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England's two tier care system deepens social care inequalities

Anders Bach-Mortensen and colleagues examine how increasing reliance on out-of-pocket payments for adult social care has created a quality divide

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In July 2024, the UK government abandoned long awaited reforms to address England's two tier care system, in which people with care needs either self-fund or receive state support if their assets fall below £23 250. For care homes—residential facilities licensed to deliver personal care and support, which may include nursing care—this two tier system has created wide care inequalities, with state funded residents experiencing worse quality care, while many others have unmet needs or rely heavily on unpaid family carers. These inequalities are not just costly for local authorities, which fund social care, but also create substantial downstream costs for the NHS.[1]

Although most countries have elements of two tier funding in their care systems, England's sharp wealth threshold has created a system in which care home providers focus on richer areas with a higher concentration of self-funders, with low incentive for homes to open and operate in poorer, high need areas. This disparity is measurable in access to care and inspection ratings of care providers,[2] and has severe consequences for the health and wellbeing of the over 850 000 people receiving formal long term care in England.[3]

Inequalities in adult social care services

Social care generally refers to the "practical care and support that disabled and older people draw on to live their lives."[4] Care needs in England are disproportionately higher in the poorest areas of the country.[5] Among people aged over 65, the proportion needing care in the most deprived areas is double that in the least deprived.[5] Unmet care need is also highest among people with the lowest socioeconomic status.[5 6]

The quality of care adds to these inequalities. The Care Quality Commission (CQC) inspects and rates the quality of residential homes as "outstanding," "good," "requires improvement," or "inadequate."[2]Figure 1 shows the number of care homes opening since 2011 that have been rated as "outstanding" or "inadequate" according to level of deprivation of their location. The best homes are predominantly located in the richest areas. The poorest areas have far fewer outstanding rated care homes, despite those areas having higher care needs. This relation is almost perfectly inversed for inadequate rated provision, with the worst rated homes more likely to be in the poorest areas. The widening gap between 2011 and 2023 corresponds with a period of substantial cuts in local government funding.[7]

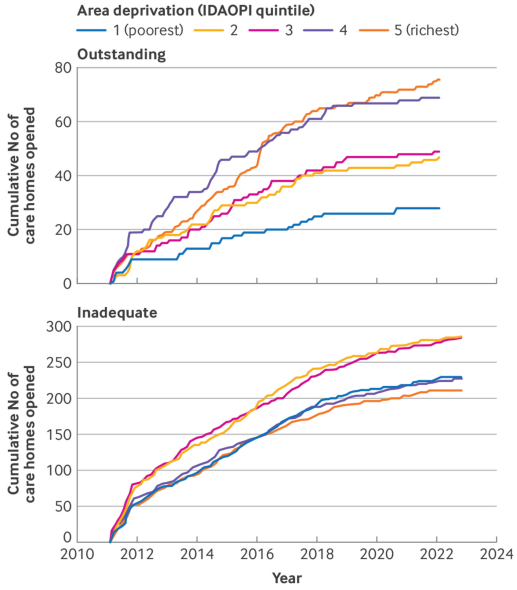

Fig 1 | Cumulative number of care homes opening during 2011-23 that have ever been rated "outstanding" or "inadequate," according to area deprivation (assessed from income deprivation affecting older people index)[2 31 32]

Quality gap between self-funded and state funded residents

A key feature of the two tier system of care in England is that self-funders pay higher rates for their care. A 2018 Competition and Markets Authority investigation found that self-funding residents are charged up to 41% more than state funded residents in the same home, creating a cross-subsidy system in which providers are forced to take on self-funded residents to subsidise the shortfalls in state funding.[8] This means that care homes with more self-funded residents have more resources to deliver quality care and are more financially viable.

The data show a clear correlation between care home quality and the proportion of self-funding residents. Homes rated as outstanding by the CQC have the highest average percentage of self-funders at 50.9%, compared with just 24% in inadequate rated homes.[9]

This affects care equity in England. Overall, 16% of self-funding residents live in homes rated as inadequate or require improvement by the CQC, compared with 22% of state funded residents. The quality gap between state funded and self-funded residents increases by area wealth: in the poorest areas, there is a 3.8 percentage point difference between state and self-funded care quality, but this

gap widens to 7.8 percentage points in the wealthiest areas (fig 2).

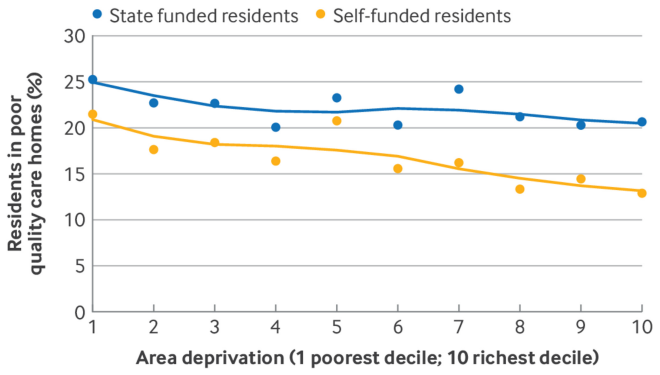

Fig 2 | Proportion of state funded and self-funded residents in English care homes rated as inadequate or require improvement by area deprivation (Income Deprivation Affecting Older People Index deciles), 2023[2]

Human and systemic toll of care inequality

The association between funding source and quality is not surprising. A system in which care homes receive more for self-funded residents than state funded residents encourages them to prioritise, and even intentionally attract, people who are self-funded. Self-funded residents also have more choice and can select the best homes. This choice rarely extends to state funded residents, who are systematically restricted in accessing quality care, either because good services are scarce in their area or because they cannot afford to self-fund higher quality homes. Although self-funders bring private funding and flexibility into the system, their presence tilts the market towards more high end "luxury" living that primarily benefits those that can pay themselves.[10] Moreover, because state funded residents have their costs paid at a lower rate, the care homes that are occupied mostly by state funded residents are at increased risk of bankruptcy.[11] This dynamic risks creating "care deserts" of severely limited access to quality care in more deprived regions.[12]

Beyond these statistics lies a profound human impact: those who cannot afford to self-fund from the outset will have often have no choice but to live in struggling homes simply because they cannot afford to pay. Others experience this inequality differently when their personal wealth is depleted from paying for their own care and they transition to state funding. Average residential care costs (without nursing) are £65 000 annually, so when someone with life savings of, say, £180 000 moves into a care home, their assets would drop below £23 250 within three years. The local authority would then conduct a financial assessment and needs assessment, and if it decides that care needs could be met in a cheaper facility, the person would be forced to move, leaving behind friendships and familiar routines, unless they could afford to pay a top-up fee.[13]

Inflation has exacerbated these challenges, and financial pressures are causing providers to respond in undesirable ways. A 2024 Care England survey found that a third of the surveyed homes are closing down parts of their organisation or handing back "loss making" contracts.[14] At worst, this can lead to state funded residents being evicted because providers risk insolvency by keeping them as residents.

This system traps publicly funded residents in a cycle of poor care that proves costly for everyone involved. Local authorities spend hundreds of millions every year on inadequate rated care homes,[15] which are at much higher risk of being suddenly closed by the regulator.[16] When such closures occur, residents face urgent relocation, which is not only expensive but also deeply distressing for individuals, who are forced to leave their home and community. Counterintuitively, this creates a cycle where inadequate funding ultimately results in higher human and financial costs.

Inadequate care access and availability does not just harm residents and strain local authorities, it also creates substantial downstream costs for the NHS. Poor care services increase preventable hospital admissions and delays discharges, particularly in areas with a higher concentration of lower rated care homes.[1] According to the Health and Social Care Committee, around 13% of NHS beds are occupied by people waiting for social care support, which has been estimated to cost the NHS £1.89bn annually.[1 17] The financial impact is most severe for patients needing nursing home placement, where 70% experience discharge delays. These costs extend beyond occupied beds and include cancelled procedures and staff time spent arranging care packages, which are all preventable expenses that divert resources from frontline healthcare.

Beyond those receiving inadequate care lies an even larger inequality: millions of people with no access to formal care at all.[1] Cases of unmet and under-met care needs are rising,[18 19] particularly in the most deprived areas where need is highest.[20] This forces more responsibility onto unpaid family carers, who often sacrifice employment and their own health to support loved ones. Recent inflation has intensified these problems by driving up care costs,[21] while the proportion of applicants who are granted state funded support continues to decline.[22]

England's uniquely sharp funding divide

Most countries use means testing in their care systems, but England stands out for its sharp divide between state funded and self-funded care.[23] At face value, England appears relatively generous in its care coverage, as around 63% people in residential care settings receive state support,[9] and some residents receive NHS funded nursing care (currently £235-£254 a week) without means testing. However, England stands out internationally in requiring substantial contribution from self-funding individuals. For older people with severe needs, the out-of-pocket costs, as a share of people's disposable income, are 112 percentage points higher for individuals with median wealth than for those with no wealth.[23]

This contrasts with systems in other countries, which have a broader base of tax or insurance income to fund care systems.[23 -25] For example, Germany employs social insurance where everyone (including retired people) pays a fixed share of income for basic support. France funds care through a combination of labour income contributions plus a 0.15% levy on pensions, wealth, and capital gains. Japan splits funding between working age (40-64) and older (≥65) citizens through mandatory insurance premiums set by municipalities, ensuring intergenerational cost sharing.[23 -25] Spain uses more progressive wealth testing that adds 5% of a person's assets to their income assessment, but unlike England it excludes the primary residence, and it has a much smaller wealth based gap in out-of-pocket costs.[23]

The outcomes of each care system are difficult to compare given the many cultural and socioeconomic determinants of health. However, these systemic differences confirm that England has adopted an approach that emphasises personal responsibility, which places a substantial burden on a subset of people at the end of their lives. Despite appearing progressive and redistributive on the surface, this system ultimately exposes some people to an

extreme level of financial risk that we do not tolerate for healthcare, while confining those without personal wealth to inferior care.

Crisis in need of action

Long awaited reforms to expand state funding of social care in England were abandoned in 2024 in favour of a new commission and delayed action (box 1). Cancelling the reform means that the fundamental problems driving care inequality remain unaddressed. Without adequate public funding, care homes will continue to rely financially on self-funding residents, which will perpetuate the uneven geographical concentration of higher quality care in affluent areas while leaving deprived regions with insufficient provision. Other parts of the UK have different regulatory arrangements and eligibility criteria for state funded care. However, no UK nation has a feasible plan to bring sufficient resources into social care. Since most fiscal policy is retained by the UK government, a new financial settlement for care will be a UK-wide arrangement.[26]

Box 1: England's scrapped social care reform plans[27]

- The government planned to introduce an £86 000 cap on lifetime care costs and raise the means tested thresholds, meaning more people would receive state support for social care
- The reform aimed to tackle unfair pricing by ensuring self-funding residents could access the same care home rates as those paid by local authorities, with £1.36 billion allocated to help councils pay providers more
- The reforms would have increased state support from covering roughly half to about two thirds of older people in care,[28] though some stakeholders questioned whether the changes would live up to expectations
- Annual costs were projected to start at £1.42bn in 2023-24 and rise to £4.74bn by 2031-32. However, concerns were raised about whether this funding would be sufficient and if local authorities had enough staff to implement the changes
- Despite being scheduled for October 2023 and then delayed until 2025, the entire reform package was cancelled in July 2024 by the chancellor, Rachel Reeves, to reduce a projected £22bn overspend
- In January 2025, the government announced that a new independent commission, chaired by Louise Casey, will work towards building cross-party consensus for long term reform of adult social care
- The commission will work in two phases, with phase 1 reporting in 2026 to develop medium term solutions aligned with current spending plans to lay foundations for a national care service. Phase 2, reporting in 2028, will make longer term recommendations for transforming the entire adult social care system to meet future demographic challenges[29]

Scotland's experience of implementing free personal and nursing care provides a lesson in how expanding care coverage will not eliminate inequalities if inverse market incentives are not addressed. Because there is no regulation on what care homes can charge self-funders, average fees for nursing homes are 50% above the national contract rate, which, like in England, has created a system where self-funders are much more lucrative than publicly funded residents.[30] Even though self-funders receive care payments from the state, these do not cover full costs, which means that care services are not free, as many are forced to pay top-up fees, and that those who cannot self-fund are much less desirable clients for care homes.[30]

The path to reform is clear—what is missing is political resolve to act. Since the Dilnot report in 2011, successive governments have acknowledged the problems, but continually postponed action because of immediate fiscal pressures. This short termist approach ignores the much higher cumulative costs of inaction that spread across the NHS, local authorities, families, and individuals. The current two tier system is not just inequitable; it is economically unsustainable. The inequalities in care are incredibly costly and lead to preventable NHS admissions, delayed discharges, and expensive emergency relocations when financially unstable homes close.

Reform will inevitably require substantial investment, but continuing the status quo means paying more for worse outcomes. It requires ringfenced funding to eliminate cross-subsidisation, fair pricing for all residents, and sufficient provision in underserved areas (box 2). Reform is not just about costs but about designing policy that can break the cycle where chronic underfunding has created geographically determined workforce and capacity shortages, which undermine service quality and jeopardise public support for investment in the sector. The new commission must learn from past reform failures to create a system that can deliver quality care for all, regardless of financial means.

Box 2: Policy priorities to reform England's social care system

Implement existing legislation on funding reform

The issues surrounding inadequate funding have repeatedly been diagnosed by previous reviews, including the Dilnot commission. Rather than starting anew, the government should implement specific policies already developed in existing legislation: introducing a care cap, raising the means test threshold, and enabling more people to purchase care through the state. This must be accompanied by adequate ring-fenced funding to local authorities and action to reduce workforce constraints, such as high vacancy and turnover rates

End the cross-subsidy through fair pricing

As well as legislating to ensure fair pricing for self-funders, the government must provide councils with adequate funding to pay providers sustainable rates that reflect inflation increases and the true costs of delivering high quality care

Achieve better commissioning by improved data integration

Better data integration must be established to measure the impact of care on people's lives, the wider health system, and the economy, rather than simply tracking care tasks and activities. These systems should monitor how funding disparities affect care quality across the country and the costs of poor care on health services.

Improve the availability and quality of care homes in underserved areas

Geographically targeted interventions are needed to ensure a fairer distribution of high quality care across the country. The government should introduce targeted incentives such as capital grants for new facilities in underserved areas and increased local authority provision to ensure capacity where market forces have failed to deliver. The exact funding mechanisms to achieve this need to be considered carefully, as relying on council tax to fund social care has proved ineffective in the long term and creates regional inequalities

Learn from past reform failures

The UK has consistently failed to implement structural social care reform despite cross-party recognition of the problems. Future attempts must learn from past challenges, such as competing political priorities that lead to postponement when fiscal pressures emerge, inadequate engagement with local authorities which ultimately deliver services, and policy proposals that lack a clear pathway from legislation to service improvement. Future reform must secure sufficient political consensus to survive changing governments, which involves establishing realistic funding mechanisms and system-wide stakeholder involvement from the outset.

Key messages

- England's two tier care system has created care inequalities between the poorest and richest areas, and between self-funded and state funded residents

- Nearly 25% of care home residents in the most deprived areas live in poor quality homes, compared with 16% in the least deprived areas
- The cancellation of planned social care funding reforms in 2024 is likely to exacerbate these inequalities, failing to bring adequate public resources into the sector
- In addition to increased funding, new policy must ensure equitability, quality, and access to care regardless of resident funding status or location

Contributors and sources: BG, ABM, MDE, CN are academics and evaluation experts in social care and policy. BG and ABM specialise in mapping and analysing social care marketisation. CN has extensive expertise on adult social care in the UK and in Europe. MDE has expertise on advanced epidemiological methods. BG and ABM conceived the initial idea, and ABM developed the first draft. Both ABM and BG curated the data, and replicated the data and analysis. All authors contributed to drafting and revising the manuscript. ABM is the guarantor.

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