Analysis

England's two-tier care system deepens social care inequalities

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KEY MESSAGES

- England's two-tier care system has created care inequalities between the poorest and richest areas, and between self-funded and state-funded residents.
- Nearly 25% of residents in the most deprived areas live in poor quality care homes, compared to just 16% in the least deprived areas.
- The cancellation of planned social care funding reforms in 2024 is likely to exacerbate these inequalities, failing to bring adequate public resources into the sector.
- Policy solutions must address both funding adequacy and ensure equitability, quality, and access to care regardless of resident funding status or location.

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England’s two-tier care system deepens social care inequalities

England’s adult social care system is increasingly funded by out-of-pocket payments. Bach-Mortensen and colleagues examine how the two-tier funding model has created a divided system of care quality.

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

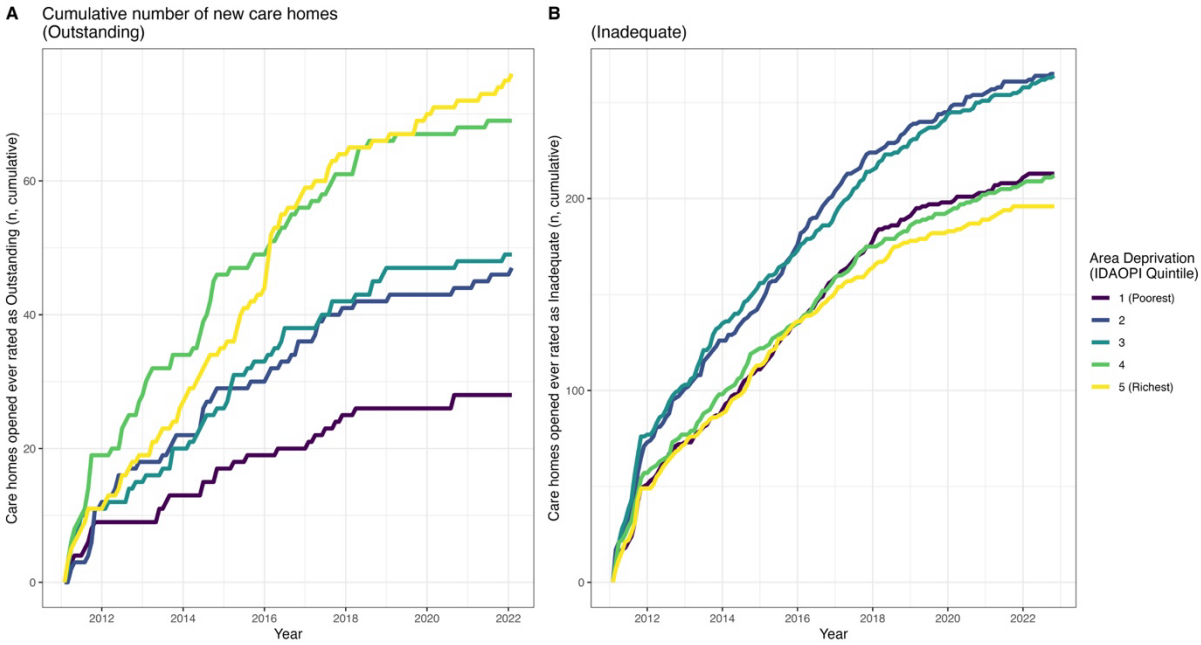
While most countries have elements of two-tier funding in their care systems, we argue that England's sharp wealth threshold has created a system where care home providers focus on richer areas with a higher concentration of self-funders, with low incentive for homes to open and operate in poorer high-need areas. Using national mandated data from the Provider Information Return (PIR) (2), we show that the failure to adequately finance state-funded care disproportionately influences residents in the most deprived parts of the country. This disparity is measurable in access to care and inspection ratings of care providers, and has severe consequences for the health and wellbeing of the over 850,000 people receiving formal long-term care in England (3).

Inequalities in adult social care services

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

Care quality reveals these inequalities. The Care Quality Commission (CQC) inspects and rates the quality of residential homes as either “outstanding”, “good”, “requires improvement”, or “inadequate”. Figure 1 shows the number of care homes opening that have been rated as “outstanding” or “inadequate” at any time since 2011. It shows that the best homes are predominantly located in the richest areas. The poorest areas have far fewer outstanding-rated care homes, despite those areas having higher care needs. This relationship is almost perfectly inversed for inadequate-rated provision, where we see that the worst-rated homes are more likely to open in the poorest areas. The widening gap between 2011 and 2023 corresponds with a period of significant cuts in local government funding (7).

Figure 1: Cumulative number of opening care homes 2011-2023, which have ever been rated “outstanding” or “inadequate", according to area deprivation.



Note: IDAOPI: Income Deprivation Affecting Older People Index. Deprivation mapped onto care homes according to their MSOA location. **Data sources:** CQC API, Finger tips, Public Health England.

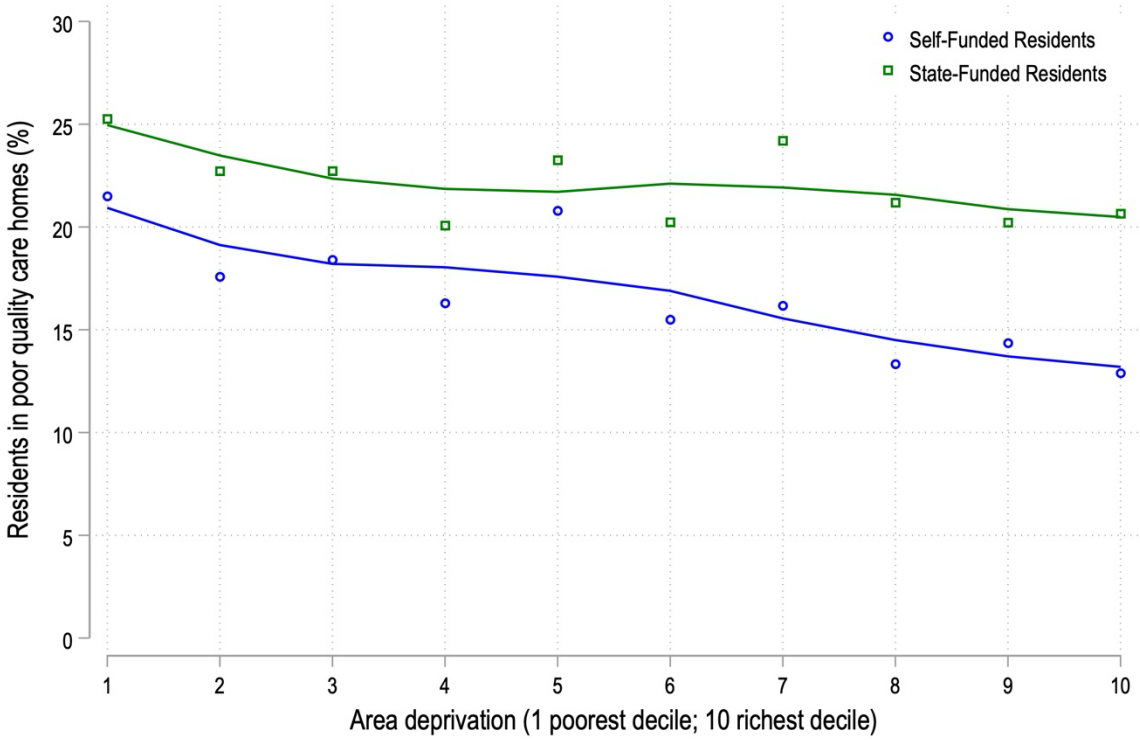
The quality gap between self- and state-funded residents

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

The data shows a clear correlation between care home quality and the proportion of self-funding residents. Homes rated as “Outstanding” by the CQC have the highest average percentage of self-funders at 50.9%, while this proportion is just 24% in inadequate-rated homes (9).

This affects care equity in England. Overall, 16.1% of self-funding residents live in homes rated as 'Inadequate' or 'Requires improvement' by the CQC, compared to 22.1% of state-funded residents. The quality gap between state-funded and self-funded residents increases by area wealth: in the poorest areas, there is a 3.8 percentage point difference between state and self-funded care quality, but this gap widens to 7.8 percentage points in the wealthiest areas (Figure 2).

Figure 2: Proportion of state- and self-funded residents in 'Inadequate' or 'Requires improvement' provision by area deprivation (IDAOPI deciles) in England (September 2023).



IDAOPI: Income Deprivation Affecting Older People Index. 'Poor quality' defined as homes rated overall 'Inadequate' or 'Requires improvement' by the CQC. **Data source:** CQC Provider Information Return (2).

The human and systemic toll of care inequality

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

Beyond these statistics lies a profound human impact: those who cannot afford to self-fund from the outset will have often have no choice but to live in struggling homes simply because they cannot afford to pay more. Others experience this inequality differently when their personal wealth is depleted from paying for their own care, and they transition from being self- to state-funded. For example, I may have moved into a care home expecting to stay there for the rest of my life, building relationships with staff and other residents. Average residential care costs (without nursing) are £65,000 annually, so if my life savings are £180,000, my assets would drop below £23,250 within 3 years. The Local Authority would

then conduct a financial assessment and an assessment of my needs, and if they decide that my needs could be met in a cheaper facility, I would be forced to move, leaving behind friendships and familiar routines, unless I could afford to pay a top-up fee (13).

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

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

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

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

England's uniquely sharp funding divide

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

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

The outcomes of each care system are difficult to compare given the many cultural and socioeconomic determinants of health. However, these systemic differences confirm that England has adopted an approach that emphasises personal responsibility, which places significant burden on a subset of individuals at the end of their lives. Despite appearing progressive and redistributive on the surface, this system ultimately exposes some individuals to an extreme level of financial risk that we do not tolerate for healthcare, while confining those without personal wealth to inferior care.

A crisis in need of action

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

Box 1: The scrapped social care reform

What was the reform meant to change? (27)

- The government planned to introduce an £86,000 cap on lifetime care costs and raise the means-tested thresholds, meaning more people would receive state support for social care.
- The reform aimed to tackle unfair pricing by ensuring self-funding residents could access the same care home rates as those paid by Local Authorities, with £1.36 billion allocated to help councils pay providers more.
- The reforms would have increased state support from covering roughly half to about two-thirds of older people in care (28), though some stakeholders questioned whether the changes would live up to expectations.
- Annual costs were projected to start at £1.42 billion in 2023/24 and rise to £4.74 billion by 2031/32. However, concerns were raised about whether this funding would be sufficient and if Local Authorities had enough staff to implement the changes.
- Despite being scheduled for October 2023 and then delayed until 2025, the entire

reform package was cancelled in July 2024 by Chancellor Rachel Reeves to address a projected £22 billion overspend.

- In January 2025, the Government announced that a new independent Commission, chaired by Baroness Louise Casey, will work towards building cross-party consensus for long-term reform of adult social care.
- The Commission will work in two phases, with Phase 1 reporting in 2026 to develop medium-term solutions aligned with current spending plans to lay foundations for a national care service, followed by Phase 2 reporting in 2028 to make longer-term recommendations for transforming the entire adult social care system to meet future demographic challenges (29).

The path to reform is clear - what is missing is political resolve to act. Since the Dilnot Commission report in 2011, successive governments have acknowledged the problems, but continuously postponed action because of immediate fiscal pressures. This short-termist approach ignores the much higher cumulative costs of inaction that spread across the NHS, Local Authorities, families, and individuals. The current two-tier system is not just inequitable, it is economically unsustainable. Inadequate state funding rates has created inequalities across the entire sector: self-funded residents cross-subsidise state-funded care through inflated fees, state-funded residents receive systematically worse care, and providers concentrate in affluent areas, leaving deprived regions with insufficient provision.

These inequalities are incredibly costly and directly impact preventable NHS admissions, delayed discharges, and expensive emergency relocations when financially unstable homes close. Reform will inevitably require significant investment but continuing the status quo means paying more for worse outcomes. Addressing this requires ring-fenced funding to eliminate cross-subsidisation, fair pricing for all residents, and sufficient provision in underserved areas (see Box 2 for policy priorities). Reform is not just about costs but about designing policy that can break the cycle where chronic underfunding has created geographically determined workforce and capacity shortages, which undermine service quality and jeopardises public support for investment in the sector. The upcoming Casey Commission must learn from past reform failures to create a system that can deliver quality care for all, regardless of financial means.

Box 2: Policy priorities to reform England's two-tier system

1. Implement existing legislation on funding reform

The issues surrounding inadequate funding have repeatedly been diagnosed by the Dilnot Commission and past reform efforts. Rather than starting anew, the government should implement specific policies already developed in existing legislation: introducing a care cap, raising the means test threshold, and enabling more people to purchase care through the state. However, implementation must be accompanied by adequate ring-fenced funding to Local Authorities to ensure these reforms can be delivered effectively and as intended. Moreover, implementation requires attention to issues beyond funding, as the sector faces significant workforce constraints, such as high vacancy and turnover rates, and generally poor working conditions, with 1 out of 5 residential care workers living in poverty (1). Without addressing the workforce challenges alongside funding reforms, implementation will remain unfeasible.

2. End the cross-subsidy through fair pricing
The current system forces self-funders to pay more than Local Authorities for similar services, which creates a cross-subsidy system, where providers are forced to take on self-funded residents to subsidise the shortfalls in state-funded fees. This disparity must be eliminated by reform that ensures fair pricing for all residents, while simultaneously providing councils with adequate funding to pay providers sustainable rates that reflect inflation increases and the true costs of delivering high-quality care. Evidence shows that 13% of care contracts are loss making (1), which forces providers to either refuse Local Authority contracts or accept financial risk. As long as Local Authority rates remain inadequate, providers will continue to cross-subsidise residents and organise their services around attracting self-funded residents.

3. Achieve better commissioning by improved data integration
Existing data tell us little about the experienced care quality of recipients and how poor care impacts health and other services. Better data integration must be established to measure the impact of care on people's lives, the wider health system, and the economy, rather than simply tracking care tasks and activities. These systems should monitor how funding disparities affect care quality across the country and the impact and costs of poor care on health services. Such measures would strengthen the case for reform and provide councils with more holistic data to commission services (1).

4. Improve the availability and quality of care homes in underserved areas
To counter the widening quality gap that has emerged following local government funding cuts, geographically targeted interventions are needed to ensure a fairer distribution of high-quality care across the country. The data clearly shows that the market has failed to deliver to high-need areas: the poorest areas have far fewer outstanding-rated care homes despite having higher care needs, while inadequate-rated homes disproportionately open in these communities. To eliminate care deserts, where residents have limited access to quality provision, the government should introduce targeted incentives like capital grants for new facilities in underserved areas and increased Local Authority provision to ensure capacity where market forces have failed to deliver. The exact funding mechanisms to achieve this need to be considered carefully, as relying on council tax to fund social care has proven ineffective in the long-term and creates regional inequalities, given the returns raised this way vary considerably according to areas' wealth, while the costs are borne disproportionately by low-income households. Using council tax as the main investment stream will exacerbate the postcode lottery and risks undermining public support, as residents in poorer areas will pay more for worse services.

5. Learn from past reform failures
The UK has consistently failed to implement structural social care reform despite cross-party recognition of the problems, which has left care recipients and their families with false hope and continued uncertainty about future costs. The recent abandonment of the funding reform parallels Scotland's difficulties in implementing its National Care Service. Scotland's experience of implementing free personal and nursing care also provides a lesson in how expanding care coverage will not eliminate inequalities if inverse market incentives are not addressed. Because there is no regulation on what care homes can charge self-funders, average fees for nursing homes are 50% above the national contract rate, which, like in England, has created a system where self-funders are much more lucrative than publicly funded residents (30). Even though self-funders receive care payments from the state, these do not cover full costs, which means that care services are not free, as many are forced to pay top-up fees, and that those who cannot self-fund are much less desirable 'clients' for care homes (30). To avoid repeating this cycle of failed reform, future attempts must learn from past challenges, such as competing political priorities that lead to postponement when fiscal pressures emerge, inadequate engagement with Local Authorities who ultimately deliver services, and policy proposals

that lack a clear pathway from legislation to service improvement. Future reform must secure sufficient political consensus to survive changing governments, which involves establishing realistic funding mechanisms and system-wide stakeholder involvement from the outset.

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