CARE ASSOCIATION ALLIANCE

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Adult Social Care Funding Reform

A proposal for a sustainable, equitable and nationally consistent funding framework for adult social care in England

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Policy Paper One

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A NOTE ON LANGUAGE

This programme is published under the heading Building a National Care Service. We use "national" in a specific and bounded sense: a national funding settlement, a national eligibility threshold, a national tariff and a national framework for the workforce within which care continues to be commissioned and delivered locally, by local authorities and an independent provider market. We do not propose a free care service funded on the model of the NHS. Individuals with the means to contribute to the cost of their care will continue to do so, subject to a reformed means test and a lifetime cap. The word "national" describes the funding architecture; it does not describe how care is provided.

Foreword

I came to social care after a very interesting career. Having qualified as a Chartered Accountant, I worked for long-established family businesses supporting their acquisitions in manufacturing, and then in Silicon Valley. This experience is what enables me to look at the social care sector in the way that I do and join policy discussions to the reality on the ground.

Having worked in social care for more than twenty years, I am struck by how rarely this country thinks about it until the moment it can no longer avoid doing so. When someone can no longer manage at home. When a family is suddenly confronted with decisions they were not prepared to make. When the questions that have always felt distant become urgent: who will provide the care, who will pay for it, and what will it mean for the people we love?

For those who have already faced those questions, and for the providers who deliver care within the system every day, the answers have too often depended on things that should not matter. Where you live. What your local authority can afford. Whether there happens to be a provider willing to operate at the rates on offer.

That is not a system. It is an accumulation of pressures and compromises, arranged in a way that passes the cost to those least able to bear it.

I have spent the better part of my career in and around social care. The problem has never been a lack of dedicated people. The care workforce is one of the most committed in the country. The problem is structural. The system was not designed for the demographic reality it now faces, and no amount of dedication at the frontline can substitute for a funding model that is fit for purpose. That is why the Care Association Alliance has decided to step up. This paper is the first in a programme of reform that we will publish over the coming months. We have not done this lightly. It represents a deliberate decision that the sector cannot wait for others to make the case on its behalf.

The Casey Commission represents a genuine opportunity to settle what a reformed funding model should look like. The proposals in this paper are detailed and evidence-based, but they rest on a principle that is straightforward. The financial risk of growing old and needing care is a national risk, and it should be managed nationally, not through a free service, the absorption of social care into the NHS, or at the expense of the local relationships and provider diversity on which good care depends, but through a national funding settlement that gives individuals certainty, providers stability, and local authorities the resources to do the job they are asked to do.

The Care Association Alliance does not publish this paper and move on. We publish it as the opening of a sustained programme of work, and as a commitment to our members, to the workforce, and to the people they care for that we will continue to make this case for as long as it needs to be made. The Casey Commission will not be short of voices. We intend to be one that speaks from direct experience of what the system actually requires.

Melanie Weatherley MBE

Co-Chair, Care Association Alliance

EXECUTIVE SUMMARY

The case for reform is beyond dispute. The question is what reform looks like.

3.6%
OLDER PEOPLE RECEIVING LA-FUNDED LONG-TERM CARE

£23,250
CAPITAL THRESHOLD — FROZEN SINCE 2010/11

1 in 7
PEOPLE FACING LIFETIME CARE COSTS ABOVE £100,000

41%
SELF-FUNDER PREMIUM OVER LA-COMMISSIONED RATE

£184bn
ANNUAL VALUE OF UNPAID INFORMAL CARE

153
LOCAL AUTHORITIES BEARING NATIONAL DEMOGRAPHIC RISK

The Problem

Social care for older people in England is financed through a model that was not designed for the demand it now faces. The number of people aged 85 and over, the group most likely to require intensive care and support, is projected to double within twenty years. The OBR projects that maintaining the current system will require real-terms growth in public social care spending of 3.1 per cent per year over the next decade, compared to the 0.7 per cent average delivered between 2009/10 and 2022/23. The gap between what the system costs and what it receives is not a temporary shortfall. It is a structural feature of a funding model that distributes national demographic risk across 153 local authority budgets that were never designed to bear it.

Only 3.6 per cent of older people now receive local authority-funded long-term care, despite annual care requests exceeding two million. The proportion of over-65s receiving long-term care has fallen from 6.0 per cent in 2015/16 to 5.2 per cent in 2024/25, not because need has diminished but because eligibility thresholds have been progressively tightened in response to financial pressure. The upper capital limit has been frozen at £23,250 since 2010/11. There is no cap on lifetime care costs, leaving one in seven people aged 65 and over facing potential lifetime costs exceeding £100,000 with no means of planning for or insuring against them. Self-funders pay on average 41 per cent more than publicly funded residents for equivalent care. Unpaid carers provide support valued at £184 billion per year, equivalent to a second NHS, yet the number receiving direct support from local authorities is lower today than in 2015/16.

The reform history compounds these failures. Proposals for structural change have been developed, legislated for and repeatedly cancelled. The most recent reversal, in July 2024, saved £1.1 billion in the short term while leaving unresolved the structural problems that have been accumulating for over a decade. The cost is not simply a saving in one year's budget. It is the continued exposure of individuals to catastrophic costs and the continued growth of a funding gap that becomes more expensive to close with every year that passes.

The Proposal

This paper proposes a national funding settlement built on three core principles:

- national pooling of financial risk;
- statutory entitlement triggered by assessed need; and
- local delivery within a national framework.

The settlement has five principal components:

- a ring-fenced national care grant distributed to local authorities on a needs-adjusted formula;
- a reformed means test with a substantially raised capital threshold combined with a lifetime cap on individual contributions;
- a national tariff covering both residential and domiciliary care;

- a bundled funding model for residential care with portable assessed packages; and
- a reformed Deferred Payment Agreement framework ensuring no individual is required to sell their home to fund residential care.

Supporting the settlement is a National Care Assessment Body operating independently of both the NHS and local government. Local authorities are repositioned as delivery leaders rather than financial risk holders, retaining meaningful local discretion within a nationally coherent framework. The international evidence (Germany's entitlement principle, Japan's national fee schedule, Australia's portability model, and Denmark's national consistency with local flexibility) confirms that systems which maintain quality and access do so through stable institutional frameworks rather than periodic political interventions. Funding reform is the necessary condition for everything else a National Care Service must achieve.

RECOMMENDATIONS

Ten steps to a sustainable system

01

Establish a national funding settlement

A ring-fenced, needs-adjusted national care grant, allocated to local authorities on a multi-year basis, replacing the current system in which social care funding competes with all other council functions.

02

Introduce a national eligibility and entitlement framework

A statutory minimum entitlement to care, consistently applied regardless of geography, eliminating the postcode lottery in access to publicly funded support.

03

Implement a national tariff for care services

A minimum fee rate for commissioned care, set at the independently assessed cost of sustainable provision. The current average of £24.10 per hour for home care falls £8 below that level. This is not acceptable.

04

Reform individual contributions and financial protection

Introduce a lifetime cap on personal care costs, raise the capital threshold from its 2010/11 level, and reform the Deferred Payment Agreement scheme to make it genuinely accessible.

05

Adopt a bundled funding model for residential care

A single residential care tariff covering accommodation, personal care and clinical care, eliminating the artificial and costly boundary between NHS-funded and LA-funded provision in care homes.

06

Ensure funding follows the individual

Portable care packages and personal budgets that move with the individual, enabling genuine choice and reducing the administrative burden on councils and providers when people move between areas.

07

Create a National Care Assessment and Oversight Framework

An independent body responsible for assessing individual need, setting the evidence base for tariff rates, monitoring outcomes and maintaining the integrity of the national framework.

08

Reposition local authorities as delivery leaders

Local authorities retain their statutory commissioning and quality oversight role, but are relieved of the role of sole financial risk-bearer for a nationally determined demographic challenge.

09

Strengthen integration with health services

Align care funding pathways with NHS discharge planning, reducing the £1.89 billion annual cost of delayed hospital discharge attributable to social care capacity constraints.

10

Stabilise and diversify the provider market

Multi-year fee certainty, transparent market oversight, and reformed CQC data publication to enable genuine investor confidence and workforce planning across the sector. The transparent, evidence-based tariff underpinning this framework should also encourage providers to be clearer with individuals and families about their pricing, without introducing new mandatory disclosure requirements.

01

SECTION ONE

The Case for Reform

Demographic change, chronic underfunding, and a system that places national risk on local shoulders have created a crisis that can no longer be managed incrementally.

Social care is not a residual service. It is the infrastructure through which people with age-related frailty, disability and complex long-term conditions are supported to live with independence, dignity and choice. Its purpose is not primarily clinical. It is to enable people to remain part of their communities, to maintain relationships, and to exercise as much control over their lives as their circumstances allow. That purpose is valuable in its own right, not as an adjunct to the NHS, and not only because good social care reduces pressure on hospitals, though it does both. Understanding what social care is for matters, because it shapes what a reformed system must deliver and what it must not sacrifice in the name of efficiency.

That system is now operating under pressure it was never designed to bear. The question this paper addresses is not whether reform is necessary, that argument has long been settled, but why funding reform must come first, and what a reformed funding model must achieve.

1.1 Demographic Change and the Scale of What Is Coming

The demand pressures facing social care in England are structural and growing. More people are living longer, and more of those longer lives are spent managing multiple long-term conditions including dementia, cardiovascular disease, musculoskeletal conditions and diabetes, often in combination. The gap between life expectancy and healthy life expectancy has widened rather than narrowed. People are not simply living longer; they are living longer with needs that require sustained, coordinated support.

The scale of this shift is visible in the data. The number of people aged 85 and over, the group most likely to require intensive care and support, is projected to double within twenty years, growing from 2.4 per cent of the population today to 6.7 per cent by 2067, according to Office for Budget Responsibility projections.[1] The age gradient of social care costs makes this demographic shift particularly consequential: public spending on social care for a 90-year-old is approximately 24 times higher than for a 30-year-old, a gradient considerably steeper than in healthcare.[2] The old-age dependency ratio is forecast to deteriorate significantly over the same period, with serious consequences for both the demand for care and the tax base available to fund it. These projections are not speculative. They reflect demographic trends already embedded in the population.

The implications for the care system are direct. Local authorities in England spent £23.3 billion on adult social care in 2023/24, the single largest area of council expenditure after education.[3] The Health Foundation has estimated that maintaining current service levels in the face of rising demand will require an additional £8.3 billion per year by 2032/33. That is not the cost of improving the system. It is the cost of standing still.[4]

Figure 1 – Local Authority Social Care Spending vs Projected Demand (2013–2033)

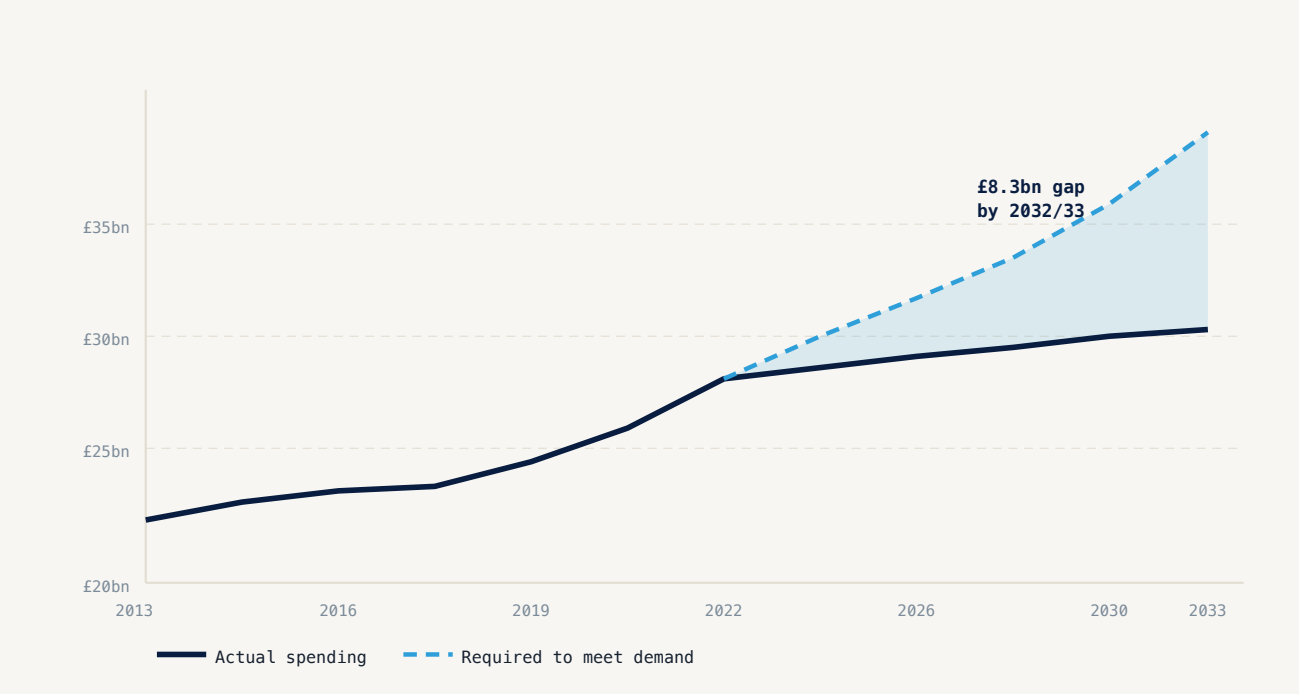


Fig. 1 — Illustrative projection based on OBR long-run projections (2024), ADASS budget surveys 2013–2024, and Health Foundation modelling (2023). Gap estimate: Health Foundation, Social Care Funding Gap, 2023.

1.2 A System Not Designed for What It Now Faces

The funding model that underpins social care in England was not designed with this demand profile in mind. It evolved incrementally, shaped by assumptions about demography, family structures and the relationship between health and care that no longer hold. The result is a system characterised not by a single design failure but by a series of structural misalignments that compound one another.

Primary statutory responsibility for adult social care rests with local authorities under the Care Act 2014. Local authorities assess need, commission services, manage provider relationships and carry the fiscal consequences of rising demand. Central government sets the legislative framework and provides a portion of local authority funding, but it does not bear the financial risk of demographic change. That risk sits with 153 individual councils whose funding capacity varies considerably and whose ability to respond to rising demand is shaped as much by their local tax base as by the scale of local need.

This arrangement made limited sense when social care demand was relatively modest and demographic pressures were more evenly distributed. It is no longer fit for purpose. Demographic ageing is a national phenomenon. It cannot be managed at local authority level, and the attempt to do so has produced a system defined by variation, instability and persistent underfunding.

Over the past decade, adult social care has consumed a steadily growing share of local authority budgets, crowding out other services in the process. In many councils, it now accounts for well over half of all discretionary expenditure. The consequence has been the progressive tightening of eligibility thresholds, the withdrawal of support for those with moderate needs, and a rationing of care that has no formal policy basis but is the practical result of demand rising faster than resources. According to the King's Fund's Social Care 360, the most comprehensive annual analysis of the sector, 889,000 people received publicly funded long-term care in 2024/25, the highest figure since comparable records began. But when population growth is accounted for, the proportion of over-65s receiving long-term care has fallen from 6.0 per cent in 2015/16 to 5.2 per cent in 2024/25.[5] More people are nominally in the system; a smaller share of those who need it are actually receiving it. The Institute for Government's Performance Tracker records the same pattern: the residual caseload is concentrated on those with the most severe and complex needs, while those with moderate needs are increasingly unsupported.[6]

This is not a system under temporary stress that will stabilise when conditions improve. It is a system whose design has not kept pace with the demographic and clinical reality it is now required to address.

1.3 The Hidden Costs of the Current Settlement

The most significant feature of the current funding model is not its overall inadequacy, though it is inadequate, but the way in which that inadequacy is obscured by a series of informal cross-subsidies that allow the system to function without resolving its underlying problems.

The first is the cross-subsidy from self-funding to publicly funded residents. Self-funders are routinely charged substantially more than publicly funded residents for equivalent care, on average 41 per cent more. This differential is structural: care providers set rates for self-funding residents at levels that partially compensate for the shortfall between what local authorities pay and the sustainable cost of care. The total value of this cross-subsidy has been estimated at over £1 billion annually. It is borne by individuals and families at a time of acute personal vulnerability, with no policy justification, and it persists because the alternative, local authorities paying sustainable rates, requires funding that the current system does not provide.

The second is the contribution of unpaid carers. Families, partners and friends provide care on a scale that substantially exceeds the formal system. Research commissioned by the Health Foundation values unpaid care at £184 billion per year, equivalent to a second NHS.[9] This contribution is rarely made visible in policy debate, but it is integral to how the system functions. Every tightening of eligibility, every reduction in respite provision, every hour of formal care that is not commissioned pushes demand onto households that are frequently already stretched. The number of carers receiving direct support from local authorities was lower in 2023/24 than in 2015/16, and respite care provision fell from 57,000 people in 2015/16 to 36,000 in 2023/24.10 Any honest assessment of the care system must account for what would happen if that unpaid contribution were reduced, and any reform programme must address the support available to those providing it.

The third is the financial pressure absorbed by providers through deferred investment, delayed maintenance and operating margins that leave little capacity for workforce improvement or capital renewal. EBITDARM margins in residential care declined from around 33 per cent in 2008/09 to 25 per cent in 2022/23, and have continued to come under pressure since.[11] That deterioration does not yet show up systematically in provider failures, but it represents a progressive weakening of the market's capacity to absorb further strain.

Together, these cross-subsidies mean that the true cost of the current system is considerably higher than public expenditure figures suggest. They obscure the extent of underfunding, defer its consequences, and distribute them onto individuals, families and providers rather than the public finances.

1.4 The Blurring Boundary Between Health and Care

The current system also assumes a clearer distinction between healthcare and social care than exists in practice. Many people entering residential care today live with multiple long-term conditions requiring medication management, clinical monitoring and complex support. Care homes routinely deliver services that sit close to clinical provision, but are funded and regulated as social care rather than health services.

This has practical consequences. When a patient is medically fit for discharge from hospital but requires care and support that the social care system cannot promptly arrange, whether because of funding disputes, provider unavailability or eligibility uncertainty, they remain in an acute hospital bed at a cost of roughly five times what equivalent support in the community would require. In 2023/24, delayed hospital discharges attributable to social care factors cost an estimated £1.89 billion in acute bed occupancy.[12] In most cases the blockage is not a lack of available care capacity. It is a failure of the funding pathway.

The evidence that this is addressable is not merely theoretical. During the first wave of Covid-19, discharge-to-assess arrangements underpinned by dedicated central funding freed up 30,000 acute beds, reduced the proportion of patients staying in hospital for more than 21 days by 28 per cent, and generated £451 million in acute bed savings.[13] That lesson was not systematically applied in the years that followed. The structural conditions that make discharge disputes routine were left in place.

1.5 Geographic Inconsistency and Unequal Access

A further consequence of distributing national demographic risk across local authority budgets is geographic inconsistency in access, eligibility and quality. The Care Act

2014 established a national framework for needs assessment, but local authorities apply it within financial constraints that vary considerably. Identical levels of assessed need are treated differently depending on geography. Eligibility thresholds have been raised in many areas not because need has changed but because budgets have not kept pace.

In some areas, persistently low local authority fee rates have contributed to care deserts, where providers have exited markets or declined placements because they cannot deliver care at the rates on offer. Individuals in these areas may be required to move away from their communities and families to access residential care, or may find that domiciliary services are unavailable at the hours and frequency their assessed needs require. Low rates also constrain providers' ability to raise wages, compounding workforce shortages and making recruitment and retention harder across the sector. Analysis by the Institute for Fiscal Studies has shown that the areas with the highest concentrations of older people have in some cases experienced the deepest cuts to adult social care spending per adult, reinforcing rather than correcting existing inequalities.[14]

1.6 Why Funding Must Come First

The relationship between funding and system performance in social care is not simply a matter of resources and capacity. It is structural. The current funding model shapes how care is commissioned, how providers price their services, how the workforce is deployed and how individuals experience the system. Improvements in any of these areas are constrained, in practice, by the funding environment within which they operate.

Workforce strategies that do not address the fee rates available to providers will not deliver sustainable pay improvement. Commissioning reforms that do not resolve the misalignment between national demographic risk and local fiscal responsibility will not produce consistent access. Quality improvement frameworks that operate within a market shaped by cross-subsidy and geographic variation will not close the gap between the best and the weakest parts of current provision.

This is not an argument that funding reform is sufficient on its own. A national funding settlement will not automatically produce a well-functioning workforce, an efficient commissioning system or a market capable of delivering high-quality care in every area. Those outcomes require further reform across each of those domains, and this paper is the first in a programme that addresses them in turn. But funding reform is the necessary condition for the rest. Without a stable, sufficient and equitably distributed funding base, the other components of reform cannot be made to work. The Office for Budget Responsibility projects that simply maintaining the current system in the face of demographic change will require real-terms growth in public social care spending of 3.1 per cent per year over the next decade, compared to the 0.7 per cent average delivered between 2009/10 and 2022/23.[15] The cost of inaction, as the Health and Social Care Select Committee has set out, is not the avoidance of expenditure. It is the deferral of expenditure while the system deteriorates and the eventual cost of repair rises.[16] That is why this paper addresses funding first.

"

153 local authorities are bearing national demographic risk. That is not a funding model. It is a managed retreat.

CARE ASSOCIATION ALLIANCE — ADULT SOCIAL CARE FUNDING REFORM, 2026

02

SECTION TWO

Core Proposal

Three principles (risk pooling, statutory entitlement, and local delivery within a national framework) underpin every comparable system that works.

The failures set out in the preceding section share a common cause. Financial risk that is national in origin is being managed through a local funding structure that was not designed to bear it. The consequences – geographic inequity, a rationed caseload, market instability and a hidden system of cross-subsidy – are not failures of administration. They are the predictable result of a structural mismatch between where demographic risk sits and where fiscal responsibility lies.

The central proposition of this paper is that resolving this mismatch requires a national funding settlement for older people's social care: a framework in which the financial risk of demographic change is pooled at the national level, entitlement to publicly funded support is established in statute rather than subject to local budget discretion, and care is delivered locally within a nationally defined funding and tariff structure.

This is not a proposal to make social care free at the point of use, nor to absorb it into the NHS. It is a proposal to establish the same basic principle that underpins other areas of public provision: that access to support should be determined by assessed need, and that the financial consequences of demographic change should be managed collectively rather than left to individuals, families and local councils to absorb as best they can.

2.1 The Three Principles of Reform

National pooling of financial risk

The case for pooling financial risk at national level is both practical and principled. On the practical side, the current system asks 153 local authorities to manage a risk that is national in character and growing in scale. No individual council can plan effectively for demographic change across a population of millions, or absorb the financial consequences when demand rises faster than resources allow. The result is the progressive rationing and geographic variation documented in Section 1.

On the principled side, the case for collective risk pooling rests on the nature of care need itself. Most people will not require intensive social care. A smaller proportion will require substantial support for months or years. An individual cannot predict in advance which group they will fall into, and the financial consequences of falling into the latter group are, under the current system, potentially catastrophic. As the King's Fund has set out, the central advantage of pooling risk through public funding is that it protects individuals from very large personal expenditure that they could not reasonably have anticipated or planned for. That is precisely the kind of risk that collective provision exists to manage.

A national funding settlement addresses this by shifting the locus of financial responsibility from local to national government, establishing a funding base that reflects the true scale of demographic demand and can be planned for on a long-term basis rather than managed year to year within local authority budgets.

Statutory entitlement triggered by assessed need

The second principle is that entitlement to publicly funded support should be established in statute and triggered by assessed need, rather than determined by local budget availability. Under the current system, the Care Act 2014 establishes a national eligibility framework, but local authorities apply it within financial constraints that vary considerably. The practical result is that eligibility thresholds are set not by need but by what a given council can afford in a given year.

A national funding settlement would establish a clear statutory baseline: individuals whose assessed needs meet the national eligibility threshold would have a right to publicly funded support, regardless of which local authority area they live in. This does not mean uniform provision. It means that the threshold for access is set nationally and applied consistently, and that local authorities are not in a position to raise that threshold in response to financial pressure.

This principle also addresses the relationship between public funding and individual contribution. The model proposed in this paper is not one of universal free provision. Individuals with the means to contribute to the cost of their care will be expected to do so, subject to a means test and a lifetime cap on personal care costs designed to protect against catastrophic financial exposure. The detail of these arrangements is set out in Section 5. The principle here is that public funding provides the floor, individual

contribution is structured and bounded, and no one faces the prospect of unlimited financial liability for the cost of their care.

A further principle follows from this. Today, too many individuals and families find themselves caught between organisations debating who should pay, rather than focusing on what support is required. Assessments become entangled with budgetary considerations, and the discussion moves from "what does this person need?" to "whose responsibility is this?". The settlement proposed here is built on the opposite principle: assessment should focus solely on identifying need and the support required to meet it, and funding arrangements should then flow from that assessment through an agreed and transparent framework. The individual should experience one assessment, one care plan and one route through the system, regardless of how funding responsibilities are ultimately allocated behind the scenes.

Local delivery within a national framework

The third principle is that care should continue to be delivered locally, within a nationally defined funding and tariff framework. This is not a proposal for the centralisation of care delivery or the removal of local authority responsibility for commissioning and managing care services. Local authorities are well placed to understand local need, manage local provider relationships and commission services that reflect the circumstances of their areas. That role is valuable and should be preserved.

What the national framework provides is the financial architecture within which local delivery operates: a national tariff that replaces the current fragmented local pricing arrangements, a nationally determined eligibility threshold, and a funding settlement that gives local authorities the resources to discharge their statutory duties without being subject to the demographic and fiscal pressures that currently drive rationing and variation. The relationship between national framework and local delivery is examined in detail in Section 8.

The distinction matters because one of the most persistent risks in social care reform is the conflation of national consistency with central control. The objective is not to create a nationally managed care service on the model of the NHS. It is to establish the framework conditions, stable funding, consistent eligibility and transparent pricing, within which local delivery can function effectively and equitably.

Current System vs Proposed National Funding Settlement

DIMENSION	CURRENT SYSTEM	PROPOSED SETTLEMENT
Eligibility	Care Act 2014 criteria applied within local financial constraints; thresholds vary by area and tighten when budgets are under pressure	National threshold set centrally; statutory right to support regardless of local authority area; cannot be raised in response to local financial pressure
Financial risk	Borne by 153 individual local authorities with varying fiscal capacity; no national mechanism for managing demographic risk	Pooled nationally; distributed via needs-adjusted ring-fenced grant; demographic risk matched to national fiscal responsibility
Fee setting	153 separate local authority negotiations; NAO-confirmed rates below sustainable cost in many areas; wide variation by geography	National tariff floor; evidence-based and independently verified; locally adjustable above floor; reviewed on a defined cycle
Geographic consistency	Significant variation in eligibility, fee rates and provider supply; care deserts in some areas; outcomes shaped by postcode not need	National entitlement and tariff floor; consistent access regardless of geography; provider market stability supported
Individual exposure	Unlimited; no cap on lifetime costs; means test eroded by frozen thresholds since 2010/11; no effective insurance market	Bounded by lifetime cap on contributions to baseline care costs; means test restored and regularly uprated; DPA framework reformed
Local authority role	Statutory duties without adequate resources; forced rationing and below-cost commissioning; primary financial risk holders for national demographic pressures	Statutory duties with ring-fenced national funding; commissioning focused on quality not rationing; delivery leaders, not risk holders

2.2 What This Proposal Is Not

Given the history of social care reform in England, it is worth being explicit about what this model does not propose, as well as what it does.

It is not a proposal for a free national care service on NHS lines. Social care will continue to involve means-tested individual contributions. The principle of personal responsibility for contributing to the cost of care, where an individual has the means to do so, is retained. What changes is that contribution is structured, bounded by a lifetime cap, and set within a nationally coherent framework rather than determined by the fragmented and often opaque arrangements that currently govern self-funding.

It is not a proposal to abolish or bypass local government. Local authorities remain the statutory commissioners and delivery leaders for adult social care. The national funding settlement changes the financial architecture within which they operate; it does not remove their role. If anything, by providing adequate and stable funding, it restores the capacity of local authorities to fulfil that role properly, rather than managing it under the chronic resource pressure of the current system.

It is not a proposal that can be implemented immediately or without cost. The funding implications of the model proposed here are addressed directly in this paper. They are significant, but they are manageable, and they need to be set against the growing cost of maintaining a system that is becoming progressively less able to meet the demand placed upon it. The cost of reform is real. The cost of inaction, as the preceding section has set out, is also real, and is rising.

What "national" does mean in this paper is a defined set of shared structures sitting above local delivery: a national tariff that sets the rates at which care is commissioned; national standards of eligibility and entitlement; a national career framework that gives the workforce a recognisable path, parity of status and consistent pay floors; and local commissioning and delivery designed to meet local needs within that framework. The objective is a guaranteed core entitlement for everyone whose assessed needs cross the national threshold, alongside personal choice over where and how care is received.

Nor does this paper resolve the long-standing question of those whose needs sit between traditional social care and NHS Continuing Healthcare, i.e. people living with dementia, Parkinson's disease, frailty and other progressive long-term conditions, who today account for a disproportionate share of the disputes, inconsistencies and delays in the current system. This is recognised as one of the most consequential unresolved issues facing the sector. It is deliberately addressed in a subsequent paper in this programme, Bridging Health and Care, which will examine the healthcare interface, the shift to neighbourhood-based services, and the role of the care sector in taking on responsibilities currently carried by overstretched parts of the NHS. The omission here is one of sequencing, not of oversight.

Two further design principles are central to the proposal and deserve to be stated explicitly here. The first is that residential care should be funded through a bundled model, treating care as a single integrated service rather than separating care and accommodation costs at the point of charging. This reflects how individuals and families experience residential care in practice and avoids forcing them to navigate artificial distinctions within a single placement. The second is that care should follow the individual: assessed packages should be portable across providers, enabling genuine choice within an approved provider market, and ensuring that the care pathway is determined by the person's needs and wishes rather than by funding structures.

03

SECTION THREE

The Existing Funding Model

Understanding what we have, and why it was always insufficient, is the prerequisite for designing what we need.

3.1 How the Current System Actually Works

Many people assume social care is funded in the same way as the NHS and is free at the point of use and available to anyone who needs it. It is not. Adult social care in England is governed by two tests applied together: a needs test, which restricts publicly funded support to those with substantial or critical needs; and a means test, which restricts it to those whose assets fall below £23,250. Above that threshold, individuals pay for their own care in full, with no cap on what they can be required to spend. Those eligible for council-funded care still typically make a contribution from their income. The home is excluded from the means test for those receiving care at home, but counted for residential care unless a partner or qualifying dependant still lives in it.

The system has been like this, in broad terms, since 2010/11, but the thresholds have not risen with inflation, which has progressively pushed more people into self-funding without any explicit policy decision. Most people only encounter these rules at the moment of crisis. This paper begins from the position that any honest reform debate must start from a shared understanding of where we are today.

Understanding why a national funding settlement is necessary requires a clear account of how the current system is financed and where that model has failed. Social care for older people in England is funded through three principal sources: local authority expenditure from a combination of central government grants and council tax; direct contributions from individuals who receive publicly funded care; and private payments from those who fund their own care entirely. NHS funding through Continuing Healthcare provides an additional, though heavily contested, stream for those whose needs are assessed as primarily health-related. Together these sources produced total adult social care expenditure of around £34.5 billion in 2024/25. The aggregate figure, however, conceals the extent to which the system depends on arrangements that are neither equitable nor sustainable.

3.2 Local Authority Funding and Its Limits

The primary statutory and financial responsibility for adult social care rests with local authorities under the Care Act 2014. In 2024/25, gross local authority expenditure on adult social care reached £29.4 billion, representing around 40 per cent of all local authority service spending.[17] That share has grown substantially over the past fifteen years as demand has risen and other budgets have been cut. Adult social care has not crowded out other services accidentally; it has done so because local authorities have statutory duties to meet assessed eligible need and no choice but to prioritise it when resources are constrained.

The funding available to local authorities to discharge those duties has not kept pace with the demands placed on them. Overall local government spending power remains around nine per cent below its 2010/11 level in real terms.[18] Council tax, which now accounts for 46 per cent of council income compared to around a third in 2010, has absorbed an increasing share of the burden.[19] In 2024/25, all 153 adult social care authorities used the adult social care precept, raising £609 million in aggregate, equivalent to an average of £32 on a Band D bill.[20] In 2025/26, 350 of 384 councils raised council tax at or near the maximum permitted level. The scope for further council tax increases to close the funding gap is limited, and it is in any case an inappropriate mechanism for managing national demographic risk.

Figure 2 – The Postcode Lottery: Adult Social Care Spend per Adult, by Region and by Authority

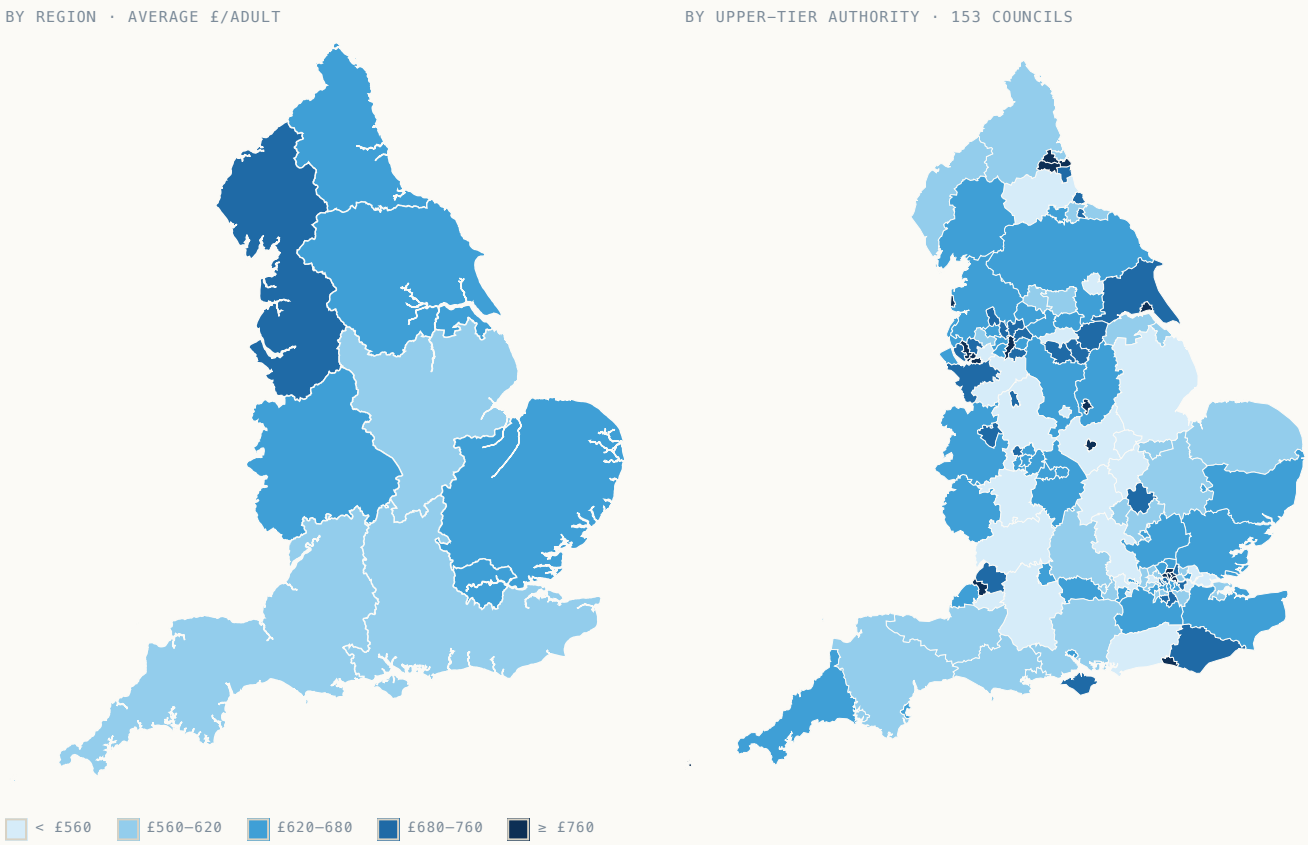


Fig. 2 — Age-adjusted for each area's population, regional averages span just £580–£688, yet individual authorities range from £392 (Warrington) to £991 (Isles of Scilly) — a divergence the regional view conceals. Boundaries: ONS Counties & Unitary Authorities, Dec 2022. Spend: NHS Digital ASC-FR 2024/25; ONS mid-year population 2024, standardised by national 18–64 and 65+ care-spend rates. Cumbria shaded at the average of its successor authorities.

Figure 3 – Disparity Within Regions: Every Upper-Tier Authority by Spend per Adult

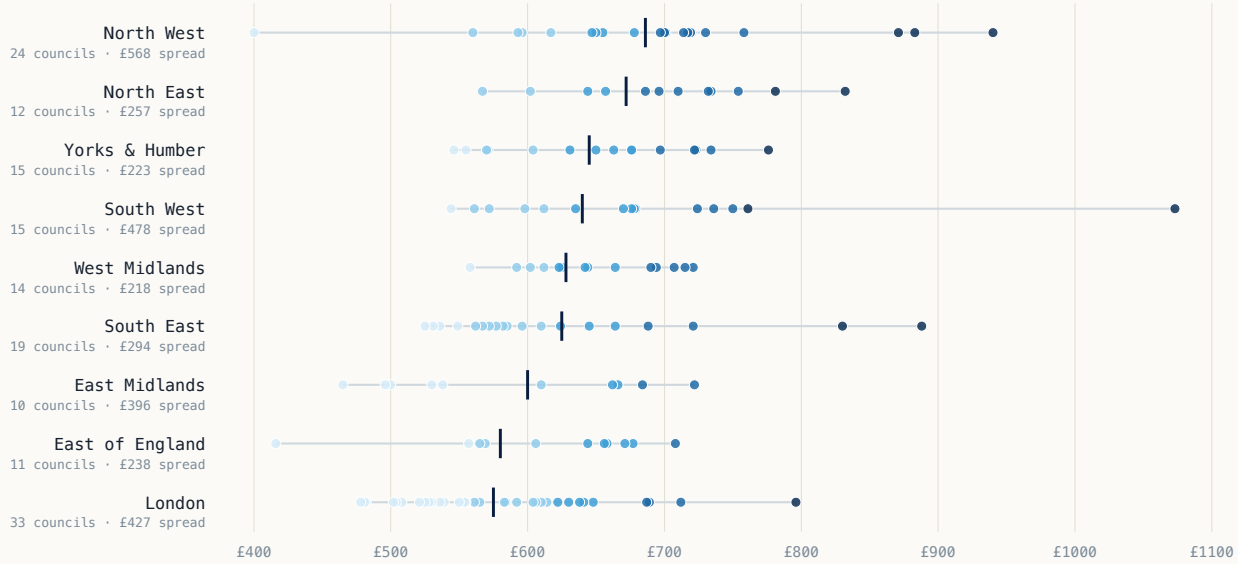


Fig. 3 — Each dot is one upper-tier authority; the navy bar marks the age-adjusted regional average. Within-region spreads reach £568 (North West) and £478 (South West) — far larger than the £108 gap between the highest- and lowest-spending regions. NHS Digital ASC-FR 2024/25.

Age is only part of the story. To test whether the wider gap reflects genuine differences in need and cost, we modelled each authority's spend per adult against its age profile, its level of deprivation (the Index of Multiple Deprivation), the local cost of providing care (the Adult Social Care Area Cost Adjustment used in the funding settlement), and the level of working-age care need (adults aged 18 to 64 receiving long-term support). Together these legitimate drivers account for less than half of the variation in spending between authorities: **between 55 and 66 per cent remains unexplained**, depending on the specification, and age on its own accounts for just 13 per cent. Figure 4 plots each authority's actual spend against the spend these need and cost factors predict. If need and cost determined spending, every authority would lie on the diagonal; most do not. Figure 5 maps the same gap authority by authority: the difference between what each area spends and what its need and cost predict. The pattern is scattered, not a simple north–south or urban–rural divide. The full method, data sources and results are set out in Appendix B.

Figure 4 – Spending Against What Need and Cost Predict: Every Upper-Tier Authority

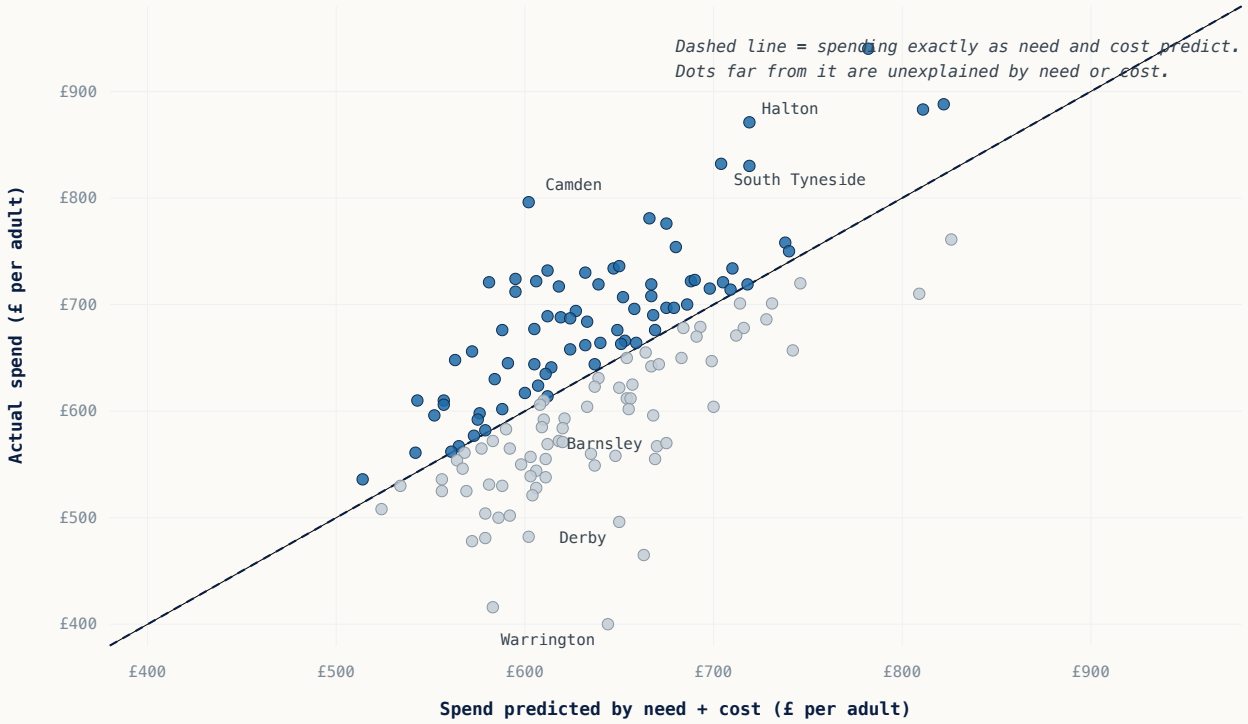
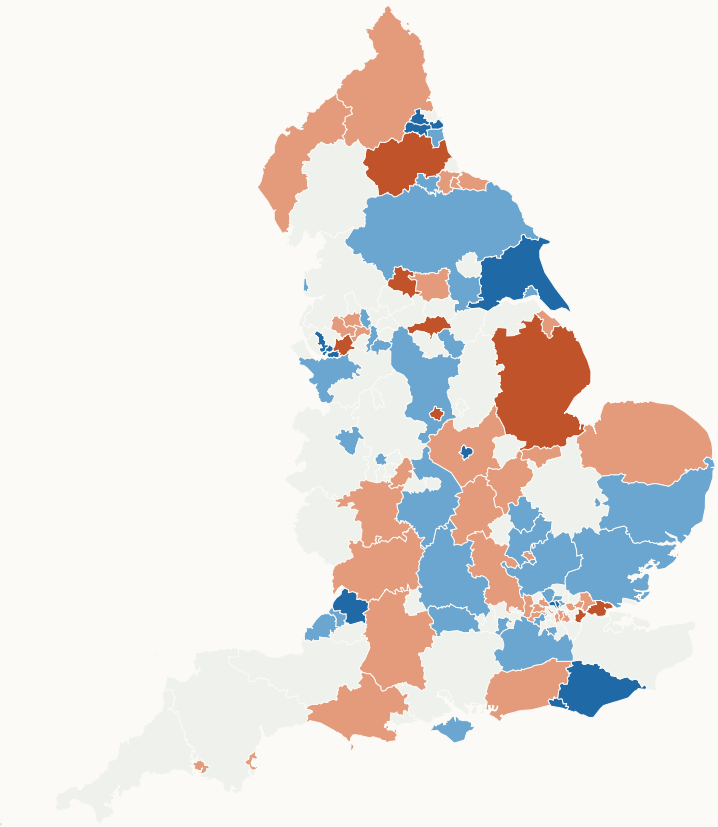


Fig. 4 — Each dot is one upper-tier authority. The dashed line marks spend exactly equal to what its age, deprivation, provider cost and working-age care need predict. Authorities above the line spend more than need and cost explain; those below spend less. The vertical scatter around the line is the unexplained variation. Model explains 43 per cent of the variation (57 per cent unexplained); 55–66 per cent unexplained across specifications. OLS, n=151. Sources and full results in Appendix B.

Figure 5 – The Unexplained Gap, Mapped: Spending Above or Below What Need and Cost Predict



spends well below need+cost | below | as predicted | above | spends well above need+cost

Fig. 5 — Each authority shaded by the difference between its actual spend per adult and the spend predicted by its age profile, deprivation, provider cost and working-age need. Blue authorities spend more than need and cost explain; coral authorities spend less. The absence of a clean geographic pattern is the point: the unexplained variation does not track region, deprivation or rurality. Estimates for individual authorities are less certain than the overall unexplained share; Isles of Scilly and the City of London are not shaded (excluded from the model). OLS residuals, n=151; see Appendix B.

3.3 The Means Test and Its Erosion

Access to publicly funded care is determined by two tests applied simultaneously: a needs test, which restricts eligibility to those with substantial or critical needs under the Care Act framework; and a means test, which restricts publicly funded support to those whose assets fall below prescribed thresholds. An individual must satisfy both tests to receive publicly funded care.

The financial thresholds that govern the means test have been frozen in cash terms since 2010/11. The upper capital limit, above which an individual is expected to fund their own care entirely, stands at £23,250. Had it risen in line with consumer price inflation since 2010/11, it would now stand at approximately £35,118. The lower limit, below which an individual makes no capital contribution, stands at £14,250, compared to an inflation-adjusted figure of around £20,800. The real-terms value of both thresholds has therefore fallen significantly, meaning that the boundary between self-funding and publicly supported care has shifted progressively against individuals without any explicit policy decision to that effect.

Figure 6 – Frozen Capital Threshold vs Inflation-Adjusted Value (2010–2026)

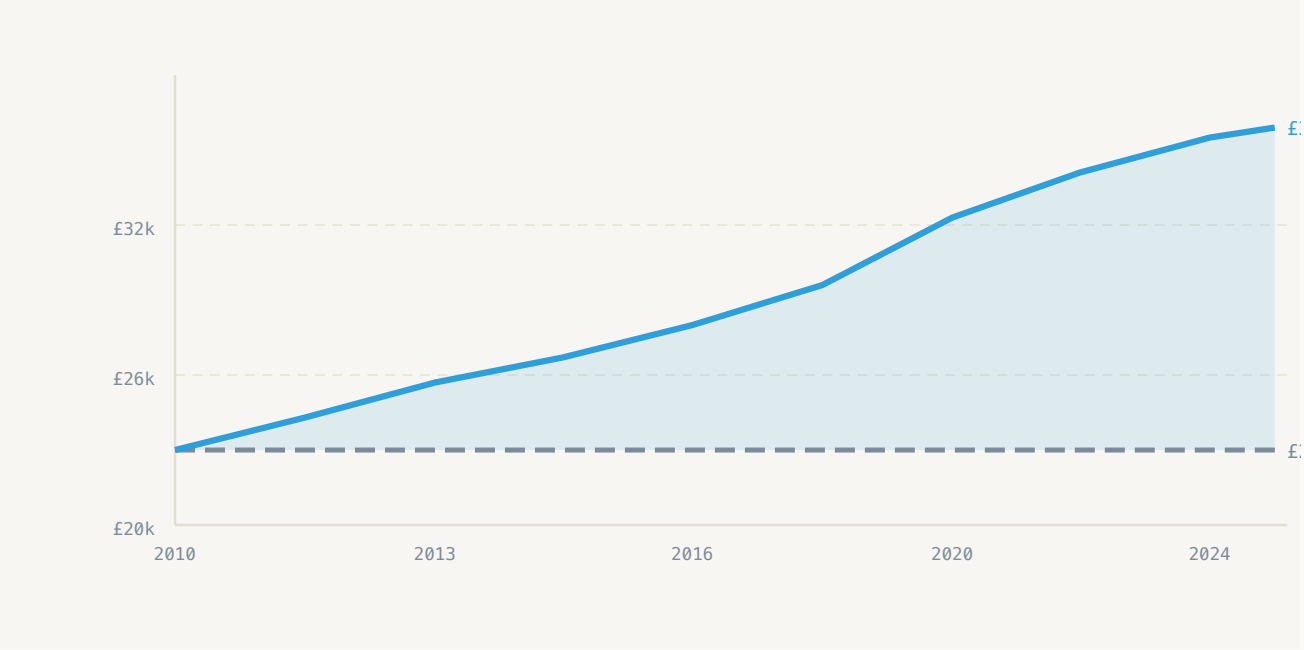


Fig. 6 — Capital threshold frozen at £23,250 since April 2010. CPI-adjusted equivalent as at April 2026 would be approximately £35,118. Source: ONS CPI series, CPIH index values 2010–2026.

The practical effect of the frozen thresholds is not straightforward to read from the headline figures. Only 13 per cent of adults aged 65 and over had total wealth, including housing, below the £23,250 upper capital limit in 2018/19. However, when housing wealth is excluded, which is relevant for those receiving domiciliary care or those with a partner or dependant still living at home, 43 per cent of adults aged 65 and over had non-housing wealth below that threshold.[23] Around 51 per cent of older people in care homes do receive state support, many having exhausted assets over time or having their primary residence excluded from the assessment. The means test is therefore both more and less generous than its headline thresholds suggest, depending on individual circumstances, and its operation is sufficiently complex that public understanding of it is limited. Research by the Joseph Rowntree Foundation found that only 21 per cent of the general public correctly identified the means test threshold, and only 19 per cent correctly understood what home care might cost.[24]

Beyond the threshold mechanics, the means test creates a structural problem that the frozen thresholds have worsened over time. An individual with assets above £23,250 faces potentially unlimited personal liability for the cost of their care. There is no cap on lifetime care costs under current arrangements. one in seven people aged 65 and over can expect to incur lifetime care costs of more than £100,000, yet there is no mechanism through which individuals can protect against that risk in advance, either through public provision or through a functioning private insurance market.[25] Private long-term care insurance has never developed at scale in the United Kingdom for structural reasons that are unlikely to change: the risks are correlated, adverse selection discourages insurer participation, and the long and unpredictable nature of care need makes pricing extremely difficult.

3.4 A History of Reform Deferred

The failures of the current means test and the absence of a lifetime cap are not newly identified problems. They have been the subject of sustained policy attention for more than fifteen years, and the record of that attention is one of repeated commitment followed by deferral, delay and reversal.

REFORM	PROPOSED	LEGISLATED / ANNOUNCED	IMPLEMENTED	OUTCOME
Independent Commission 2011	Lifetime cap on care costs; substantially higher capital limit; national eligibility framework	Care Act 2014 (modified: cap £72,000, upper limit £118,000)	No	Implementation delayed 2015, postponed indefinitely
Care Act 2014 provisions	Cap £72,000; upper capital limit £118,000	Legislated	No	Delayed and deferred repeatedly
Johnson Government 2021	Cap £86,000; upper capital limit £100,000; lower limit £20,000	Health and Care Act 2022	No	Reversed by Chancellor July 2024
2024 Reversal	N/A	N/A	N/A	Upper capital limit remains £23,250. No lifetime cap. £1.1bn saved in 2025/26

REFORM HISTORY — FOUR MISSED OPPORTUNITIES

The consequence of this repeated cycle is not merely the absence of reform. It is the progressive deterioration of a system whose underlying problems have been clearly understood for over a decade. Each deferral has allowed the means test to erode further in real terms, the provider market to weaken further, and the gap between what the system costs and what it receives in public funding to widen. The cost of continued deferral is not simply financial. It falls directly on individuals who exhaust their assets funding care, on families who provide unpaid support in the absence of formal provision, and on a provider market whose capacity to invest is constrained by fee rates that have not kept pace with costs.

3.5 Fee Rates, Provider Viability and the Limits of the Current Market

The sustainability of the provider market that delivers publicly commissioned care is directly connected to the adequacy of local authority fee rates. The National Audit Office confirmed in 2021 that local authorities were paying below the sustainable rate for care.[26] The King's Fund's most recent analysis of the sector found that in 2025/26, fee increases ran at around 5 per cent while provider costs rose by 8 to 10 per cent, driven by National Living Wage increases and rises in employer National Insurance contributions.[27] The gap between what local authorities pay and what it costs to deliver care is not new, but it has widened, and providers have absorbed it through the mechanisms described in Section 1: operational compromise, deferred investment, and the cross-subsidy from self-funder fees.

That cross-subsidy varies considerably by region. The Competition and Markets Authority's analysis showed a differential of £121 per week in the North East and £348 per week in the South East, broadly tracking regional property values and the concentration of self-funding residents.[28] As the proportion of self-funders in a given home decreases, the cross-subsidy becomes harder to sustain. In areas where self-funder demand is thin, the viability of publicly commissioned provision is directly at risk.

The structural consequence is visible in supply trends. In 2019, care home closures exceeded openings for the eighth consecutive year, with over 900 closures against around 600 openings and a net loss of more than 23,000 beds nationally.[29] Care deserts have formed in some areas while supply remains adequate in others. The result is a market that is not allocating supply to match local demand, and in which nearly three-quarters of Directors of Adult Social Services reported overspending their adult social care budgets in 2023/24, the highest overspend in a decade, a direct consequence of demand rising faster than resources.[30]

3.6 What the Current Model Cannot Deliver

The picture set out in this section is not one of a system performing adequately under strain. It is one of a system whose design prevents it from functioning as intended. The means test excludes an increasing proportion of people from publicly funded support without any deliberate policy choice, through the simple mechanism of frozen thresholds. The local authority funding model distributes national demographic risk across 153 councils with different fiscal

capacities and different political priorities. The absence of a lifetime cap leaves individuals exposed to potentially catastrophic costs that they have no means of planning for or insuring against. Fee rates that do not cover the cost of care transfer financial pressure onto providers, who absorb it until they cannot.

These are not problems that can be resolved by incremental adjustment within the current architecture. They are the direct result of that architecture. The case for a national funding settlement rests not on dissatisfaction with the existing system but on a clear-eyed reading of what that system structurally cannot deliver, and what needs to change in order for it to do so.

04

SECTION FOUR

A National Funding Settlement

The financial architecture of English social care must be rebuilt around national risk pooling and ring-fenced, needs-adjusted funding.

The preceding sections have set out why the current funding model fails and what principles should govern a reformed one. This section sets out how a national funding settlement would work in practice: the financial architecture it would establish, the statutory framework it would create, and the relationship between national and local responsibility it would redefine.

4.1 The Core Financial Architecture

A national funding settlement for older people's social care would establish a dedicated, nationally held funding stream for publicly funded adult social care, distinct from the general local government finance settlement and protected from the short-term pressures of annual spending rounds. The central mechanism is the transfer of financial risk from local to national government. Under the current system, the fiscal consequences of demographic change fall on 153 local authorities with different tax bases, different reserve positions and different capacity to respond. Under a national settlement, that risk is pooled centrally, and funding flows to local authorities on the basis of assessed local need rather than local fiscal capacity.

This does not mean that local authorities cease to have a financial role. They would continue to commission services, manage provider relationships and hold budgetary responsibility for the delivery of care in their areas. What changes is the basis on which they are funded to do so. Rather than relying on a combination of central grants, council tax and the adult social care precept (which is not ring-fenced), all of which are variable, contested and insufficient in aggregate, local authorities would receive a ring-fenced national care grant calculated on a transparent needs-adjusted formula. That formula would take account of the size and age composition of the local population, the prevalence of complex need, and relevant cost factors including rurality and labour market conditions. The principle is that funding follows need, not postcode.

The case for ring-fencing is straightforward. The history of adult social care funding is in part a history of general local government grants being diverted from care to cover pressures elsewhere. A dedicated funding stream, with a clear statutory purpose and transparent accountability arrangements, is the mechanism through which the national settlement acquires practical force. Without it, the risk is that additional central funding is absorbed by other local authority pressures rather than reaching the people and providers it is intended to support.

The Health and Social Care Select Committee has identified the Casey Commission as the appropriate vehicle for settling the architecture of a reformed funding model. This paper does not pre-empt that process. It sets out what a national funding settlement should contain and why, in order to inform the Commission's work and to ensure that the interests of care providers, care workers and the people who rely on care are clearly represented in that debate.

4.2 Statutory Entitlement and National Eligibility

A national funding settlement requires a national eligibility framework that operates consistently regardless of geography. Under the current system, the Care Act 2014 establishes a common framework for needs assessment, but local authorities apply it within financial constraints that vary considerably and that have driven progressive tightening of eligibility thresholds in many areas. The practical result is that the threshold for access to publicly funded care is determined as much by local fiscal pressure as by the level of need an individual presents.

Under the proposed settlement, the national eligibility threshold would be set centrally and applied uniformly. Individuals whose assessed needs meet that threshold would have a statutory right to publicly funded support, irrespective of which local authority area they live in. This statutory entitlement is the mechanism through which the principle of need-based access is given legal force. It means that an individual cannot be refused support because their council has exhausted its budget, and that the eligibility threshold cannot be raised in response to local financial pressure.

The assessment process itself would remain with local authorities, which are well placed to carry out needs assessments and to translate national eligibility criteria into individual care and support plans. What changes is not who conducts assessments but the framework within which they are conducted and the consequences that follow from them. A positive assessment triggers a nationally funded entitlement, not a locally discretionary decision. This is the fundamental shift the settlement achieves at the level of the individual.

A national eligibility framework would also address one of the most persistent sources of inequity in the current system: the boundary between NHS Continuing Healthcare and social care funding. The determination of whether an individual's needs are primarily health-related, and therefore NHS-funded, or primarily social care-related, and therefore means-tested, is currently highly complex, variable in its application and a significant source of dispute and delay. A national settlement, by establishing a clearer and more adequately funded social care entitlement, reduces the pressure on both individuals and systems to contest that boundary.

4.3 The Role of the National Tariff

A national funding settlement cannot function coherently without a consistent national pricing framework. Under the current system, local authorities set their own fee rates for commissioned care, which vary considerably across the country and which the National Audit Office has confirmed are in many cases set below the sustainable cost of delivery. The consequence, as Section 3 set out, is a provider market that is financially fragile, geographically uneven and dependent on cross-subsidy to remain viable.

The national settlement therefore includes the introduction of a national tariff for publicly commissioned care services: a transparent, evidence-based pricing framework that sets the rates at which care is commissioned nationally, with adjustments for unavoidable local cost variations. The tariff would replace the current fragmented local pricing arrangements and provide the market stability that providers need to plan investment, develop their workforce and maintain quality. The design of the national tariff, including its methodology, its treatment of different care settings and its relationship to provider cost structures, is addressed in detail in Section 7.

4.4 Nationalising the Funding, Localising the Delivery

One of the central tensions in any reform of this kind is the relationship between national consistency and local flexibility. The failures of the current system are largely attributable to a funding model that is insufficiently national: risk is distributed locally, eligibility varies locally, and fee rates are set locally. But the response to those failures cannot be the wholesale centralisation of care delivery. Social care is, by its nature, a locally rooted service. Good care depends on relationships, continuity and an understanding of individual circumstances that cannot be standardised from the centre.

The proposed settlement addresses this tension through a clear division of responsibility. The funding architecture, the eligibility framework, the pricing structure and the national workforce framework are national. The assessment of individual need, the commissioning of care services, the management of provider relationships and the development of local provision are local. This is the principle of nationalising the funding while localising the delivery, and it is the approach that the most successful international comparators, including Germany and Japan, have adopted in different ways. Those models are examined in Section 6.

Local authorities retain meaningful discretion within this framework. They can commission services beyond the national baseline where local need warrants it and where they have the resources to do so. They can develop innovative models of provision suited to their areas. They retain democratic accountability for the quality and character of care in their communities. What they lose is the capacity to ration care in response to financial pressure, and the responsibility of bearing national demographic risk on local budgets. That is not a loss of local autonomy. It is a removal of an impossible position.

Figure 7 – Annual Funding Required Under Three Reform Scenarios

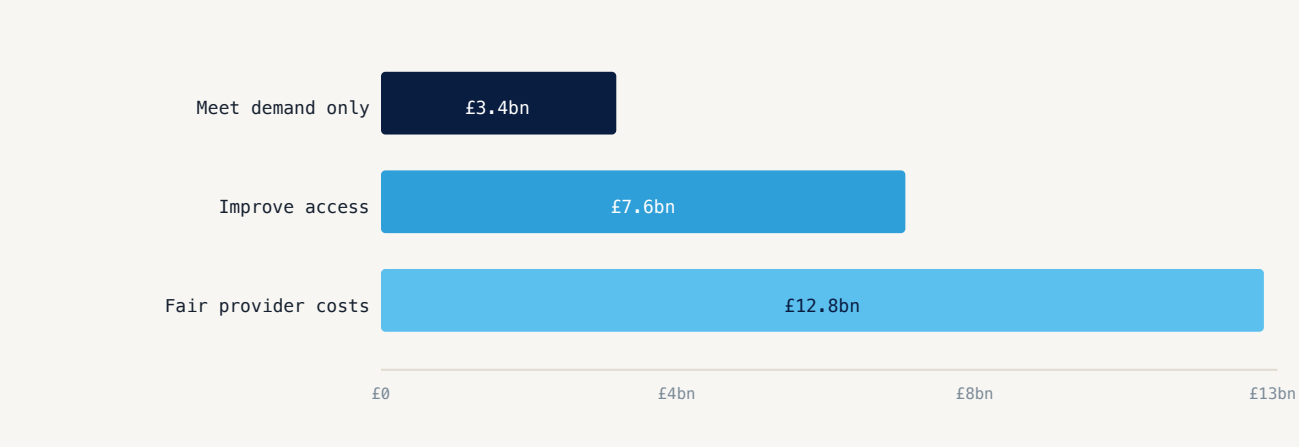


Fig. 7 — Annual additional funding required by scenario. Sources: Health Foundation (2023); Homecare Association (2024); ADASS Budget Survey (2024); Institute for Government analysis (2023).

4.5 The Casey Commission and the Path to Reform

The Government established the Casey Commission in 2025 to develop proposals for the long-term reform of adult social care. Its work represents the most significant opportunity for structural change in a generation, and the most important test of whether the cycle of commitment and deferral that has characterised social care policy for fifteen years can finally be broken.

This paper is intended to inform that process. It does not prescribe the Commission's conclusions. But it does argue that a national funding settlement of the kind set out here should be among the central outcomes the Commission recommends, and that the Commission's credibility will be substantially diminished if it produces proposals that do not address the structural misalignment between national demographic risk and local fiscal responsibility that lies at the root of the current system's failures.

The experience of previous reform attempts is instructive. Independent commissions have produced proposals that commanded broad expert support. The Care Act 2014 legislated for some of them. Implementation was delayed, deferred and ultimately reversed. The lesson is not that reform is impossible but that reform requires a funding commitment that is durable, a political consensus that is sustained, and an implementation plan that is credible. The Casey Commission has an opportunity to provide the architecture for all three.

4.6 Governance, Transparency and Accountability

Pooling financial risk at a national level only achieves its purpose if the resources it makes available remain visible, ring-fenced and demonstrably directed to the care for which they are intended. Experience suggests that care funding can become difficult to track once absorbed into larger budgets. The settlement proposed here, therefore, requires that:

- the national care grant is published annually in disaggregated form by local authority area;
- the National Care Assessment Body (Section 6) audits and publishes the relationship between funding received and care commissioned in each area; and
- any redirection of ring-fenced resources to other purposes triggers a statutory reporting requirement to Parliament.

The citizen should experience a joined-up service. Policymakers, providers and taxpayers should still be able to see where the money goes. How funding is governed, protected and accounted for matters as much as how it is raised. A national settlement that does not embed transparency at every level will not retain public confidence over the multi-decade horizon required to make it work.

4.7 Phasing and Implementation

Implementation Roadmap – Three Phases

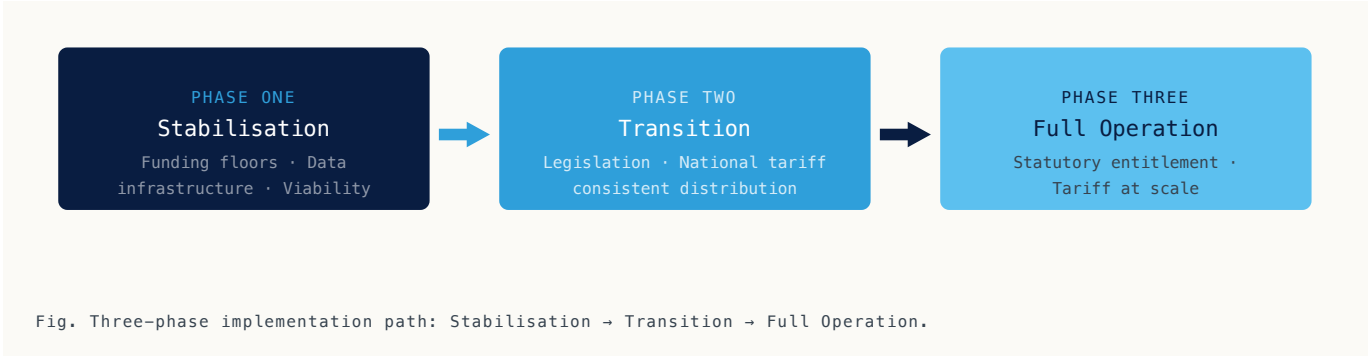


Fig. Three-phase implementation path: Stabilisation → Transition → Full Operation.

A national funding settlement of the scope described here cannot be implemented immediately. The financial, legislative and operational changes required are substantial, and a realistic implementation path is a precondition for credibility.

The phased approach this paper envisages has three broad stages. The first is stabilisation: providing adequate funding to local authorities to arrest the further deterioration of the current system, addressing the most acute provider viability pressures and establishing the data and assessment infrastructure that a national settlement will require. The second is transition: legislating the national eligibility framework, establishing the national tariff methodology, and beginning the shift from locally variable to nationally consistent funding distribution. The third is full operation: the national settlement operating at scale, with the statutory entitlement in force, the tariff applied consistently, and the funding formula distributing resources on a needs-adjusted basis across all local authority areas.

What this paper argues is that the direction of travel, towards national risk pooling, statutory entitlement and a national pricing framework, should be settled now, so that the decisions taken in each phase are consistent with a coherent long-term objective rather than a series of incremental adjustments that fall short of the structural change the system requires.

05

SECTION FIVE

Financing Individual Contributions

People should make fair contributions to their care costs. But those contributions must be predictable, capped and not catastrophic.

A national funding settlement does not mean the abolition of individual contributions to the cost of care. It means that those contributions are structured, bounded and set within a nationally coherent framework rather than determined by the fragmented and often opaque arrangements that currently govern the relationship between individuals, local authorities and the care market. This section sets out how individual contributions would work under the proposed model, why a lifetime cap is an essential component of a fair system, and how Deferred Payment Agreements can be reformed to ensure that homeowners are not forced to sell their properties to fund care.

5.1 The Reformed Means Test

Under the proposed national funding settlement, the means test would be retained as the mechanism for determining the level of individual financial contribution to the cost of care. The principle of personal responsibility, that individuals who have the means to contribute should do so, is preserved. What changes is the framework within which that principle is applied.

The upper capital limit, which has been frozen at £23,250 since 2010/11 and has therefore eroded significantly in real terms, would be raised substantially. The appropriate level is a matter for the Casey Commission to determine in the context of the overall funding settlement, but the principle is clear: the threshold must reflect the actual distribution of wealth among older people and must not exclude from public support individuals whose assets are modest. Had the upper capital limit risen with inflation since 2010/11, it would stand at approximately £35,118 today. Any serious reform must at minimum restore the real value of the threshold, and the direction of travel should be toward a substantially higher threshold that provides genuine protection for those of modest means.

The means test would also be reformed to treat income and assets more consistently and transparently. Research by the Joseph Rowntree Foundation found that only 21 per cent of the general public correctly identified the means test threshold. That level of public confusion about the basic terms of the system is not acceptable in a framework that asks individuals to plan for significant financial exposure.

5.2 The Case for a Lifetime Cap

The most significant structural gap in the current funding model is the absence of any limit on the total amount an individual can be required to spend on their own care. There is no cap on lifetime care costs. one in seven people aged 65 and over can expect to incur lifetime care costs of more than £100,000. For those with dementia or other conditions requiring long-term residential care, costs can run to several hundred thousand pounds over a number of years. An individual has no reliable way of knowing in advance whether they will be in this group, and no effective means of insuring against it.

This is the insurance problem that the IFS has described as the fundamental unresolved failure of the current system. Private long-term care insurance has never developed at scale in the United Kingdom, for structural reasons that are unlikely to change: care risks are correlated across the population, adverse selection discourages insurer participation at affordable premiums, and the long and unpredictable nature of care need makes pricing extremely difficult. The private market has not filled the gap left by public policy, and there is no realistic prospect of it doing so.

A lifetime cap on personal care costs addresses this directly. By setting a defined ceiling on the amount any individual can be required to spend, it converts an open-ended and unplannable liability into a bounded and insurable one. It does not eliminate individual contribution, individuals still contribute up to the cap, but it removes the prospect of catastrophic financial exposure for those who require intensive or long-term care. It also creates the conditions in which private financial products, including care annuities and insurance instruments, can develop alongside the public settlement.

The cap proposed in this paper is set at a level that provides genuine protection against catastrophic costs while remaining fiscally manageable. The precise figure is a matter for the Casey Commission, but the design principle is that it should sit below the level at which most people with substantial care needs would exhaust their assets, and that it should be set in a way that does not disproportionately benefit the wealthiest. The 2022 amendment to the Johnson reforms, which removed means-tested support from counting toward the cap and thereby weakened its protection for people of modest wealth, should not be replicated.

5.3 The Cost of Reform and Who Bears It

The Health Foundation's projections illustrate the range of fiscal commitment that different levels of reform ambition would require. Even the most modest scenario, maintaining current service levels in the face of demographic and cost pressures alone, requires an additional £3.4 billion per year by the end of this parliament. A settlement that genuinely improves access and addresses workforce pay requires substantially more.[31]

These are significant sums. They should be set against two considerations. The first is the cost of inaction, which is not zero. Continuing to fund the current system at current rates means progressive deterioration in access, further provider market instability, and growing pressure on NHS acute services from delayed discharges and inadequate community support. The second is the distributional character of social care spending. Analysis by the Social Market Foundation has shown that the net impact of additional social care spending, funded through general taxation, is strongly progressive: the bottom income deciles are substantial net beneficiaries, while the top decile makes a modest net contribution. Social care investment is not primarily a transfer to the wealthy. It is a form of collective provision whose benefits are concentrated among those with the least capacity to purchase equivalent support privately.

The question of how a reformed system is financed, through general taxation, a hypothecated levy, social insurance contributions or some combination, is one that the Casey Commission must address. What this paper argues is that the costs of reform are manageable relative to the overall scale of public expenditure, and that the cost of continued deferral, measured in deteriorating services, provider failures and unmet need, is rising every year.

5.4 Deferred Payment Agreements

For many older people, the largest component of their wealth is their home. The current system requires individuals in residential care whose assets exceed the means test threshold to contribute to the cost of their care from those assets, which in practice often means selling or charging against their property. Deferred Payment Agreements, introduced universally under the Care Act 2014, were designed to address this by allowing local authorities to cover care costs and recover the debt from the property on sale or from the estate, preventing forced home sales during an individual's lifetime.

The principle is sound. The practice has fallen well short of what was intended. In 2024/25, only 3,025 new Deferred Payment Agreements were agreed across England, compared to a care home population of approximately 372,000 residents. Government impact assessments had projected around 11,000 new agreements per year. Actual uptake is less than 30 per cent of that projection, and less than one per cent of the care home population in any given year. Geographic variation in uptake is substantial: outstanding DPAs per 100,000 adults range from 7.6 in London to 31.7 in the North East, and the average value of an outstanding agreement varies from £32,000 in the North East to £101,000 in London.[32]

The reasons for this low uptake are largely remediable. Many families are unaware that DPAs exist. Local authority promotion of the scheme is variable, and the moment at which families typically encounter care funding decisions, often under time pressure, recently bereaved or managing a crisis, is not conducive to careful financial planning.

Under the national funding settlement, Deferred Payment Agreements would be reformed and substantially expanded. A national framework would establish consistent eligibility rules, standardise the information provided to individuals and families at the point of assessment, and ensure that DPAs are presented as a standard option rather than an obscure entitlement. The objective is that no individual should be required to sell their home to fund care during their lifetime if they do not wish to do so.

5.5 The Partnership Principle

The individual contribution framework set out in this section rests on a partnership principle: the state bears the primary financial risk of care need, through national risk pooling and a statutory entitlement triggered by assessed need, while individuals with the means to contribute do so, up to a defined and protected limit. This is not a model of free care at the point of use. It is a model in which the collective and the individual each play a defined role, and in which neither is asked to bear a burden that properly belongs to the other.

Under the current system, that balance has been progressively distorted. The frozen means test has shifted more individuals into self-funding without any deliberate policy choice. The absence of a cap has left self-funders with open-ended financial exposure. The cross-subsidy between self-funders and publicly funded residents has transferred the consequences of public underfunding onto individuals

already managing significant costs. A reformed individual contribution framework, set within a national funding settlement, corrects each of these distortions.

06

SECTION SIX

International Lessons

Every comparable nation that has addressed this challenge successfully has done so through national risk pooling and a statutory entitlement framework.

No country has fully resolved the challenge of funding social care for an ageing population. The systems that have come closest to doing so share certain characteristics: a clearly defined national entitlement, a transparent and sustainable funding mechanism, a consistent national pricing framework, and independent oversight with the data and authority to maintain system stability over time. None of those characteristics are present in the current English system in anything approaching a complete form. The international evidence does not offer a template that can be transplanted wholesale into the English context. It does offer a body of hard-won experience about what works, what does not, and why certain design choices matter more than others.

6.1 Germany: The Entitlement Principle

Germany introduced statutory long-term care insurance, the Pflegeversicherung, in 1995. The scheme is compulsory and funded through mandatory payroll contributions, currently set at between 2.6 and 4.2 per cent of gross salary depending on family circumstances, split equally between employer and employee. Entitlement is not means-tested: anyone assessed as meeting defined eligibility criteria acquires a legal right to support regardless of their financial position.

Assessment is conducted by an independent body, the Medical Service of Health Insurance Funds, which applies a nationally standardised framework across five care grades. Each grade is determined by the degree of impairment to independence across six weighted domains, including mobility, cognitive ability and self-sufficiency. Each grade carries a defined entitlement to specific types and levels of support. The assessment is consistent regardless of where in Germany an individual lives.

The lesson England should draw from the German model is not primarily about the social insurance funding mechanism, which has its own limitations and which has required repeated increases in contribution rates as costs have risen. It is about the entitlement principle: that assessed need triggers support automatically and predictably, that the threshold is national and applied consistently, and that individuals know in advance what they are entitled to. A national fee framework with guaranteed minimum rates has largely prevented the care desert problem that characterises parts of the English market.

6.2 Japan: The National Fee Schedule and the Community Balance

Japan introduced compulsory long-term care insurance in 2000. The scheme covers those aged 65 and over and those aged 40 to 64 with care-related conditions. It is funded approximately half from general taxation and half from mandatory premiums, with a co-payment of 10, 20 or 30 per cent depending on income. Service prices are set by the national government and apply uniformly across regions, with seven unit-price levels adjusted for local cost of living. The fee schedule is reviewed every three years, at which point the government can adjust prices to incentivise care in one setting over another.

Japan has half the number of people in residential care as the United Kingdom, despite having a substantially older population. That reflects a deliberate policy choice, embedded in the fee schedule and the assessment framework, to support community and home-based care as the default rather than residential placement. Two lessons are particularly relevant for England. The first is that a national fee schedule, properly designed with local cost adjustments, can function at scale and maintain market stability without eliminating the role of local delivery. The second is that the balance between institutional and community care is shaped by how the funding system prices different settings, and a national tariff offers the opportunity to correct England's historically poor structure in this respect.

6.3 Denmark: National Consistency and Local Flexibility

Denmark provides free personal care at the point of need, funded through general taxation, with municipal governments responsible for assessment, commissioning and delivery within a national framework. Eligibility criteria and the basic entitlement to free personal care are set nationally. Municipalities have considerable discretion over how services are organised, what preventative programmes they develop, and how they work with local communities and providers. The national framework sets the floor; local government shapes the delivery above it.

Denmark has also invested substantially in preventative and rehabilitative care, with the explicit objective of supporting independence and reducing the intensity of care need over time. The full Danish model, including free personal care, is

not what this paper proposes for England. The lesson is more specific: that national consistency in eligibility and entitlement is compatible with local flexibility in delivery, and that investment in prevention and community-based support produces better outcomes for individuals and, over time, reduces pressure on more intensive and costly forms of provision.

6.4 Australia: Portability and Consumer Choice

Australia's aged care system offers a further lesson that is directly relevant to the model proposed in this paper. The Australian system is largely funded from general taxation alongside means-tested contributions, and it allows care users to take their personal care packages with them when they move between providers. The core principle is that funding follows the person, enabling genuine choice within an approved provider market and encouraging competition and a focus on quality. The system also distinguishes between care and accommodation costs, illustrating how these two elements can be managed separately within a single national framework. The transferable insight for England is that a national funding settlement should be designed with portability built in from the outset, so that individuals are not locked into providers by administrative funding structures but retain meaningful choice and control over how their assessed care is delivered.

6.5 Scotland: A Cautionary Tale

Scotland introduced free personal care for older people in 2002 following the Sutherland Commission. The policy commands broad public and political support and has provided genuine protection for many older Scots against the costs of personal care. It is also a cautionary tale about the consequences of reform without adequate and sustained funding. Free personal care was introduced without a long-term funding settlement to underpin it, and over time the combination of demographic pressure, inadequate fee rates and workforce instability has produced a system under significant strain. The lesson is not that free personal care was the wrong policy. It is that entitlement without sustainable funding is not a stable position. Reform must be accompanied by a funding settlement that is adequate from the outset, ring-fenced against short-term pressures, and planned for the demographic trajectory ahead.

International Comparators – Funding Models for Social Care

DIMENSION	GERMANY	JAPAN	DENMARK	AUSTRALIA	SCOTLAND
Funding mechanism	Compulsory social insurance (2.6-4.2% payroll)	Half taxation, half mandatory premiums	General taxation	General taxation (devolved)	General taxation + means-tested contributions
Eligibility basis	National, non-means-tested; five care grades	National; age 65+ or 40-64 with care conditions	National eligibility, municipally assessed	Free personal care; means test for residential	National assessment; means-tested contribution framework
Fee setting	National framework; regional negotiation against costs	National fee schedule; 7 regional cost bands	Municipal within national framework	Local authority rates; national guidance	Nationally set subsidy rates; provider market sets prices above floor
Individual contribution	None for personal care; co-pay for accommodation	10-30% co-payment depending on income	None for personal care	None for personal care; means test for residential costs	Means-tested; accommodation deposit model for residential
Local/national balance	National entitlement; regional delivery	National entitlement and pricing; local delivery	National floor; strong municipal flexibility	National entitlement; local authority delivery	National entitlement and funding; local provider market
Key lesson for England	Entitlement principle; consistent assessment; fee stability	National tariff works at scale; community care balance	National consistency compatible with local flexibility	Entitlement without sustained funding is unstable	Funding follows the person; portability enables real choice

6.6 Institutional Design: The Case for a National Care Assessment Body

A national funding settlement requires institutional architecture to sustain it. The history of social care policy in England is partly a history of commitments made without the independent oversight and long-term data infrastructure needed to maintain them. Funding decisions have been made on the basis of inadequate cost information. Markets have been allowed to deteriorate without early intervention. Reform cycles have produced announcements that were never implemented because no independent body had the authority or the data to hold government to account for delivery.

This paper proposes the establishment of a National Care Assessment Body, operating independently of both the NHS and local government. Its functions would be distinct from those of the existing regulatory framework. The first is assessment consistency: applying and overseeing the national eligibility framework, ensuring that assessed need triggers funding in a consistent and fair way regardless of geography, and providing structured appeals for individuals who contest assessment outcomes. The second is cost of care analysis: independent assessment of the full costs of delivering care at different levels and in different settings, providing the transparent evidence base on which the national tariff depends. The third is market oversight: regular assessment of provider financial health, market concentration and geographic gaps in supply. The fourth is demand forecasting: statutory long-term projections of care need by geography and care type, over a horizon long enough to inform provider investment and commissioning decisions.

Alongside the Assessment Body, a statutory Care Commissioner function would support individuals who are unable to navigate provider choices or personal budgets independently, including those without family members or informal support networks, providing advocacy and ensuring that the system is accessible to those who most need it.

The broader institutional lesson from the international comparators is consistent: systems that have maintained quality and access over time have done so through stable institutional frameworks, not through periodic political interventions. Germany's independent assessment body, Japan's three-year fee schedule review, and Australia's nationally administered funding model all reflect institutional discipline rather than political enthusiasm. England needs the same, and a National Care Assessment Body, properly resourced and with a clear statutory mandate, is the right vehicle to provide it.

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The average home care rate paid by local authorities is £24.10 per hour. The minimum sustainable rate is £32.14. That £8 gap is paid by the workforce, in suppressed wages, and by providers, in unsustainable margins.

HOMECARE ASSOCIATION, MINIMUM PRICE FOR HOMECARE 2024

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SECTION SEVEN

National Tariff Design

A tariff that does not reflect the true cost of quality care is not a tariff. It is a rationing mechanism with extra steps.

The national funding settlement proposed in this paper cannot function without a coherent national pricing framework. Fee rates are not a technical detail. They are the mechanism through which the funding settlement reaches providers, and through providers, the workforce that delivers care and the individuals who receive it. A national settlement that pools financial risk and establishes statutory entitlement but leaves fee setting to 153 individual local authority negotiations will not resolve the market instability, cross-subsidy and geographic variation documented in earlier sections. It will simply relocate those problems within a different institutional framework.

A national tariff for social care is therefore an integral component of the proposed settlement, not an optional addition to it. This section sets out how that tariff should be designed, what it must cover, and how it can be implemented in a way that provides market stability without eliminating legitimate local variation in costs.

7.1 The Evidence Base for the Tariff

The cost structure of social care is dominated by staffing. Staff costs account for approximately 60 per cent of total expenditure in residential and nursing care settings, and approximately 75 per cent in domiciliary care.[33] Any tariff methodology that does not begin with a detailed and honest assessment of what it costs to employ, train, retain and deploy a care workforce at the required scale and quality will produce fee rates that are structurally insufficient, regardless of what other adjustments are made around the margins. The national tariff must therefore be built on a workforce cost floor, updated regularly to reflect changes in the National Living Wage, employer National Insurance contributions, pension costs and the other employment costs that together determine what providers need to receive to operate sustainably.

This is not a novel requirement. The NHS national tariff, published annually by NHS England, is built on exactly this principle: a transparent methodology that accounts for the costs of delivering healthcare, including staff costs, with a market forces factor that adjusts for unavoidable cost differences by location. The social care tariff proposed here follows the same logic, applied to the different cost structure and delivery models of social care.

7.2 Residential and Nursing Care: The Bundled Tariff

The current system sets residential care fees through fragmented local negotiations, producing wide variation in what providers receive for comparable services. Councils pay around £908 per week on average for residential care, while for nursing care the figure is approximately £1,225 per week. These figures mask significant variation: some local authorities pay substantially below even these averages, while others have moved closer to sustainable rates. The national tariff replaces this variation with a transparent, evidence-based rate that reflects actual delivery costs, adjusted for location, and reviewed on a defined cycle.

7.3 Domiciliary Care: Addressing the Travel Time Problem

That gap is not a marginal shortfall. It is a structural underpayment that makes it impossible for many providers to deliver home care sustainably at the rates on offer, and that is driving providers to exit local authority commissioned markets, concentrate in areas where rates are higher, or cross-subsidise from privately paying clients in precisely the same way that residential providers cross-subsidise from self-funders. The result is the same: instability, geographic variation and a hidden transfer of the cost of public underfunding onto individuals who are already funding their own care.

Central to this problem is the treatment of travel time. Care workers in domiciliary settings spend a significant proportion of their working time travelling between clients. The average paid travel time is approximately 12 minutes for every hour of care delivered. Fewer than two per cent of providers receive separate payment for travel from commissioners.[35] In practice, this means that the hourly rate paid to providers is expected to cover both the care delivered and the travel required to deliver it, at a rate that does not in most cases cover even the care element alone. The minimum pay guarantee introduced by the National Living Wage applies to all working time, including travel. Providers that do not pay workers for travel time are in breach of that requirement. Yet the commissioning framework makes compliance structurally difficult by setting rates that assume travel is not a cost.

The national tariff for domiciliary care must address this directly. The tariff methodology would include an explicit travel cost component, calculated on the basis of average

travel time in different geographic settings and updated to reflect changes in staff costs. Block contracts, used by only one per cent of commissioners at present, would be promoted as the standard vehicle for homecare commissioning, providing the income stability that providers need to employ staff on secure contracts, invest in training and operate sustainably. The current pattern, in which 61 per cent of councils and health and social care trusts purchase too few hours from any individual provider to sustain employment rights and financial viability, is incompatible with a stable homecare market and must change.

Figure 8 – Home Care: Council Average vs Minimum Sustainable Rate

Fig. 8 — Average LA-commissioned home care rate £24.10/hr vs Homecare Association minimum sustainable rate £32.14/hr. Sources: Homecare Association Minimum Price for Homecare 2024; ADASS Budget Survey 2024.

7.4 Local Cost Adjustments

A national tariff does not mean a uniform rate applied identically across all areas regardless of local circumstances. Unavoidable cost differences between areas, principally driven by differences in labour market conditions, property costs and the density and geography of local demand, are real and must be reflected in the tariff methodology. The NHS Market Forces Factor provides a well-established model for how this can be done: a nationally set base rate, adjusted by a location factor derived from independent analysis of relative input costs, producing a rate for each area that reflects both the national standard and local cost realities.

The social care equivalent would apply the same principle. Areas with higher labour market costs, principally London and the South East, would receive a higher tariff than areas where staff costs and property costs are lower. The adjustment factor would be calculated independently, updated regularly, and published transparently. The tariff would not preclude local authorities from commissioning care at above the national tariff rate where they choose to do so. What it prevents is commissioning below the tariff rate, which is the practice that has driven provider instability and care deserts in the current system.

7.5 The Review Cycle and Long-Term Maintenance

A national tariff is only as good as the process through which it is maintained. Rates that are set adequately at introduction but not updated in line with cost changes will reproduce the underfunding problem in a new form. The tariff must therefore be subject to a regular, transparent and independently verified review cycle, conducted on a defined timetable and insulated from short-term fiscal pressures.

This paper proposes a three-year review cycle, consistent with the approach used in Japan's national fee schedule and with the multi-year funding commitments that the most stable international systems have adopted. The review would be conducted by the National Care Assessment Body, drawing on independently verified cost data, demand projections and workforce cost forecasts. Its conclusions would be published and would form the basis for the tariff rates applied in the following period. Local authorities and the Secretary of State would be required to explain publicly any departure from the tariff recommendations, creating an accountability mechanism that does not currently exist.

7.6 What the Tariff Achieves

The national tariff does several things simultaneously that the current commissioning framework cannot. It removes the cross-subsidy between self-funders and publicly funded residents by ensuring that the publicly commissioned rate covers the actual cost of care. It provides market stability by giving providers a predictable income base against which to plan workforce and capital investment. It creates the conditions for geographic consistency by ensuring that the rates available to providers do not vary arbitrarily by local authority area. And it establishes a transparent accountability framework in which the adequacy of public funding for care can be assessed against an independent cost standard rather than obscured by local negotiation.

7.7 Price Transparency for Self-Funders

Transparency of price is a necessary companion to transparency of methodology. The national tariff sets a floor and a reference point, but it does not, by itself, give individuals and families the information they need at the point of choosing a provider. Self-funders and their families frequently struggle to establish, in advance, what a given provider actually charges, and are often required to request a bespoke quotation before receiving even indicative figures. This opacity leaves people negotiating price at the point of greatest vulnerability, immediately after a crisis or diagnosis, rather than in a position to compare providers calmly and in advance.

The system proposed in this paper is designed to close that gap without introducing a new regulatory requirement. A transparent, independently verified national tariff gives individuals and families a public benchmark against which to judge what any individual provider is charging, and providers operating in a market with a visible reference point have a stronger incentive to be clear about their own pricing than they do today. Over time, this should encourage more providers to publish their fee rates voluntarily, particularly as self-funders become better able to compare the price they are quoted against the tariff rate for equivalent care.

08

SECTION EIGHT

The Role of Local Authorities

Reform must strengthen the local commissioning function, not displace it. Local authorities are delivery leaders, not the financial shock-absorbers of last resort.

The case for a national funding settlement does not rest on a view that local government has failed in its management of adult social care. In many areas, local authorities have demonstrated real skill and commitment in commissioning and managing care services under conditions of sustained financial pressure. The argument is not that local delivery should be replaced but that the financial architecture within which it operates has made it impossible to succeed consistently. A reformed funding model changes that architecture. It does not change the fundamental case for local delivery.

This section sets out what local authorities do under the proposed settlement, how their role evolves, and how the relationship between social care and the NHS is reframed in a way that makes integration practical rather than aspirational.

8.1 What Local Authorities Do and Why It Matters

Local authorities carry statutory responsibility for adult social care under the Care Act 2014. That responsibility encompasses the full range of functions required to operate a care system at local level: assessing individual need, developing care and support plans, commissioning services from a diverse provider market, managing provider relationships, developing local care markets to ensure adequate supply, and providing or arranging support for unpaid carers. These functions require knowledge of local communities, relationships with local providers, and an understanding of local demographic pressures and service gaps that cannot be replicated from the centre.

This is not a theoretical argument for localism. It reflects the practical reality of how care works. Good care is built on relationships and continuity. The care worker who visits an older person at home, the residential home that understands a resident's history and preferences, the local commissioner who knows which providers are struggling and which are developing new models of provision: these are the building blocks of a care system that works for individuals, and they are inherently local. A national framework that attempted to manage these relationships centrally would not improve them. It would replace local knowledge and accountability with national bureaucracy.

8.2 What Changes Under the Reformed Model

The reformed model changes three things about the local authority role without removing any of its core functions.

The first is the basis of funding. Local authorities currently fund adult social care from a combination of central government grants, council tax and the adult social care precept. Under the national settlement, they receive a ring-fenced national care grant, calculated on a needs-adjusted formula and sufficient to fund the statutory entitlement. In 2025/26, 350 of 384 councils raised council tax at or near the maximum permitted level. The adult social care precept, raising £609 million in aggregate across all 153 authorities in 2024/25, equivalent to £32 on an average Band D bill, cannot close a gap measured in billions. Replacing it with a national care grant resolves this structural contradiction.

The second is the eligibility framework. Local authorities currently apply the Care Act 2014 needs assessment framework within financial constraints that have driven progressive tightening of eligibility thresholds. Under the reformed model, the national eligibility threshold is set centrally and local authorities apply it as a statutory obligation rather than a discretionary decision shaped by budget availability. This represents a genuine change in the local authority's position: from a commissioner managing rationing under financial pressure to a commissioner managing quality and appropriateness within a funded entitlement.

The third is the pricing framework. Local authorities currently set their own fee rates through individual negotiations with providers. Under the national tariff, they commission within a nationally defined pricing framework, with local adjustments for unavoidable cost differences. They retain discretion to commission above the tariff floor where local circumstances warrant it. They lose the capacity to commission below the tariff, which is the capacity that has driven provider instability and care deserts. For most local authorities, that is not a loss of meaningful autonomy. It is a removal of a practice that the National Audit Office has confirmed produces unsustainable outcomes.

Local Authority Role: Current vs Proposed

DIMENSION	CURRENT POSITION	UNDER NATIONAL FUNDING SETTLEMENT
Funding basis	Combination of central grants, council tax and adult social care precept; highly variable by area	Ring-fenced national care grant on needs-adjusted formula; stable and adequate by design
Eligibility framework	Care Act 2014 criteria applied within local financial constraints; thresholds tightened by budget pressure	National threshold set centrally; applied as statutory obligation regardless of local budget position
Fee setting	Local authority negotiation with individual providers; NAO-confirmed rates below sustainable cost in many areas	National tariff floor; local authorities commission at or above tariff; local uplift discretion retained
Prevention investment	Funded from residual budget after statutory duties met; cut when budgets are constrained	Dedicated ring-fenced prevention stream within national settlement; insulated from statutory demand pressure
NHS relationship	Separate funding streams; financial incentive to delay discharge; boundary disputes routine	Funded statutory entitlement removes LA disincentive to commission; discharge pathway financially cleared
Democratic accountability	Theoretical discretion; in practice forced choices under financial duress	Genuine discretion over commissioning, quality and prevention within a funded national framework

8.3 Integration With the NHS

The relationship between social care and the NHS is the most persistently difficult operational challenge in the English care system, and it is not one that the national funding settlement alone can resolve. The full architecture of health and care integration is the subject of a subsequent paper in this programme. But the funding settlement materially changes the conditions under which integration operates, and that change deserves to be set out clearly.

The central problem in the current system is that health and social care are funded through separate streams with different accountability frameworks, different eligibility criteria and different incentive structures. When a patient in an NHS hospital is assessed as medically fit for discharge but requires care and support that the social care system cannot promptly arrange, the cost of the resulting delayed discharge falls on the NHS while the cost of providing the care falls on the local authority. Neither system has a financial incentive to resolve the blockage quickly. The cost of delayed discharges attributable to social care factors was estimated at £1.89 billion in 2023/24.37 The NAO has calculated that the cost of delayed transfers of care to the NHS is approximately 4.5 times higher than the cost of providing appropriate community support.[38] In December 2024 alone, 272,000 bed days were lost to delayed discharges nationally.[39]

The national funding settlement addresses the structural dimension of this problem by ensuring that local authorities have adequate funding to commission the care packages that enable timely discharge. A funded statutory entitlement removes the constraint that delayed discharges frequently persist not because suitable care is unavailable in principle but because commissioning the required care would place additional pressure on an already overstretched local authority budget. During the first wave of Covid-19, discharge-to-assess arrangements backed by dedicated central funding freed 30,000 acute beds and generated over £450 million in acute bed savings. The same logic applies under the national settlement, but as a permanent structural feature rather than an emergency measure.

The Government's Neighbourhood Health Service framework, published in March 2026, represents the most current expression of the ambition to shift care closer to home and to integrate health and social care at community level. The framework identifies a set of neighbourhood-level functions, including proactive care for people with complex needs, mental health support, frailty assessment and falls prevention, that require coordinated working between primary care, community health services and social care. Local authorities are identified as essential partners in delivering this agenda, alongside NHS Integrated Care Systems. The national funding settlement creates the conditions for that partnership to function. An adequately

funded local authority, operating within a clear statutory framework and a stable provider market, is a credible partner for NHS Integrated Care Systems. An underfunded local authority managing rationed eligibility and fragile provider relationships is not.

8.4 Prevention and Early Intervention

One of the most significant casualties of the funding pressure on local authorities over the past decade has been investment in prevention and early intervention. Prevention spending by councils fell from £1.55 billion to £1.43 billion between 2023/24 and 2024/25, a reduction that is particularly difficult to justify given the evidence on its returns.[40] The Local Government Association estimates that investing in preventative social care saves £3.17 for every pound spent.[41] Reductions in social care spending for over-65s are associated with a 3.8 per cent increase in the probability of accident and emergency attendance.[42] Preventative interventions including regular home visits, falls prevention programmes and rehabilitation services enable older people to remain active and independent for longer, reducing the intensity of care need over time.

The funding pressure that has driven cuts to prevention is not incidental. It is the direct result of a local authority funding model in which statutory duties to meet assessed eligible need must be met first, and prevention is funded from whatever remains. When budgets are constrained, prevention is cut. The consequence is that more people reach crisis point requiring intensive and costly intervention, which places further pressure on the budget, which reduces prevention further. The national funding settlement disrupts this pattern by providing a stable and adequate resource base from which both statutory provision and prevention can be funded.

Local authorities are well placed to develop and deliver prevention programmes because they understand local communities and have established relationships with the voluntary sector, housing providers and other local institutions that are central to effective preventative work. Areas such as Greater Manchester, which has developed an integrated approach to prevention as part of its broader health and wellbeing strategy, demonstrate what is achievable when local authorities are properly resourced and empowered. The national funding settlement does not prescribe how prevention is delivered. It creates the financial conditions in which local authorities can invest in it without sacrificing statutory provision.

The Treasury accounting framework, which counts the costs of social care investment in the care budget without crediting the savings that accrue to the NHS, to the benefits system and to the wider economy, is a persistent obstacle to rational decision-making about prevention. A national settlement that pools social care funding at the centre creates better conditions for cross-departmental analysis of the true costs and returns of prevention investment than the current fragmented local model.

8.5 Funding Follows the Individual

Where appropriate, this portability should be supported by personal budgets, enabling individuals and families to exercise meaningful choice and control over how their assessed care is delivered. Personal budgets have operated within the current system in a limited form, but their potential has been constrained by the fragmented commissioning environment and the financial pressures that have led local authorities to prioritise cost management over individual choice. A national funding settlement, by providing an adequate and stable resource base, creates the conditions in which personal budgets can function as a genuine vehicle for individual choice rather than a mechanism for cost transfer. Individuals who cannot manage personal budgets independently, or who do not wish to do so, should be supported by the Care Commissioner function described in Section 6 to navigate provider choice and ensure that the care pathway reflects their needs and wishes.

8.6 Democratic Accountability

A concern sometimes raised about any shift toward national funding frameworks is that it reduces democratic accountability by removing financial decisions from locally elected bodies. This concern deserves a direct response.

Under the current system, local authority discretion over adult social care is largely theoretical. Councils bear statutory duties they cannot meet adequately with the resources available to them. The decisions they take about eligibility thresholds and fee rates are not expressions of local democratic preference; they are forced choices under financial duress. The adult social care precept, which notionally gives councils a mechanism to raise additional resource for care, is in practice a compulsory levy whose proceeds are absorbed by cost pressures rather than expanding provision. There is no meaningful local choice involved.

The national funding settlement does not reduce democratic accountability. It restores the conditions under which genuine local accountability can exist. A local authority that receives adequate funding to meet its statutory duties, operates within a national eligibility framework and commissions within a national tariff retains real discretion over how services are organised, what prevention programmes are developed, how provider relationships are managed and how local care markets are shaped. Those are genuinely consequential decisions for which local elected representatives can properly be held to account. That is more meaningful local democracy than the current system provides.

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SECTION NINE

Conclusion

The window for orderly reform is narrowing. The cost of another deferral will not be paid by policymakers. It will be paid by the people who need care.

This paper opened with a simple proposition: that social care is not a residual service but the infrastructure through which people with frailty, disability and complex need are supported to live with independence and dignity. Everything that follows from that proposition has been set out in the preceding sections. The funding model that currently finances social care in England is not fit for purpose. It distributes national demographic risk across local authority budgets that were never designed to bear it. It exposes individuals to potentially catastrophic financial liability without the means to plan for or insure against it. It sustains a provider market through cross-subsidies that are neither equitable nor stable. And it produces outcomes that vary by postcode rather than by need.

These are not new findings. The structural failures of the current system, inadequate funding, an eroded means test, the absence of a lifetime cap, and a provider market dependent on cross-subsidy, have been clearly identified for over a decade. Proposals for reform have been developed, legislated for and cancelled. The cycle has been repeated so many times that scepticism about whether any reform can be delivered has become the default position of many who understand the system best.

That scepticism is rational. The political history of social care reform in England is a history of the doom loop: persistent unanswered policy questions producing paralysing uncertainty about costs, daunting fiscal estimates shutting down deliberation before it can begin, and an act-omission bias in which slow failure is treated as less risky than bold change. The most recent reversal, in July 2024, saved £1.1 billion in the short term while leaving unresolved the structural problems that have been accumulating for a decade and a half.

This paper does not pretend that the Casey Commission will find reform easy, or that the political barriers have diminished. What it argues is that the costs of continued inaction are now rising faster than the costs of reform, and that the window for a sustainable settlement is narrowing rather than widening with each passing year.

The affordability argument matters here and deserves to be stated plainly. The Health Foundation has modelled the cost of different levels of reform ambition, and even the most modest scenario, maintaining current service levels against demographic and cost pressures alone, requires several billion pounds of additional annual investment within this parliament. A settlement that genuinely improves access and protects individuals from catastrophic costs requires more. These sums are significant. But UK tax revenues as a share of national income are slightly below the average for G7, OECD and EU14 countries, and the fiscal headroom to fund a reformed system exists. What has been lacking is not resources but the political commitment to deploy them.

The cost of inaction is not zero. It falls on the individuals who exhaust their assets paying for care they could not have anticipated needing, on the families who provide unpaid support worth £184 billion per year to fill gaps the formal system cannot meet, on a provider market whose capacity to invest and develop is constrained by fee rates that do not cover sustainable costs, and on an NHS that spent £1.89 billion in 2023/24 on delayed discharges that reflect a failure of the care funding pathway rather than a shortage of care capacity. Reform that is deferred does not become cheaper. It becomes more expensive, because the system it is intended to fix continues to deteriorate in the meantime.

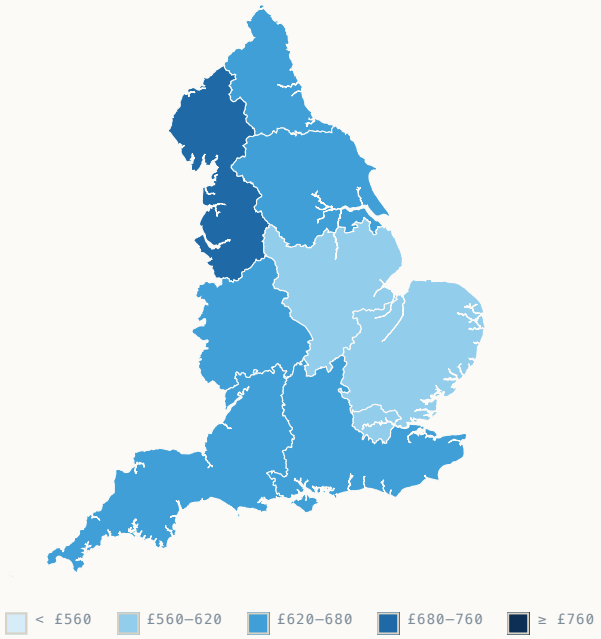
The proposals set out in this paper are designed to break that pattern. A national funding settlement, built on national pooling of financial risk, a statutory entitlement triggered by assessed need, a transparent national tariff, and a reformed individual contribution framework with a lifetime cap, addresses the structural causes of the current system's failures rather than their symptoms. It does not resolve everything. A well-functioning care system also requires a stable and valued workforce, an efficient commissioning framework, effective integration with health services and a provider market capable of delivering high-quality care in every area. Those are the subjects of the papers that follow in this programme. But none of those reforms can be made to work without the funding foundation this paper proposes.

The Casey Commission has an opportunity that its predecessors did not fully have: a clear mandate, a body of evidence that has never been more complete, and a political context in which the consequences of further deferral are visible to an increasing number of people. The Care Association Alliance and its members, who deliver care to hundreds of thousands of older people across England every day, understand those consequences directly. This paper is intended to ensure that the Commission's work is informed

by that experience, and that the proposals it considers are grounded in the operational and financial realities of the system as it actually functions.

REGIONAL DATA

Adult Social Care Spend per Adult Population – England by Region



Spend per adult population varies significantly across England's nine regions, reflecting differences in demographic composition, deprivation, labour market costs and commissioning practices. The North West records the highest average at £686 per adult; London the lowest at £575, driven by high private provision rates and a younger demographic profile in the capital's outer boroughs.

Region	Avg £/adult	Councils
North West	£686	15
North East	£672	7
South West	£640	15
Yorkshire & Humber	£645	15
West Midlands	£628	14
South East	£625	19
East Midlands	£600	10
East of England	£580	11
London	£575	32

APPENDIX A

Local Authority Adult Social Care Expenditure – All 153 Upper-Tier Councils

Ranked by gross spend per adult population. Sources: NHS Digital Adult Social Care Finance Return (ASC-FR) 2024/25; ONS mid-year population estimates 2024; NHS Digital DoLS Annual Return 2024/25. The age-adjusted column standardises each authority's spend for its 18-64 and 65+ population; the "vs need + cost" column shows spend above (+) or below (–) what a regression on age, deprivation, provider cost and working-age need predicts (Appendix B); the "need-adjusted rank" orders authorities by that gap, where 1 spends most above what need and cost predict. An interactive, sortable version of this table is available online at bridgeheadcommunications.com/reports/caa-spend-table.

#	LOCAL AUTHORITY	REGION	£/ADULT	AGE-ADJ. £/ADULT	VS NEED +COST £	NEED-ADJ. RANK	GROSS SPEND	ADULT POP	DOLS MEAN	≤21 DAYS
1	Isles of Scilly	South West	£1073	£991	–	–	£2.2m	2k	–	–
2	Knowsley	North West	£940	£960	+158	2	£119m	127k	134	5%
3	Isle of Wight	South East	£888	£747	+66	28	£105.1m	118k	87	12%
4	Blackpool	North West	£883	£852	+72	23	£101.8m	115k	51	5%
5	Halton	North West	£871	£861	+152	3	£90.5m	104k	82	16%
6	South Tyneside	North East	£832	£793	+128	6	£100.5m	121k	25	38%
7	East Sussex	South East	£830	£729	+111	11	£378.8m	456k	126	5%
8	Camden	London	£796	£925	+194	1	£144.6m	182k	40	16%
9	Gateshead	North East	£781	£760	+115	10	£126.8m	162k	16	42%
10	East Riding of Yorkshire	Yorkshire and The Humber	£776	£680	+101	12	£227.4m	293k	78	8%
11	Torbay	South West	£761	£665	−65	128	£87.8m	115k	264	17%
12	Westmorland and Furness	North West	£758	£673	+20	54	£144.8m	191k	170	65%
13	Sunderland	North East	£754	£730	+74	22	£174.8m	232k	18	43%
14	Cornwall	South West	£750	£668	+10	66	£358.3m	478k	345	7%
15	North Somerset	South West	£736	£672	+86	17	£132.7m	180k	267	7%
16	Hartlepool	North East	£734	£714	+24	47	£56.6m	77k	43	23%
17	North Yorkshire	Yorkshire and The Humber	£734	£653	+87	16	£381.1m	520k	80	6%
18	Newcastle upon Tyne	North East	£732	£797	+120	7	£189.8m	259k	41	62%
19	Cheshire West and Chester	North West	£730	£697	+98	14	£219.2m	300k	94	56%
20	South Gloucestershire	South West	£724	£726	+129	5	£176.4m	244k	252	14%
21	Kingston upon Hull, City of	Yorkshire and The Humber	£723	£765	+33	43	£154m	213k	97	2%
22	Rotherham	Yorkshire and The Humber	£722	£707	+34	41	£156.8m	217k	121	12%
23	Leicester	East Midlands	£722	£822	+116	9	£214.7m	298k	132	6%
24	Brighton and Hove	South East	£721	£801	+140	4	£171.1m	237k	101	8%
25	Shropshire	West Midlands	£721	£638	+16	61	£196.3m	272k	136	30%
26	Wirral	North West	£720	£673	−26	99	£189.2m	263k	68	5%
27	Stockport	North West	£719	£698	+80	20	£171.8m	239k	356	17%
28	St. Helens	North West	£719	£698	+1	75	£108.7m	151k	78	10%
29	Bury	North West	£719	£719	+52	33	£110.8m	154k	32	34%
30	Manchester	North West	£717	£871	+99	13	£328.2m	458k	61	25%
31	Herefordshire, County of	West Midlands	£715	£627	+17	57	£111.9m	157k	167	6%
32	Rochdale	North West	£714	£735	+5	69	£126.7m	177k	66	5%
33	Islington	London	£712	£872	+117	8	£133.4m	187k	30	39%
34	Middlesbrough	North East	£710	£733	−99	143	£85.6m	121k	72	89%
35	Suffolk	East of England	£708	£645	+41	38	£448.6m	634k	359	6%
36	Wolverhampton	West Midlands	£707	£734	+55	30	£150.4m	213k	46	21%

#	LOCAL AUTHORITY	REGION	£/ADULT	AGE-ADJ. £/ADULT	VS NEED +COST £	NEED-ADJ. RANK	GROSS SPEND	ADULT POP	DOLS MEAN	≤21 DAYS
37	Sefton	North West	£701	£645	−30	105	£162.4m	232k	106	40%
38	Liverpool	North West	£701	£754	−13	89	£288.2m	411k	193	12%
39	Blackburn with Darwen	North West	£700	£751	+14	62	£84.5m	121k	186	7%
40	Doncaster	Yorkshire and The Humber	£697	£684	+22	50	£175.4m	251k	139	10%
41	Lancashire	North West	£697	£669	+18	56	£720.4m	1034k	411	3%
42	Darlington	North East	£696	£667	+38	40	£62.5m	90k	89	—
43	Telford and Wrekin	West Midlands	£694	£700	+67	26	£105.3m	152k	170	21%
44	Solihull	West Midlands	£690	£653	+22	51	£118.7m	172k	68	30%
45	Haringey	London	£689	£805	+77	21	£144.9m	210k	19	62%
46	West Berkshire	South East	£688	£665	+69	25	£89.2m	130k	168	6%
47	Hackney	London	£687	£856	+63	29	£146m	213k	24	39%
48	Northumberland	North East	£686	£606	−42	112	£186.8m	272k	56	32%
49	Derbyshire	East Midlands	£684	£642	+51	34	£455.9m	666k	159	10%
50	Devon	South West	£679	£603	−14	90	£471.2m	694k	162	19%
51	Oldham	North West	£678	£705	−6	81	£127.1m	187k	115	9%
52	Dorset	South West	£678	£565	−38	110	£218.7m	323k	129	16%
53	Bedford	East of England	£677	£692	+72	24	£101.9m	150k	26	19%
54	Calderdale	Yorkshire and The Humber	£676	£663	+7	67	£112m	166k	212	4%
55	Sheffield	Yorkshire and The Humber	£676	£705	+27	45	£315m	466k	148	13%
56	Bristol, City of	South West	£676	£771	+88	15	£271.4m	402k	194	21%
57	Norfolk	East of England	£671	£607	−41	111	£515.7m	769k	193	28%
58	Somerset	South West	£670	£599	−21	95	£318.5m	475k	143	28%
59	Nottingham	East Midlands	£666	£768	+13	64	£174.8m	262k	245	36%
60	Kent	South East	£664	£639	+24	48	£852.5m	1284k	152	25%
61	Stoke-on-Trent	West Midlands	£664	£680	+5	70	£138.1m	208k	135	20%
62	Wakefield	Yorkshire and The Humber	£663	£657	+12	65	£192.4m	290k	72	28%
63	Nottinghamshire	East Midlands	£662	£630	+30	44	£453.9m	685k	255	18%
64	Essex	East of England	£658	£632	+34	42	£812.1m	1234k	112	12%
65	Redcar and Cleveland	North East	£657	£599	−85	135	£73.4m	112k	37	27%
66	Hertfordshire	East of England	£656	£667	+84	19	£628.6m	959k	202	12%
67	Tameside	North West	£655	£666	−9	85	£122.3m	187k	56	15%
68	Bolton	North West	£650	£663	−33	108	£152.4m	234k	34	19%
69	North Lincolnshire	Yorkshire and The Humber	£650	£603	−4	79	£88.8m	137k	41	28%
70	Sutton	London	£648	£685	+85	18	£106.1m	164k	185	19%
71	Cumberland	North West	£647	£594	−52	122	£147.5m	228k	290	32%
72	Surrey	South East	£645	£637	+54	31	£632m	979k	209	21%
73	Southend-on-Sea	East of England	£644	£635	+7	68	£93.8m	146k	66	4%
74	North Tyneside	North East	£644	£619	−27	100	£111.3m	173k	58	10%
75	Warwickshire	West Midlands	£644	£623	+39	39	£323.6m	503k	64	31%
76	Dudley	West Midlands	£642	£622	−25	98	£167.4m	261k	219	13%
77	Croydon	London	£641	£701	+27	46	£202.1m	315k	143	5%
78	City of London	London	£638	£808	—	—	£9.1m	14k	18	50%
79	Bournemouth, Christchurch and Poole	South West	£635	£608	+24	49	£212.2m	334k	208	15%
80	Kirklees	Yorkshire and The Humber	£631	£635	−8	84	£219.7m	348k	45	26%
81	Barnet	London	£630	£672	+46	36	£196.1m	311k	172	3%
82	Walsall	West Midlands	£625	£635	−32	107	£139.9m	224k	38	41%
83	Hampshire	South East	£624	£585	+17	58	£723.3m	1158k	256	16%

#	Local Authority	Region	£/Adult	Age-Adj. £/Adult	vs Need +Cost £	Need-Adj. Rank	Gross Spend	Adult Pop	DOLS Mean	≤21 Days
84	Sandwell	West Midlands	£623	£667	−14	91	£165.2m	265k	25	34%
85	Enfield	London	£622	£664	−28	102	£153.7m	247k	35	20%
86	Trafford	North West	£617	£622	+17	59	£113.6m	184k	52	20%
87	Greenwich	London	£614	£722	+2	73	£143.7m	234k	46	12%
88	Plymouth	South West	£612	£615	−44	115	£134.6m	220k	160	14%
89	Birmingham	West Midlands	£612	£677	−42	113	£544.9m	891k	148	50%
90	Bracknell Forest	South East	£610	£640	+67	27	£61.9m	101k	60	7%
91	Rutland	East Midlands	£610	£536	0	77	£20.4m	33k	56	31%
92	Richmond upon Thames	London	£610	£627	+53	32	£93m	153k	37	20%
93	Central Bedfordshire	East of England	£606	£609	+49	35	£149m	246k	34	14%
94	Tower Hamlets	London	£606	£806	−2	78	£163m	269k	37	14%
95	North East Lincolnshire	Yorkshire and The Humber	£604	£572	−96	141	£76.4m	126k	52	14%
96	Westminster	London	£604	£699	−29	104	£108.8m	180k	90	10%
97	Stockton-on-Tees	North East	£602	£591	−53	123	£97.4m	162k	12	67%
98	Coventry	West Midlands	£602	£659	+14	63	£171.8m	285k	79	7%
99	Swindon	South West	£598	£623	+22	52	£113.4m	190k	167	12%
100	Oxfordshire	South East	£596	£601	+44	37	£361.8m	607k	257	6%
101	Wigan	North West	£596	£590	−72	129	£162.8m	273k	107	7%
102	Cheshire East	North West	£593	£556	−28	103	£200.6m	338k	82	16%
103	Staffordshire	West Midlands	£592	£555	−18	93	£433.6m	732k	31	26%
104	Hammersmith and Fulham	London	£592	£705	+17	60	£92.7m	157k	72	–
105	Medway	South East	£585	£605	−24	97	£131m	224k	88	11%
106	Kensington and Chelsea	London	£584	£636	−36	109	£71.2m	122k	80	11%
107	Waltham Forest	London	£583	£685	−7	82	£126.5m	217k	132	2%
108	Southampton	South East	£582	£647	+3	72	£121.4m	208k	149	5%
109	Wokingham	South East	£577	£585	+4	71	£82.5m	143k	144	1%
110	Portsmouth	South East	£572	£619	−11	87	£98m	171k	37	7%
111	Wiltshire	South West	£572	£532	−46	117	£239.9m	419k	189	21%
112	Leeds	Yorkshire and The Humber	£571	£607	−49	120	£382.1m	669k	204	15%
113	Bradford	Yorkshire and The Humber	£570	£596	−105	145	£240.1m	421k	229	11%
114	Peterborough	East of England	£569	£608	−43	114	£94.4m	166k	47	21%
115	County Durham	North East	£567	£540	−103	144	£248.2m	438k	38	31%
116	Milton Keynes	South East	£567	£612	+2	74	£131.2m	231k	27	12%
117	Bromley	London	£565	£571	−27	101	£147.9m	262k	17	66%
118	Cambridgeshire	East of England	£565	£564	−12	88	£320.4m	567k	148	10%
119	Slough	South East	£562	£664	+1	76	£67.8m	121k	354	5%
120	Kingston upon Thames	London	£561	£602	+19	55	£76.1m	136k	61	4%
121	Bath and North East Somerset	South West	£561	£559	−7	83	£91.7m	163k	228	9%
122	Salford	North West	£560	£633	−75	131	£129.3m	231k	73	26%
123	Worcestershire	West Midlands	£558	£516	−90	138	£279.7m	501k	152	15%
124	Luton	East of England	£557	£637	−46	118	£98.6m	177k	62	9%
125	Barnsley	Yorkshire and The Humber	£555	£542	−114	146	£110.9m	200k	90	8%
126	Barking and Dagenham	London	£555	£674	−56	124	£92.2m	166k	25	27%
127	Harrow	London	£554	£584	−10	86	£116.4m	210k	270	6%
128	Lambeth	London	£550	£677	−48	119	£145.9m	265k	63	15%
129	West Sussex	South East	£549	£507	−88	137	£402.5m	733k	103	5%
130	York	Yorkshire and The Humber	£546	£551	−21	96	£95.2m	175k	115	18%
131	Gloucestershire	South West	£544	£513	−62	126	£291.9m	536k	98	16%

#	LOCAL AUTHORITY	REGION	£/ADULT	AGE-ADJ. £/ADULT	VS NEED +COST £	NEED-ADJ. RANK	GROSS SPEND	ADULT POP	DOLS MEAN	≤21 DAYS
132	Havering	London	£539	£549	−64	127	£114.5m	212k	94	11%
133	North Northamptonshire	East Midlands	£538	£538	−73	130	£156.5m	291k	185	3%
134	Wandsworth	London	£536	£651	+22	53	£149.6m	279k	31	21%
135	Windsor and Maidenhead	South East	£536	£532	−20	94	£66.6m	124k	161	4%
136	Buckinghamshire	South East	£531	£523	−50	121	£238.2m	448k	210	7%
137	West Northamptonshire	East Midlands	£530	£540	−58	125	£182.2m	344k	222	8%
138	Redbridge	London	£530	£593	−4	80	£128.8m	243k	56	—
139	Southwark	London	£528	£653	−78	133	£136.8m	259k	96	7%
140	Lewisham	London	£525	£626	−44	116	£125.7m	239k	21	40%
141	Reading	South East	£525	£600	−31	106	£75.5m	144k	148	—
142	Hounslow	London	£521	£592	−83	134	£120.9m	232k	—	—
143	Merton	London	£508	£566	−16	92	£87m	171k	81	7%
144	Hillingdon	London	£504	£560	−75	132	£127.8m	254k	57	2%
145	Brent	London	£502	£573	−90	139	£139.5m	278k	102	5%
146	Leicestershire	East Midlands	£500	£481	−86	136	£299.3m	598k	63	40%
147	Derby	East Midlands	£496	£517	−154	148	£105.1m	212k	141	5%
148	Bexley	London	£482	£498	−120	147	£95.3m	198k	20	72%
149	Newham	London	£481	£610	−98	142	£139.4m	290k	50	4%
150	Ealing	London	£478	£541	−94	140	£145m	304k	255	17%
151	Lincolnshire	East Midlands	£465	£426	−198	150	£298.4m	642k	70	—
152	Thurrock	East of England	£416	£454	−167	149	£56m	135k	55	10%
153	Warrington	North West	£400	£392	−244	151	£68.3m	171k	39	43%

APPENDIX B

Does need and cost explain the spending gap?

We tested whether the variation in spend per adult between authorities is explained by legitimate differences in need and cost, rather than local choice. An ordinary least squares regression was fitted across 151 English upper-tier authorities (the Isles of Scilly is excluded for lack of comparable data, and the City of London as a 14,000-resident statistical anomaly; including the City of London leaves the result unchanged at 58 per cent unexplained). The dependent variable is gross adult social care spend per adult. The explanatory variables and their sources are: the share of the adult population aged 65 and over (ONS mid-2024 population estimates); deprivation, measured by the Index of Multiple Deprivation 2019 average score (MHCLG); the cost of providing care, measured by the Adult Social Care Area Cost Adjustment (MHCLG local government finance settlement); the level of working-age care need, measured as adults aged 18 to 64 receiving long-term support per 1,000 working-age residents (DHSC Adult Social Care Activity 2024/25); and rurality (ONS Rural-Urban Classification 2011). Every figure below was independently reproduced and each data point verified against its source.

Table B1 – Share of the spending gap left unexplained, by model

Model	Variation explained (R^2)	Unexplained
Age (65+ share) only	0.13	87%
Age (65+ and 85+)	0.19	81%
Need + cost, excluding working-age need (conservative)	0.39	61%
Full model, including working-age need	0.43	57%
Full model, spend in logs	0.40	60%
Full model, weighted by population	0.34	66%
Full model, with regional fixed effects	0.45	55%
Full model, three most-influential authorities removed	0.43	57%

Table B2 – What drives spending (conservative model, robust standard errors)

Driver	Effect on £/adult	Significant?
Deprivation (per IMD score point)	+£6.92	Yes (p<0.001)
Age (per percentage-point of 65+)	+£10.25	Yes (p<0.001)
Cost of provision (per unit of Area Cost Adjustment)	+£451	Yes (p=0.007), control only
Working-age need (per client per 1,000)	+£10.24	Yes (p=0.004, full model)
Rurality	−£5.5	No (p=0.28)

How to read this. The unexplained share is best understood as an *upper bound* on discretionary variation: it captures everything the five factors above do not, which includes some drivers we could not measure (the size of the self-funder market, actual unit costs, care-home supply, and working-age disability prevalence) as well as genuine local choice. It is therefore consistent with a substantial "postcode lottery" and it rules out the argument that the gap is simply a product of demographics or cost, but it is not by itself proof of discretion. Two points strengthen the finding: including working-age need makes the estimate conservative, because the number of people an authority supports is partly a consequence of how much it spends, so removing it raises the unexplained share to 61 per cent; and the result is stable whether spending is weighted by population (66 per cent unexplained), modelled in logs (60 per cent), or with the most influential authorities removed (57 per cent). The Area Cost Adjustment coefficient is reported as a control and should not be read as a causal price effect. Deprivation is measured on 2019 data; deprivation ranks are highly persistent, so this introduces only minor measurement error.

ABOUT

About the Care Association Alliance

The Care Association Alliance is the national membership body for local and regional care associations across England. Its member associations collectively represent thousands of independent and voluntary sector providers of residential, nursing and home care. It exists to support those providers in delivering high-quality, person-centred care, and to ensure that the voice of the sector is heard at every level of policy-making.

The Alliance engages with government, Parliament, regulators and commissioners on the issues that matter most to providers: workforce, funding, quality, regulation and the conditions needed for a sustainable care market. It provides a shared platform for providers to collaborate, develop good practice and respond collectively to the challenges facing the sector.

In producing this paper, the Alliance has drawn on the direct operational experience of its member associations and their provider members across England. The positions set out in this paper reflect the considered view of the Alliance and its membership, and have been developed through extensive consultation with those who commission, deliver and receive adult social care.

The Care Association Alliance is committed to constructive engagement with the government's review of adult social care funding, and to working with the Casey Commission, Parliament and all relevant stakeholders to develop a sustainable, fair and effective funding settlement for adult social care in England.

For more information about the Care Association Alliance and its work, please visit `www.careassociationalliance.co.uk`.

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