introducing National Insurance contributions for pensioners is the likelihood of political backlash. This is likely to come not just from pensioners themselves, but more broadly. The extent of backlash common with policies seen to harm pensioners is exemplified by the strong reaction to this Government's changes to the Winter Fuel Payment to be means-tested, rather than universal (now largely reversed).

A property levy on high-value homes, even one as limited as that proposed in the *Budget 2025*, can have adverse consequences – working as a 'tax on aspiration' or potentially contributing to international capital flight. However, expansion of this policy could also have the additional benefit of incentivising later-life adults to downsize in order to avoid the property levy. This could help to ease housing market pressures, as well as freeing up capital for older people who are 'asset rich, cash poor'.

Recommendation 14: To fund the transition period, Government should develop a package of transition-funding levies or tax changes, including the expansion of personal National Insurance contributions to the incomes of pensioners, and/or the creation of a high-value property levy to ensure greater contributions by the wealthiest homeowners and incentivise more down-sizing among older people.

[175] Adam Stuart et al., *A Blueprint for a Better Tax Treatment of Pensions* (Institute for Fiscal Studies, 2023).
[176] Dan Goss, *Solving the Tax Puzzle: Eight Popular, Pragmatic, pro-Growth Tax Reforms to Plug the Fiscal Hole* (Demos, 2025).

6. Conclusion

England's adult social care system is in crisis. Unmet need continues to grow, regional inequalities in access and quality remain entrenched, and structural injustice – across socioeconomic groups, generations, and places – is now all but hardwired into the system. Financial pressures are overwhelming local authorities and care providers, while individuals face unexpected, high and unpredictable personal costs.

These realities not only pose a critical moral issue, they undermine the legitimacy of the current social care model which taxpayers fund, and erode the social contract between citizen and state.

Demographic changes are only exacerbating the problems. A growing older population, living longer with complex health conditions, combined with a shrinking working-age base, places unsustainable pressure on a system that is already underfunded and illogically structured.

Incremental reforms have repeatedly failed to fix the problems. A complete transformation of the funding model for later-life social care is now essential. The sooner this action is taken, the better.

This report proposes a new model built on four fundamental principles: risk pooling, sustainability, fairness, and deliverability. It centres on a national, prefunded social insurance model, with mandatory contributions during working life and a clearly defined offer of support in later life. In contrast to the current model, no one in the new scheme will be required to fully self-fund their own care. All assessed users will be entitled to support, though the share covered by the Fund will vary with wealth and contributory history.

Co-payments for later-life care services should be structured to reflect ability to pay, with meaningful protections in place.

The model set out in this report blends the best of international examples with key innovations tailored to the English context: long-term prefunding, wealth-based co-payments, and a structured, reviewable design. It redistributes risk across the population, protects individuals from catastrophic care costs, and gradually replaces regressive local council tax funding with a fairer, more resilient alternative.

This report sets out a "baseline" approach: a starting point establishing the duration and scale of contributions, a co-payments regime, asset protections, and an annual co-payment-free allowance for later-life care users. The specific parameters laid out – which under our proof-of-concept modelling would be able to fund a more generous future care system while maintaining a funding surplus – should be seen as just one proposal to implement a prefunded social insurance model, reflecting one set of approaches to the trade-offs and difficult decisions inherent in this policy area.

In practice, the Government could investigate public appetite for where these different decisions should land, through participatory, consultative, or other means. Would the public prefer a shorter contribution period in exchange for slightly higher levels of contribution? Would they rather start contributing earlier, or retire later? By definition, the conditions for these recommendations are susceptible to change. What matters is that the elements of this model – prefunded, invested for growth, supplemented by co-payments, and pooled over the national population – are workable, and vastly preferable to what exists now.

Delivering reform on this scale will not be easy. It will require political leadership, upfront investment, and public engagement. But the current system is neither fair nor financially viable. With clear public expectations, mounting need, and after decades of drift, now is the time for a serious, sustainable, and implementable solution.

7. Appendix – the method behind the model

7.1 The key variables

This paper sets out a 'proof of concept' model in order to establish the viability of the proposed approach to funding later-life social care in England.

This modelling is designed to test the viability of the destination model for cohorts participating fully in the Fund. It does not constitute a full fiscal simulation of the transition from the current system, which would depend on the pace of implementation, the treatment of legacy cohorts, and the mix of transition-funding measures adopted, as well as a host of other variables.

This stress test model combines:

1. a set of contribution-and-investment mechanisms to establish the affordability of the Fund, using a notional cohort of 100,000 users;
2. a stylised estimate of later-life care demand for the same cohort; and
3. a simplified co-payment design that reduces demand on the Fund according to wealth.

Figure 11: Stress testing the sustainability of the proposed model in different scenarios (same as Figure 9)

	Usage rate (of later-life population)	Average user care costs	Investment return	Fund size	Total cost after co-payments	Buffer (£bn)	Sustainability ratio
Base case	75 per cent	£61,872	4 per cent	£4.24 billion	£3.82 billion	+0.42	1.11
Higher usage	80 per cent	£61,872	4 per cent	£4.24 billion	£4.07 billion	+0.17	1.04
Higher user cost	75 per cent	£66,872	4 per cent	£4.24 billion	£4.19 billion	+0.05	1.01
Higher usage and user cost	80 per cent	£66,872	4 per cent	£4.24 billion	£4.47 billion	-0.23	0.95
Lower return (3 per cent)	75 per cent	£61,872	3 per cent	£3.53 billion	£3.82 billion	-0.29	0.92
Contributions from 30	75 per cent	£61,872	4 per cent	£5.54 billion	£3.82 billion	+1.73	1.45
Higher return (4.5 per cent)	75 per cent	£61,872	4.5 per cent	£4.66 billion	£3.82 billion	+0.84	1.22

The baseline parameter set is chosen to be plausible, transparent and easy to stress. Where national datasets do not provide a single definitive value that maps directly onto the model structure, baseline choices are set as simple, defendable approximations and then tested through scenarios.

Contribution window and rate: contributions are assumed to be paid over a fixed window from 34 to retirement age, reflecting a contribution period that is long enough to allow

meaningful prefunding while avoiding the earliest career years. The baseline contribution rate is 1.8 per cent of gross income and is applied above a contribution floor pegged to the lower earnings limit used in pension auto-enrolment.

Figure 12: Baseline Fund and contribution assumptions

Variable	Baseline value
Contribution window	34 years (from 34 to 68 years old)
Cohort size	100,000
Mean salary (start of contribution period)	£46,202
Contribution floor	£6,240
Contribution rate	1.8 per cent
Proportion contributing (effective share of theoretical contributions collected in a given financial year, reflecting that some people on the Fund are less economically active or may spend time without employment)	77 per cent
Annual wage growth (real terms)	0.7 per cent
Investment return (real)	4 per cent

Earnings level across the contribution window: the baseline earnings assumption uses a mean salary for the contributing ages, rather than the median, because aggregate contributions depend on the sum of earnings across contributors and earnings grow over the course of careers. The mean salary is constructed by taking mean earnings for broad age bands and weighting them by the number of years each band occupies within the 34 to 68 contribution window. Concretely, the model weights mean salaries for ages 30 to 39, 40 to 49, 50 to 59 and 60 and above by 6, 10, 10 and 8 years respectively, then sums the weighted values to produce a single mean salary for the contribution window.

Earnings growth: the model assumes real earnings growth of 0.7 per cent per year and applies this to the earnings base across the contribution period.[177]

Investment return: Fund assets are assumed to have a real return of 4 per cent per year, which compounds over time (i.e. the returns are reinvested into the Fund, and are also grown at the same rate in subsequent years). The stress tests then vary returns to show sensitivity to lower (and higher) long-run performance.[178]

Care usage and baseline care cost: later-life care demand is modelled using a baseline usage rate and an average lifetime care cost per user, expressed in today's prices. The baseline usage rate is set at 75 per cent, reflecting the proposition that most people will require

[177] Office for Budget Responsibility, *Economic and Fiscal Outlook* (2026).
[178] Professor Elroy Dimson et al., *Global Investment Returns Yearbook 2025: What 125 Years of History Tells Us about the Future* (UBS, 2025).

some formal care at some point in later life, consistent with estimates used in charging reform analysis by the Department of Health and Social Care.[179] The baseline mean lifetime care cost per user is set at £45,000 for care costs excluding accommodation, which is the starting point for calculating the growth in costs over time (see Figure 13). This structure uses mean, not median, because the distribution of care costs is skewed and a minority of high-cost cases materially increases average costs.

Figure 13: Baseline care demand and cost build-up

Variable	Baseline value
Usage rate (share of later-life cohort expected to require formal care)	75 per cent
Baseline mean lifetime care cost per user (today's prices, care costs only)	£45,000
Years from contribution start to eligibility	34 years
Care cost growth above inflation (real)	1 per cent
Uprated mean lifetime care cost per user at eligibility (today's prices)	£61,872
Total gross cost for cohort before co-payments	£4.64 billion
Total co-payments for cohort	£0.82 billion
Total cost for cohort after co-payments (net demand on Fund)	£3.82 billion

Care cost growth above inflation: the model assumes care costs rise by 1 per cent above inflation each year, between the start of contributions and the point of eligibility.[180] The average lifetime cost per user is uprated by this real growth factor across the contribution period. The potential for further care cost inflation between the point of eligibility and the year post-retirement where care service usage becomes most likely is another reason to target a 10 per cent buffer in the baseline model.

Wealth distribution, protected floor and co-payment design: co-payments are modelled by segmenting the eligible cohort into wealth bands with fixed population shares. The model applies a protected asset floor of £75,000 and band-specific co-payment rates. The model also incorporates the costs of an annual co-payment-free allowance, pegged at 60 per cent of the value of the full State Pension (rounded to £7,000 for the proof-of-concept model in this report). The model applies the annual allowance over an effective duration of three years. This is a simplifying parameter rather than an estimate of literal mean duration. It is intended to reflect a distribution in which many users experience short-term or time-limited support, while a smaller number experience longer and more expensive episodes. This is consistent with

[179] Department of Health and Social Care, *Social Care Charging Reform Impact Assessment*.
[180] This slightly exceeds the current year-on-year growth in the average hourly rate for social care of 0.9 per cent (The King's Fund, 'Social Care 360: Expenditure', Web Page, 3 March 2025). By other measures, real terms care cost inflation is currently higher than 1 per cent, reflecting current high wage and price pressures. Our model assumes that over the long run these effects will reduce and cost growth will be further mitigated by new practices and technology to improve productivity.

national evidence showing substantial volumes of short-term care and care home stays typically measured in months rather than many years. A three-year assumption also avoids overstating the value of the allowance for the highest-cost users, whose overall co-payments would, in most cases, substantially exceed the allowance even if they drew on it over multiple years. Because floors and allowances reduce what can practically be collected, the model uses effective co-payment rates for each wealth band. These effective rates are the mechanism that translates the policy rules into an expected co-payment share of costs at cohort level.

Figure 14: Wealth bands and co-payment calculations (baseline)

Wealth band	Population share	Headline co-payment rate	Users	Total co-payments (factoring in allowance)	Net cost to fund
Up to £75k	9 per cent	0 per cent	6,750	£0 billion	£0.42 billion
£60k-£100k	6 per cent	10 per cent	4,500	£0.02 billion	£0.26 billion
£100k-£600k	40 per cent	20 per cent	30,000	£0.25 billion	£1.61 billion
£600k-£2m	41 per cent	40 per cent	30,750	£0.50 billion	£1.40 billion
More than £2m	4 per cent	45 per cent	3,000	£0.06 billion	£0.13 billion
Total	100 per cent		75,000	£0.82 billion	£3.82 billion

7.2 Limitations and areas not explicitly modelled

Administrative costs

The model does not include an explicit administrative cost line. Applying a fixed administrative percentage to a stylised 100,000-person proof-of-concept risks misrepresenting what the national-scale Fund could achieve through economies of scale in collection, administration and investment management. Administrative overhead is therefore treated as one reason the stress tests seek to establish a clear buffer between the Fund size and projected net demand, since administrative costs could be funded from that margin.

Movement between co-payment bands over time

The model does not simulate how individuals might move between wealth bands as co-payments reduce assets. In practice, some individuals who begin in higher co-payment bands may transition into lower bands or fall below the protected floor, which would reduce co-payment receipts later in a care journey. The model approximates this through fixed wealth-band shares and effective co-payment rates. This means co-payment receipts may be overstated if spend-down effects are large, particularly over long periods.

Safety net pathway not modelled

The model does not explicitly model the safety net or backstop version of the scheme, even though reduced contributions are included to reflect differentiated contribution patterns. The direction of bias is therefore likely to be conservative with respect to Fund adequacy, since the model does not credit the Fund with the potential cost reduction associated with the safety net pathway.

7.3 Step-by-step: how the model is calculated

Step 1: construct the mean salary for ages 34 to 68

A single mean salary is derived for the contribution window using age-weighted mean earnings between the ages of 34 and 68:

- Age-band mean salaries are taken for four bands: 30 to 39, 40 to 49, 50 to 59, and 60 plus.
- The contribution window from 34 to 68 spans 34 years within those bands, allocated as 6 years in 30 to 39, 10 in 40 to 49, 10 in 50 to 59, and 8 in 60 plus.
- Each band's mean salary is multiplied by its year-weight, then summed to produce the mean salary for the contribution window.

This produces the starting baseline mean salary used in the stress tests.

Figure 15: The modelled weighted contributions for ages 34 to 68

Age band	Years within contributing period	Weighting (rounded)	Mean annual earnings	Weighted contribution
30 to 39	6	0.19	£42,122	£8,153
40 to 49	10	0.32	£46,636	£15,044
50 to 59	10	0.32	£44,463	£14,343
60+	8	0.26	£33,569	£8,663

Note: The resulting weighted mean annual earnings across ages 34-68 is £46,202.

Step 2: calculate annual contributions and apply earnings growth

The model calculates an initial annual contribution per contributor as:

- contribution base = *max(0, mean salary minus the contribution floor)*
- initial contribution = *contribution rate* × *contribution base*

The model then applies real earnings growth to the contribution flow:

- Contribution in year *t* = *initial contribution* × *(1 + wage growth)^(t − 1)*

This element allows contributions to grow in real terms over time, rather than remaining flat.

A reduced contribution or coverage factor is applied to reflect that not all contributors pay the full rate in every year due to labour market patterns, lower earnings and other real-world frictions.

Step 3: convert growing annual contributions into Fund size at drawdown

The model then accumulates the growing annual contributions into a Fund, at the point of drawdown, using an investment return assumption. Where annual contributions grow at a constant rate *g* and investment returns are *r*, the Fund at drawdown is calculated using a growing annuity structure.

In simplified form:

- Fund size is proportional to the annual contribution flow multiplied by a growing annuity factor that depends on *r, g* and the number of contribution years.

This element captures the interaction between wage-linked contributions and compounding investment returns.

Step 4: uprate lifetime care costs using above-inflation care cost growth

The model uprates the baseline mean lifetime care cost per user to reflect real care cost pressures:

- Uprated lifetime cost per user = *baseline lifetime cost × (1 + care cost growth)^(years)*

With care cost growth set to 1 per cent per year above inflation, this raises the expected lifetime cost burden at drawdown relative to today's prices.

Step 5: calculate gross cohort costs

Gross demand on the scheme before co-payments is calculated:

- Number of users = *cohort size × usage rate*
- Gross cost = *number of users × uprated lifetime cost per user*

Stress tests vary the usage rate and the average cost per user to test how sensitive the scheme is to higher prevalence of need and higher intensity of care packages.

Figure 16: Calculating the implied coverage factor

Metric (ages 34 to 68, average)	Value
Unemployment rate	2.9 per cent
Inactivity rate	19.6 per cent
Unemployment + inactivity	22.5 per cent
Implied coverage factor (1-unemployment/inactivity)	0.77

Note: The coverage factor is used as a simple scaling parameter for effective contribution receipts, reflecting the share of the working-age population not in employment and therefore less likely to contribute at the full headline rate in every year.

Step 6: apply co-payments using wealth bands and effective co-payment rates

Co-payments are calculated by distributing users across wealth bands and applying band-specific effective co-payment rates:

- Users in band *i* = *number of users* × *population share in band i*
- Co-payment in band *i* = *users in band i* × *uprated lifetime cost per user* × *effective co-payment rate in band i*
- Total co-payments = *sum across all bands*

The protected floor, annual co-payment free personal allowance, and co-payments are reflected in the effective co-payment rates.

Step 7: calculate net demand, buffer and sustainability ratio

Net demand on the Fund:

- net cost = *gross cost − total co-payments*

The buffer and sustainability ratio:

- buffer = *Fund size − net cost*
- sustainability ratio = *Fund size ÷ net cost*

These outputs are reported for the baseline and for each stress scenario.

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