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Understanding the incidence of long-term care costs for older people under the English charging system and previously planned reforms

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Summary

This report presents analysis of the current system of long-term care charging in England as it affects older people, and also the most recent planned, but not implemented, reforms to that system. It is intended to provide background information to aid consideration of alternative reforms to the English long-term care funding system which remain the subject of much debate. A particular focus is on the progressivity of the system. Analysis of the associations between income, non-housing and housing wealth amongst older people was conducted to derive summary classifications of income and wealth for assessing progressivity. Two linked simulation models – the Care Policy and Evaluation Centre (CPEC) long-term care projections model for older people and the CARESIM dynamic microsimulation model of long-term care charging for older people – were then used to investigate how the incidence of long-term care costs for older people under the current charging system varies according to these classifications and also how the financial gains from the previously planned reforms are distributed across these classification. The work represents phase 1 of a study for which phase 2 will analyse a range of potential reforms to the charging system. The analysis is novel in providing a thorough assessment of the progressivity of the current means test for long-term care for older people, considering both income and wealth, and highlighting often overlooked aspects of the current system.

Income, savings and housing wealth of older people

Our analysis of the relationship between income, non-housing and housing wealth led us to conclude that, in assessing the progressivity of the long-term care charging system and potential reforms to it, it is important to:

- consider levels of income, savings (i.e. non-housing wealth) and housing wealth in combination;
- distinguish homeowners from non-homeowners;
- distinguish older people who have a partner from those who do not.

This is partly because of the workings of the current means test for paying for long-term care but also because of the associations between income, savings, homeownership and, for those who own their homes, their housing wealth (i.e. the value of their homes). Analysis of these associations shows that:

- Non homeowners have markedly lower incomes than homeowners and this is the case for both partnered and unpartnered older people.
- Over 80% of non-homeowners have non housing wealth below the lower capital limit (LCL) in the current long-term care means test, compared with under 40% of homeowners. So, homeowners in general have higher levels of non-housing wealth than non-homeowners.
- However, nearly 50% of older homeowners have non housing wealth below the upper capital limit (UCL) meaning that substantial proportions of homeowners are currently ineligible for any state help with their care costs principally by virtue of being homeowners.
- Overall, more than 50% of older people have non-housing wealth below the UCL.
- Unpartnered homeowners have higher housing wealth than partnered homeowners if equal sharing of their housing wealth with their partners is assumed.
- Low-income older people are the most likely to be non-homeowners. However, substantial proportions of them do own their homes but they are unlikely to have large amounts of non-housing wealth.
- Larger amounts of non-housing wealth are concentrated amongst those in the top income quintile, almost all of whom own their homes.

Long-term care funding sources by income, savings and housing wealth

Our analysis of funding source for long-term care for older people distinguished the following sources:

The funding sources identified are:

- 1) NHS through 'funded nursing care' or through 'continuing health care' for the small number of care home cases fully funded by the NHS.
- 2) A local authority (LA);
- 3) User charges for LA-funded care recipients
- 4) Self-funder payments, i.e. payments from older people who are required to meet the full costs of their care themselves (apart from any disability benefit that they may receive and put towards their care costs).
- 5) Attendance Allowance or equivalent disability benefit plus disability additions to means-tested benefits. These benefits cease to be paid to care home residents who receive any LA funding so their contribution to care costs changes under reforms which affect the proportion of care home residents entitled to LA funding.

At an aggregate level, the combined total of private, Local Authority, NHS expenditure and disability benefits paid to self-funding care home residents amounts to £27.7 billion in 2023, of which 35% is paid by people who receive no LA or NHS funding, 12% comes from charges paid by LA-funded users, 11% is funded through the NHS (CHC and FNC in care homes), 3% from disability benefits paid to self-funding care home residents and the remainder, 39%, is funded from LA budgets. Private expenditure including user charges represents a higher proportion of residential than community care spending (51% compared with 34%).

Analysing average amounts of funding from each source according to income and wealth level, homeownership and partnership status shows that the funding mix under the current system depends on a person's wealth, homeownership and partnership status in ways which would be expected given the form of the means test. However, some points stand out:

- User contributions for LA-funded care home residents can be substantial, even for those who are not homeowners, are on low incomes and have savings below the UCL. For example, we estimate that unpartnered non-homeowners with savings below the UCL and incomes in the lowest 40% of the income distribution pay on average £200 per week in user charges towards care home fees, effectively towards the 'hotel' or 'daily living costs' components of the fee (if they are not amongst the small number fully funded by the NHS). The figure for otherwise similar older people with higher incomes is over £300. User contributions are less for partnered people in care homes and for people receiving community care. Nonetheless, older people receiving high intensity community care can face considerable user charges even when they are entitled to some LA funding.
- For those with wealth below the UCL, income level affects user contributions, but the 'cliff-edges' created by the capital thresholds mean that wealth is generally much more important than income in determining the mix of funding sources.
- For community care, the funding mix is far less variable between homeowners and non-homeowners and between partnered and non-partnered people because, under the current means test, the value of the home is always disregarded in the means test. Moreover, the operation of the 'minimum income guarantee' for community care protects a much larger share of income than does its equivalent – the 'personal expenses allowance' – in care homes.

The previously planned reforms

Under the reforms planned by the Conservative Government of 2019-2024 there would be a lifetime cap on an individual's contribution to eligible care costs, but not daily living costs (DLC) in care homes (accommodation, food, heating etc.). Prior to reaching this cap, LA help with care costs (both in care homes and in the community) and help with DLC in care homes would remain means tested. Once the cap was reached, eligible care costs would be met by the LA without a means test but help with DLC would remain means tested. The reforms also included increases to the capital limits.

Our modelling looked at three reform scenarios:

- Increases in capital limits without a lifetime cap: upper and lower capital limits of £100,000 and £20,000 in 2023 prices compared with £23,250 and £14,250 respectively.
- A lifetime cap of £86,000 and DLC of £227 a week in 2023 prices, progress towards the cap based on the minimum of eligible care costs and the user's contribution towards them.
- A lifetime cap and increases in capital limits: combining the two reformed scenarios above, which is the reform originally planned by the then UK government.

An increase in the capital limits is projected to result in net public expenditure being higher by £0.9 billion (in 2023 prices) in 2033 and £1.6 billion in 2043, respectively, in comparison to the current funding system. These amounts represent increases of 4% and 5.2% of what we project for 2033 with no change in the funding system. Implementing a lifetime cap of £86,000 would result in net public expenditure being higher by £3.7 billion (16.5%) in 2033 and £5.4 billion (17.6%) in 2043, respectively. If both the lifetime cap and the raised capital limits were implemented, net public expenditure is

projected to be £4.3 billion (19.2%) higher in 2033 and £6.3 billion (20.8%) higher in 2043, respectively, than under the current funding system.

Considering care home residents and the full package of reforms, amongst non-homeowners the benefits are largest for those with higher levels of savings and incomes, while those on low incomes (lowest 40% of the income distribution) and savings below the UCL gain little. On average we project that care home residents who are unpartnered non-homeowners would gain over £220 per week if they have savings greater than the median level for those with savings above the UCL, compared with only £4 a week for those with low incomes and savings below the UCL. The pattern is similar for partnered non-homeowners although the gains amongst those with savings above the UCL are somewhat higher than their unpartnered counterparts.

Amongst homeowners there are substantial benefits (over £200 per week) for all groups of unpartnered care home residents. For them the variations across income and wealth groups are not very marked but it is striking that at over £250 per week, the highest average weekly gains are for those with low incomes, non-housing wealth below the UCL and housing wealth below the median. Amongst partnered homeowners the picture is similar to that for non-homeowners because housing wealth is disregarded in the current means test for both groups.

Turning to older people receiving community care, gains from each component of the reforms are concentrated amongst those receiving the highest level of care. They face the highest costs and so are most likely under the current system to need to draw on their savings to fund their care, whether as self-funders or through LA user charges. They are also most likely to reach a lifetime cap set as a monetary amount. Those receiving only low levels of domiciliary care are more likely to be able to fund their care costs from income and are unlikely to reach the cap. Amongst community care recipients receiving the highest level of care, those, with savings above the median level, the overall reform would bring financial benefits of over £200 per week, reaching over £270 per week for partnered non homeowners.

Conclusion

The analysis reported here is the first phase of a study whose aims are to provide analysis which can be used by those contributing to the debate over reform of the long-term care funding system in England, as it affects older people. The points from our analysis which are most relevant to this debate include:

- While older non-homeowners generally have markedly lower levels of income and savings than homeowners, substantial proportions of unpartnered low-income older people do own their homes and as a result are precluded from state help with their care home costs under the current means test.
- User contributions for those who do receive some state help with their care cost can be substantial under the current system, even for those who are not homeowners, are on low incomes and have savings below the threshold which renders them ineligible for any state help with their care costs.
- While both income and wealth affect entitlements to state help with care costs, the 'cliff-edges' in the capital test mean that wealth is generally more critical than income in determining the division of costs between the individual and the state.
- As with any means test reforms that make the means test less stringent, the reforms planned but not implemented by the 2019-2024 Conservative government would have tended to benefit the better off. But they would have brought substantial financial gains to

unpartnered low-income homeowners with modest levels of housing wealth. Both components of the intended reforms would have been important to achieve this.

1. Introduction

This report presents analysis of the current system of long-term care charging in England as it affects older people, and also the most recent planned, but not implemented, reforms to that system. It is intended to provide background information to aid consideration of alternative reforms to the English long-term care funding system which remain the subject of much debate. A particular focus is on the progressivity of the system. To inform this, analysis of the associations between income, non-housing and housing wealth amongst older people was conducted to derive summary classifications of income and wealth for assessing progressivity. Here we summarise the derivation of that classification and use it in analysis of the incidence of long-term care costs for older people under the current charging system and the most recent reforms which had been planned, but not implemented, by the UK Conservative Government of 2019-2024. The work represents phase 1 of a study for which phase 2 will analyse potential reforms to the charging system. It is novel in providing a thorough assessment of the progressivity of the current means test for long-term care for older people, considering both income and wealth, and highlighting often overlooked aspects of the current system.

2. Policy background

Adult social care in England is funded very differently from healthcare. Whereas the National Health Service (NHS) is largely free at the point of use, social care is means tested. Local authorities arrange and partly fund care, but most older people are expected to contribute towards their costs from their income and assets, and many meet those costs in full. The system operates within the framework of the Care Act 2014 (Care Act 2014; Department of Health and Social Care, 2025). A person who approaches their local authority is assessed first for the level of care they need and, if found eligible, for their financial means. The financial assessment then determines how much the local authority pays and how much the individual contributes (House of Commons Library, 2024a).

This section summarises the main features of the charging system that are relevant to the analysis which follows. Box 1 sets out the current system. We then describe briefly how the costs falling on individuals and on the state are expected to change over time under the system as it currently stands, and we place the analysis in the context of the reforms that were planned but not implemented by the UK Conservative Government of 2019-2024, which are examined in detail in section 6.

Box 1: Main features of the current charging system for older people in England

Needs and means tests. Local authorities assess a person's eligible care needs under the Care Act 2014 and then carry out a financial assessment. Support depends on both.

Two charging regimes. The rules differ between care provided in a care home (residential or nursing care) and care provided in a person's own home (community care).

Capital means test. A person whose assessed capital is above the upper capital limit (UCL) of £23,250 receives no help with care costs from the local authority and meets the full cost themselves, becoming a self-funder. Capital below the lower capital limit (LCL) of £14,250 is disregarded. Between the two limits, a tariff income of £1 per week for each £250 of capital is added to assessed income.

Treatment of the home. In community care the value of the person's main home is always disregarded. In a care home, the person's home is counted as capital, unless a partner, or a qualifying relative such as one aged 60 or over, a disabled relative, or a dependent child, still lives there. The value is disregarded for the first 12 weeks of a permanent placement, and a deferred payment agreement can allow a person whose non housing capital is below the UCL to delay paying the share of their care home fees which is not required to be met from their income by using the property as security.

Income protection. People with capital below the UCL must be left with a protected minimum income. In a care home this is the personal expenses allowance (£31.80 per week for financial year 2026/27). In community care it is the minimum income guarantee (£241.45 per week for a single older person in 2026/27), and housing costs and certain disability-related costs are also disregarded.

Disability Benefits

People with care needs may also be eligible for one of two non-means-tested cash disability benefits –Attendance Allowance (AA) or Disability Living Allowance (DLA)/Personal Independence Payment (PIP). Receipt of these benefits can also trigger increases in means-tested social security benefits. If someone receives help with care home fees from their LA, payments of these disability-related benefits cease.

Treatment of couples. Partnered and single people are treated differently: jointly held resources are generally divided between the partners, and only the person receiving care is financially assessed.

NHS-funded care. Care arranged and paid for by the NHS sits outside the charging system and is free to the individual. This includes NHS Continuing Healthcare, for people whose needs are primarily health related, and NHS-funded Nursing Care, a flat-rate contribution towards the cost of nursing provided in a care home.

Frozen thresholds. The capital limits have been unchanged in cash terms since 2010 and the personal expenses allowance was frozen between 2015 and 2022. Their real values have therefore fallen over time.

Sources: Care Act 2014; The Care and Support (Charging and Assessment of Resources) Regulations 2014; Department of Health and Social Care, 2023a, 2023b, 2025a; House of Commons Library, 2024a; Age UK, 2025

Pressures on costs over time

Even with no change to the rules, the cost of long-term care for older people, and the way that cost is divided between individuals and the state, is expected to rise over the coming decades. The principal driver is demographic: the number of older people, and especially the number of the oldest old who are most likely to need care, is growing, and with it the number of people living with disability and long-term conditions (Hu et al., 2026). Costs are pushed up further by growth in the real cost of providing care, which tends to outpace general inflation. Our latest projections quantify these effects (Hu et al., 2026).

The current system places no ceiling on the care costs an individual may face, and a minority of older people incur lifetime care costs running into hundreds of thousands of pounds (Commission on Funding of Care and Support, 2011; House of Commons Library, 2024b).

Successive attempts to address this have not been carried through. The proposals of the Dilnot Commission in 2011 were partly legislated for in the Care Act 2014 but never brought into force. A revised package announced in 2021, combining a lifetime cap on personal care costs with more generous capital limits, was due to begin in October 2023, was postponed to October 2025, and was then cancelled by the incoming government in July 2024 (HM Government, 2021a; HM Government, 2021b; HM Treasury, 2022; HM Treasury, 2024). An independent commission into adult social care, chaired by Baroness Casey, is now considering options for reform and is due to report in two phases, in 2026 and 2027, brought forward from 2028 (Department of Health and Social Care, 2025b, HM Government 2026). The reforms assessed in this report are those that were announced in 2021 but not implemented; they are described and analysed in section 6. During phase 2 of this work, a range of other reform options will be examined.

3. Methods

The analyses presented in this report use two linked simulation models – the Care Policy and Evaluation Centre (CPEC) long-term care projections model for older people and the CARESIM dynamic microsimulation model of long-term care charging for older people.

The CPEC long-term care projections model for older people makes projections of four key variables: the future numbers of disabled older people, the likely level of demand for long-term care services and disability benefits, the public and private costs associated with meeting this demand and the social care workforce required. It is a cell-based (macro-simulation) model and takes the form of Microsoft Excel spread-sheets. It includes data from a range of sources including ONS population projections (Office for National Statistics, 2025), Health Survey for England data for 2011 to 2019 (NatCen Social Research, 2019) and local authority data on numbers of people in care homes and numbers of users of home care services and on social care expenditure (NHS England, 2024) and estimates of the unit costs of care.

CARESIM is a microsimulation model which uses a sample of people aged 65+ living in England from the UK Family Resources Survey (FRS) (Department for Work and Pensions, 2021) to simulate how much sample members would need to contribute to the costs of their care, should they need care, under the current or variant funding systems. Using information on the income, wealth and other relevant characteristics of sample members, CARESIM calculates what each sample member would be required to pay towards the cost of different types of care services, should they need such care,

allowing for asset depletion during a randomly assigned time to date in receipt of care. In effect, this mimics the observation of a cross-section of care recipients. Projections of the number and characteristics of older service users from the CPEC model are used as weights so that the CARESIM sample of older people is rendered representative of the projected population of older long-term care service users. CARESIM passes results to the CPEC model which are used to apportion projected total expenditure between the public and private expenditure. CARESIM also provides distributional analyses. For example, it is used to assess how public spending on adult social care is distributed by income and wealth, or how the financial gains from potential reforms to the means test are distributed across income/wealth groups or by demographic characteristics.

The models do not make forecasts about the future. They make projections on the basis of specific assumptions about trends in such variables as future mortality rates, disability rates and unit costs of care. The approach involves simulating the impact on demand for care and support of specified changes in demand drivers or specified changes in policy. It does not involve forecasting future policies or future patterns of care. This means that the projections reported in this paper should be treated as indications of likely future expenditures on care and support if policies are unchanged and drivers of demand follow the specified trends. In practice not only may drivers of demand not follow the assumptions, but also policies may change.

The models produce projections based on specific assumptions about future trends in the key drivers of demand for long-term care. The main economic and demographic assumptions used here are summarised in Box A1 in Appendix Two. The projections take account of changes in factors exogenous to long-term care policy, such as demographic trends. They hold constant factors endogenous to long-term care policy, such as patterns of care. Further details of the models are provided in Appendix Two.

4. Categorising income and wealth to assess the progressivity of long-term care charging for older people

This section sets out some analysis of the relationship between income and wealth among a sample of older people in England drawn from the FRS. The sample is that used in CARESIM. We start by presenting information on the separate distributions of each of income, housing and non-housing wealth among the sample of older people, and their partners if any, used in the simulation of care charges. This is followed by analysis showing the associations amongst the three measures and the derivation of a classification which combines all three. All money values are in 2023 prices as this is the base year used for the simulations of the previously planned reforms. Income is 'equivalised' to render the incomes of single people and couples comparable, with the equivalisation normalised (=1) on a single person using the equivalence scales used for the official 'Households Below Average Income statistics'¹. For couples, one half of their combined housing wealth is assigned to each partner; similarly for non-housing wealth. In most of the analysis which follows we distinguish older people with and without partners since they are treated differently in the current means test and it seems likely that any means test reforms would retain such a distinction although of course the nature of the differential treatment could be different.

An important caveat about this analysis is that, as with other household surveys, the information that the FRS records on sample members' housing and non-housing wealth is inevitably imperfect – and probably more so than the information on sample members' incomes. It is likely that the estimates on which the analysis is based do not capture the full range of people's wealth holdings and probably underestimate wealth and housing values at the upper end of the distribution. The method of

¹ These differ between the before and after housing cost measures [reference to be added].

estimating housing wealth cannot capture very local variations in house prices, although in the analysis below, regional variations are captured to some extent.

The distributions of income, housing and non-housing wealth

Table A 1 in Appendix One shows how the older population, as estimated by our modelling, breaks down according to homeownership and partnership status. Estimates for the general population of older people are contrasted with those for the population of older people receiving care. For example, while the proportion of the general population who do not have partners is 43%, amongst those receiving care it is 76%. In the general population 77% are homeowners, amongst care recipients the corresponding proportion is only 60%. These differences are driven largely by the older ages of care recipients.

Table 1 below presents the threshold points (quantiles) when the distribution of income amongst the general population of older people is divided into fifths or quintiles. The thresholds are shown for income measured before housing costs (BHC), i.e. before deducting what are often considered to be fixed (unavoidable) costs and after deducting such costs (AHC). The latter is close to the concept of ‘disposable income’ that is used in the means test for community care².

Two points are worthy of note:

- The threshold defining the lowest quintile for AHC, at £200, is close to, if a little above, the 2023 single older person’s Minimum Income Guarantee (MIG) of £194.70 used in the means test for community care, for which housing costs must be disregarded.
- The thresholds for the higher quintiles may seem rather low. This is because we have used the income distribution for older people rather than for the general population³.

Table 1: Quantile points of the distribution of income amongst older people in England, £s per week, 2023 prices⁴

	Quantile 20	Quantile 40	Quantile 60	Quantile 80
Before housing costs	£230	£290	£400	£600
After housing costs	£200	£260	£360	£540

Table 2 presents estimates by region of the proportions of older individuals who own their homes together with lower/upper quartiles and the median of the distribution of estimated house wealth for homeowners. Regional differences in rates of homeownership and in housing wealth are very apparent. Undoubtedly there is also further variation within regions, especially for example in London, that we are unable to capture in our models.

² The former is potentially a more appropriate income measure for an unpartnered person who moves into a care home permanently since they would, arguably, no longer need to maintain a home in the community.

³ If we were to use the distribution for adults of all ages, older people would be concentrated in the lower quintiles. Thus, to capture the spread of older people’s incomes we prefer to classify them according to the 65+ distribution.

⁴ The median (quantile 50) values are: before housing costs - £340; after housing costs - £300.

Table 2: Homeownership and housing wealth by region, older people in England, £s 2023 prices

	Homeowners	Housing wealth of homeowners		
	(%)	Quartile 1	Median	Quartile 3
North East	70%	£106,400	£146,600	£202,400
North West	76%	£133,900	£169,300	£257,300
Yorks & Humberside	72%	£112,900	£163,000	£228,200
East Midlands	78%	£136,100	£172,800	£265,300
West Midlands	77%	£133,200	£196,200	£288,400
East	82%	£189,400	£270,000	£397,000
London	63%	£278,800	£411,700	£629,600
South East	82%	£199,600	£280,500	£390,000
South West	85%	£179,900	£247,100	£350,800
England	77%	£153,400	£221,500	£331,900

Note: For partnered older people, housing wealth is set to half the estimated value of their shared home.

The lower/upper quartiles and the median of the distribution of estimated non-housing wealth are shown in Table 3. From the quantiles for total non-housing wealth, it is apparent that many older people have only small amounts of non-housing wealth. At around £16,500, the median is not much above the current lower capital limit (LCL) of £14,250 i.e. the amount which is disregarded completely in the means test. Clearly many older people have very small amounts of money in the bank which do not really amount to 'wealth'. The second row of Table 3 therefore shows the quartiles of the distribution of non-housing wealth for those who have more than £500 in wealth. Now the lower quartile is nearly £6,000, the median is about 15% above the UCL and the upper quartile approaches £120,000. The third row of the Table 3 below gives the quartiles of the distribution of non-housing wealth for those who have non-housing wealth above the current upper capital limit (UCL) of £23,250. Anyone with non-housing wealth above this level is generally excluded from Local Authority help with their community or care home costs. Conditional on having estimated non-housing wealth above the UCL, the levels of non-housing wealth are much greater, with 25% of such individuals having non-housing wealth of about £245,000 or more.

Table 3: Non housing wealth, older people in England, £s 2023 prices

	Quartile 1	Median	Quartile 3
Total non housing wealth (including zeros)	£970	£16,500	£77,470
Non housing wealth above £500	£5,850	£26,950	£117,840
Non housing wealth above UCL (£23,250)	£45,570	£103,280	£244,980

Note: For partnered older people, non-housing wealth is set to half the estimated value of their combined non-housing wealth.

Analysis contained in Appendix One shows there are strong correlations between partnership and homeownership status on the one hand, and each of income, estimated housing and non-housing wealth. Key points are:

- non homeowners have markedly lower incomes than homeowners and this is the case for both partnered and unpartnered older people

- over 80% of non-homeowners have non housing wealth below the LCL compared with under 40% of homeowners. So, homeowners in general have higher levels of non-housing wealth than non-homeowners.
- However, nearly 50% of older homeowners have non housing wealth below the UCL meaning that substantial proportions of homeowners are affected by the capital rules in the means test mainly by virtue of being homeowners.
- Overall, more than 50% of older people have non-housing wealth below the UCL.
- Unpartnered homeowners have higher housing wealth than partnered homeowners as a result of our assumed equal sharing of their housing wealth with their partners.

Combining income, housing and non-housing wealth

Any classification using these three variables needs to accommodate sparse cells – there are few older people who have low income and high non-housing wealth, for example. Nonetheless, such people could be a target for means test reforms – the fact that there may be few of them does not mean their treatment in the means test is unimportant. To work towards an appropriate categorisation of income and wealth, we present below graphs which show the composition of the older population by quintiles of the AHC⁵ income distribution simultaneously distinguishing:

- Homeowners from non-homeowners
- For homeowners, those with housing wealth below and above the median value of the distribution amongst homeowners, where the median is region specific (see Table 2)
- Those who have non-housing wealth below the LCL, between the LCL and UCL, below and above the median level (£103,280) for those with non-housing wealth above the UCL

The graphs are shown separately for homeowners and non-homeowners and for older people with and without partners. Figure 1 and Figure 2 relate to unpartnered and partnered older people, respectively, with the percentages falling into each wealth and income group summing to 100 for each partnership group. Figure 3 shows the analysis for both partnered and unpartnered older people in which the denominator for the percentages in each wealth and income group is the total of unpartnered and partnered older people. The colour coding is as follows:

- Shades of blue: non-homeowners
- Shades of red: homeowners whose non-housing wealth is up to the UCL
- Shades of green: homeowners whose non-housing wealth is above the UCL

The graphs indicate, for example, that:

- Low-income older people are the most likely to be non-homeowners. However substantial proportions of them do own their homes but they are unlikely to have large amounts of non-housing wealth.
- Larger amounts of non-housing wealth are concentrated amongst those in the top income quintile almost all of whom own their homes.

On the basis of the analysis above we adopt the following classifications when analysing the progressivity of care charging systems:

⁵ The general picture portrayed in the graphs is largely unaffected by whether income is measured AHC or BHC although more unpartnered older people and fewer partnered older people have incomes in the lowest quintile when income is measured BHC.

- Homeowners and non-homeowners are distinguished throughout as are housing wealth and non-housing wealth. We use the terms 'non-housing wealth' and 'savings' interchangeably.
- When bringing further dimensions into the analysis (e.g. funding sources for care costs, gains from reforms) we retain the current LCL and UCL as distinguishing savings thresholds but reduce the number of income categories. For homeowners we provide either a disaggregation by savings or by housing wealth but not both simultaneously.

Figure 1: Wealth group by After Housing Costs income and whether homeowner, unpartnered older people in England.

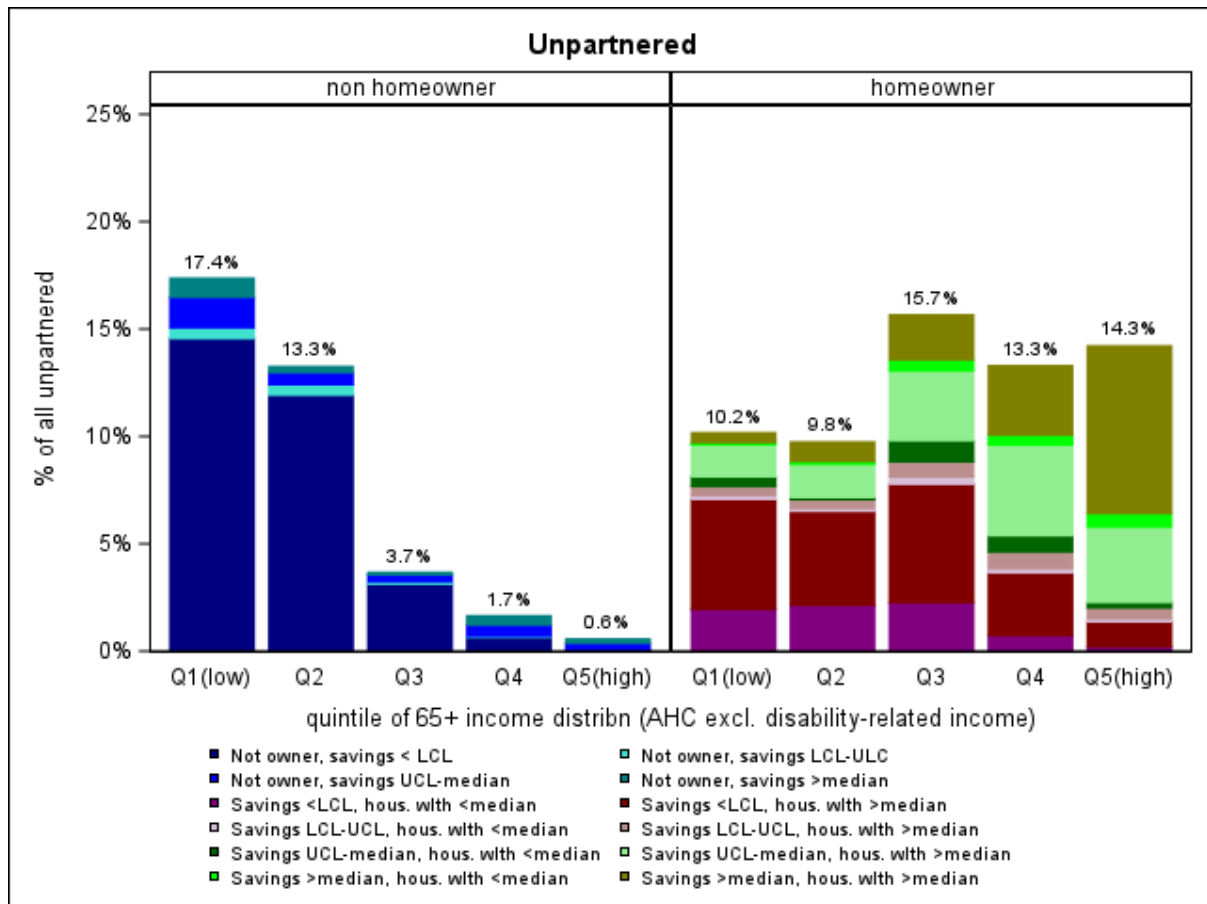


Figure 2: Wealth group by After Housing Costs income and whether homeowner, partnered older people in England.

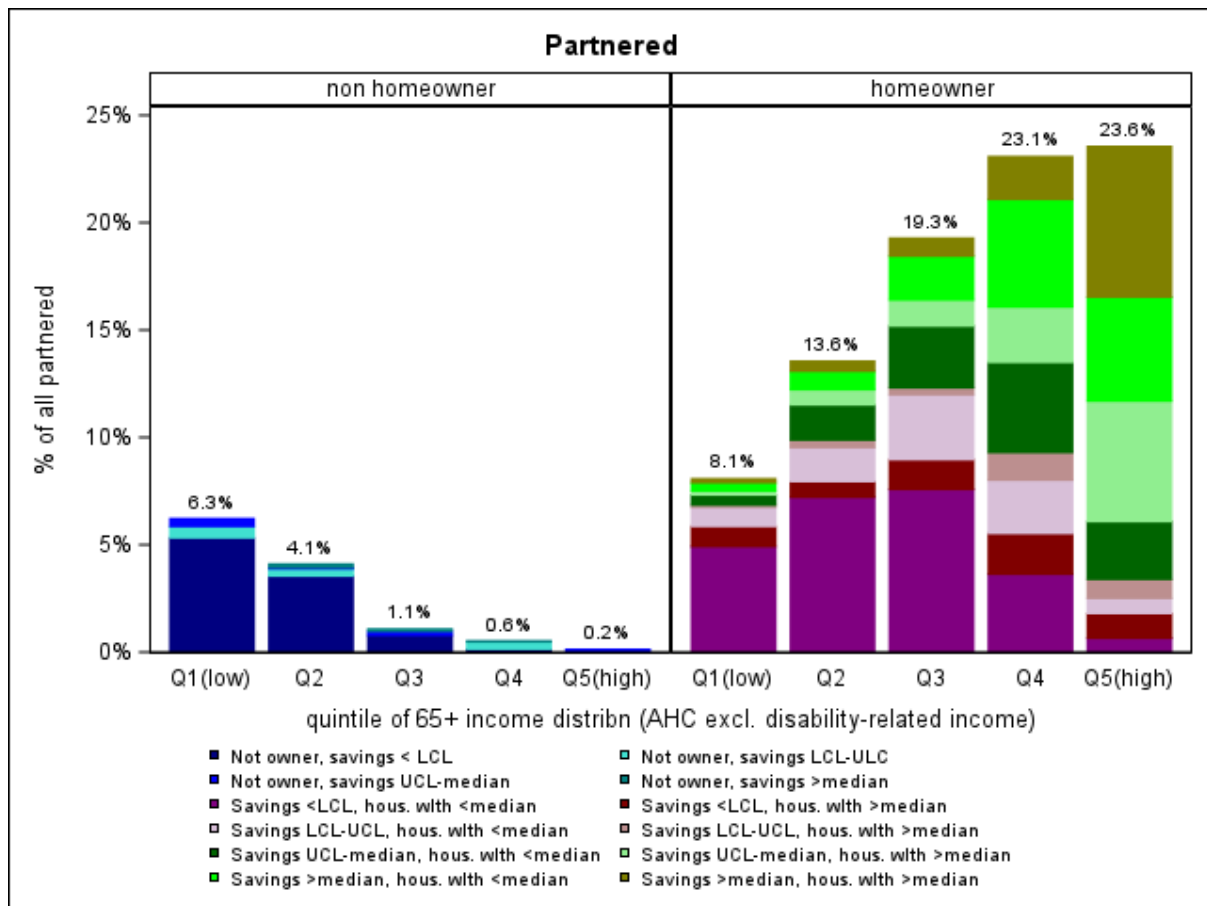
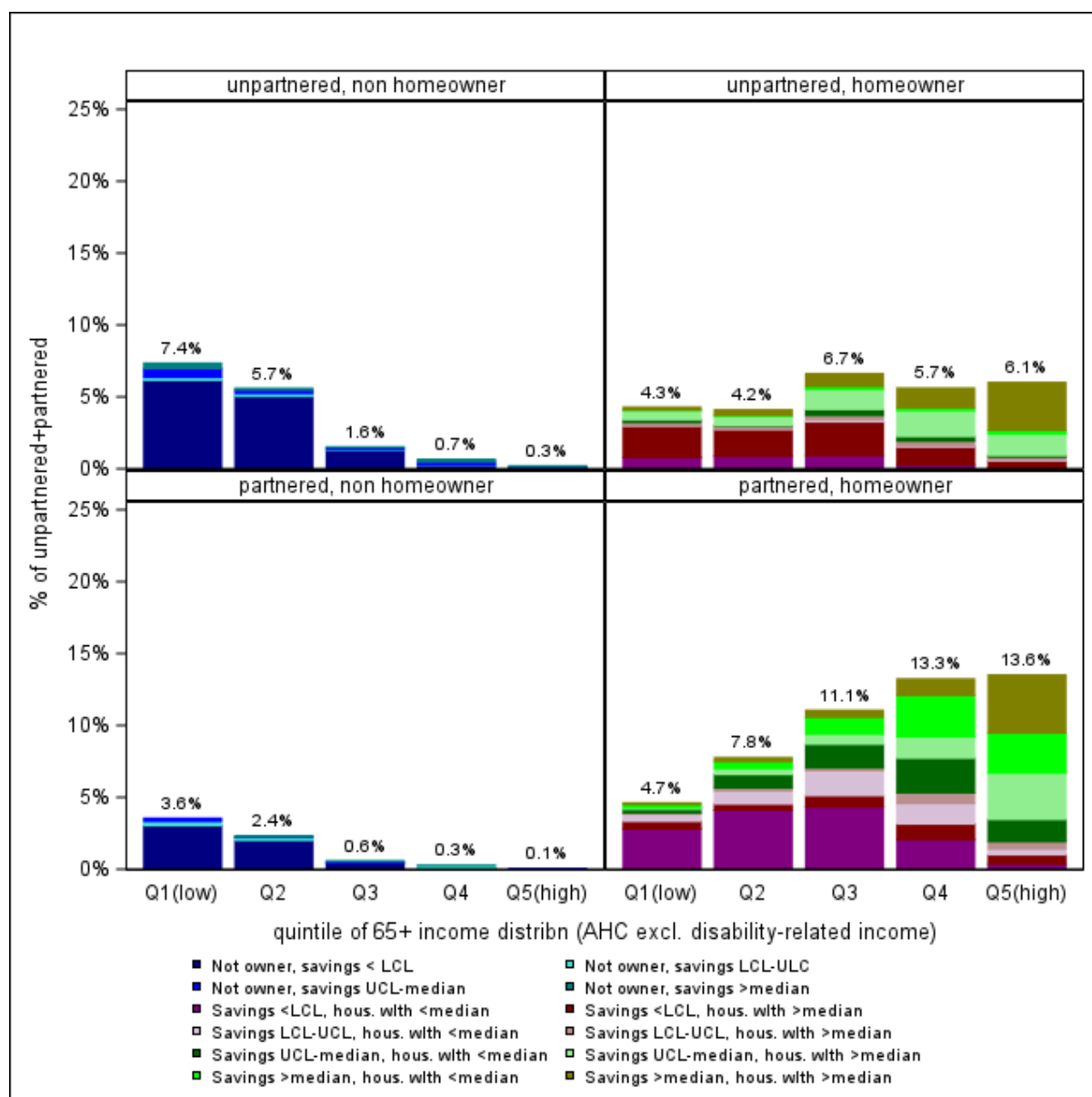


Figure 3: Wealth group by After Housing Costs income, whether homeowner and whether partnered, older people in England.



5. Funding sources for long-term care

In this section we provide base year (2023) estimates of annual aggregate spending on long-term care for older people in England by funding source. We also present estimates of the average weekly contribution from different sources, according to service type and characteristic of the recipients: income and non-housing wealth level, homeownership and partnership status. For homeowners there is also a classification by housing wealth level. Note that these levels and characteristics pertain to the individual's circumstances at the start of their care journey. Hence at the point that we 'observe' them in CARESIM, they can have depleted their savings. This explains why some local authority (LA) funding is received by some people classified as having savings above the UCL at the start of their care journey. These are mostly non homeowners and homeowners with partners for whom housing wealth is disregarded.

The funding sources identified are:

- 1) NHS through 'funded nursing care' or through 'continuing health care' for the small number of care home residents fully funded by the NHS when they are included in the analysis (NHS);
- 2) A local authority (LA);
- 3) User charges for LA-funded care recipients (LA user);
- 4) Self-funder payments (S/Funder);
- 5) Attendance Allowance or equivalent disability benefit plus disability additions to means-tested benefits⁶, together labelled 'AA'. For the aggregate estimates these are shown only for care homes because these benefits cease (after 4 weeks) for care home residents who have any LA funding. Any reform that provides some LA funding to those who self-fund under the current system could thus result in savings in aggregate expenditure on these benefits for care home residents.

Our estimates of aggregate annual expenditure on long-term care for older people in England in 2023 are presented in Table 4. The combined total of private, LA, NHS expenditure and disability benefits paid to self-funding care home residents amounts to £27.7 billion, of which 35% is paid by people who receive no LA or NHS funding, 12% comes from charges paid by LA-funded users, 11% is funded through the NHS (CHC and FNC in care homes), 3% from disability benefits paid to self-funding care home residents and the remainder, 39%, is funded from LA budgets. Private expenditure including user charges represents a higher proportion of residential than community care spending (51% compared with 34%).

⁶ Pension credit and for those receiving community care, housing benefit and council tax support. Note that entitlements to these benefits are simulated within CARESIM and it is assumed here that all entitlements are claimed.

Table 4: Estimated aggregate annual private and public expenditure on long-term care for older (65+) people, England 2023 (£s million 2023 prices)

	Residential care		Community Care		Total	
	(£m, 2023 prices)	% of total	(£m, 2023 prices)	% of total	(£m, 2023 prices)	% of total
Private expenditure						
Self-funder expenditure, Less disability benefits paid to care home residents	8,609	40%	1,212	19%	9,821	35%
Charges paid by LA-funded users	2,190	10%	1,015	16%	3,205	12%
Total private expenditure	10,799	51%	2,227	34%	13,026	47%
Public expenditure						
LA expenditure net of user charges	6,614	31%	4,234	66%	10,848	39%
NHS expenditure (FNC and CHC in care homes)	3,150	15%			3,150	11%
Disability benefits paid to self-funding care home residents	724	3%			724	3%
Total public expenditure	10,488	49%	4,234	66%	14,722	53%
Private plus public expenditure	21,287	100%	6461	100%	27,748	100%

The service types that are distinguished for the analysis of average weekly contributions are:

- 1) Care home without nursing, which includes both LA-run homes and independent homes;
- 2) Care home with nursing but excluding those who are fully NHS funded;
- 3) Low intensity community care;
- 4) Medium intensity community care;
- 5) High intensity community care;

Average weekly contributions are also shown for:

- 6) all types of care home places combined, adding in those fully funded by the NHS;
- 7) all types of levels of community care combined, adding in those funded via Direct Payments which can be for any level of care.

For purposes of apportioning contribution sources from individuals, it is assumed that they first put any disability benefits (in excess of assumed disability-related expenditure for community care) towards their contribution to care costs, with the remainder paid from disposable⁷ income (state pension, private pension, other social security benefits), in excess of the PEA or MIG or from wealth. Thus, on the graphs below, 'LA-user' or 'S/Funder' identify the individual's contribution excluding that part which can be met from AA. Graphs in the main text show average absolute amounts (£s per week) from each funding source. Corresponding graphs showing average proportionate amounts are provided in Appendix One.

⁷ i.e. after meeting housing costs.

In classifying care recipients by income and wealth, each of Figure 4 to Figure 7 simultaneously distinguishes:

- 1) Two income levels: quintiles 1 & 2 and quintiles 3-5
- 2) Three non-housing wealth groups: below UCL, UCL – median, above median (where the median is for those with wealth > UCL)

Separate graphs are shown for each homeownership status by partnership category, meaning that for each graph there are 6 income/non-housing wealth categories represented along the horizontal axis and 5 funding sources (4 for community care as there is no NHS source) measured on the vertical axis.

Figure 8 to Figure 11, and their equivalents in Appendix One, are restricted to homeowners. In these graphs non-housing wealth is categorised only by whether it is below and above the UCL to allow a breakdown of housing wealth by whether it is below or above the median housing wealth level. Hence there are 2 non-housing wealth groups for each of 2 housing wealth groups as well as 2 income groups measured along the horizontal axes.

As can be seen throughout the figures, the funding mix for long-term care depends on a person's wealth, homeownership and partnership status, and on the type of care they receive. In residential and nursing care, the self-funder contribution rises once non-housing wealth passes the UCL, and it is larger for homeowners (see Figures 4 and 5). Because the home is disregarded as capital while a partner remains in it, partnered homeowners retain meaningful LA support even at higher initial levels of non-housing wealth, whereas unpartnered homeowners with the same non-housing wealth see their LA contribution fall away much faster, since their property is counted towards the means test (see, for example, Figure 8, contrasting the unpartnered and partnered panels, also Figure 4). For care in a care home, wealth is much more important than income in determining funding. There are only small differences between lower and higher income groups with similar levels of wealth under the current means test.

The picture in community care is different since the home is always disregarded and the Minimum Income Guarantee protects a larger share of income relative to care costs than the Personal Expenses Allowance does in a care home. As a result, the funding mix is far less variable between non-homeowners and homeowners (e.g., compare Figure 6 and Figure 7 with Figure 4 and Figure 5, respectively) and, within homeowners, between partnered and unpartnered individuals (e.g., compare Figure 10 with Figure 8). Disability benefits also play a larger role in community care, forming a fairly stable contribution to funding across most wealth groups, since they are not means-tested (see Figure 7 and Figure 11). In care homes, by contrast, this benefit is only relevant for self-funders, since it ceases to be paid once someone receives any LA support (see Figure 4). In contrast to care homes, there are greater differences according to income for community care, at least for those with savings below the median level. These differences depend to some extent on the level of home care received and hence the cost of the care package.

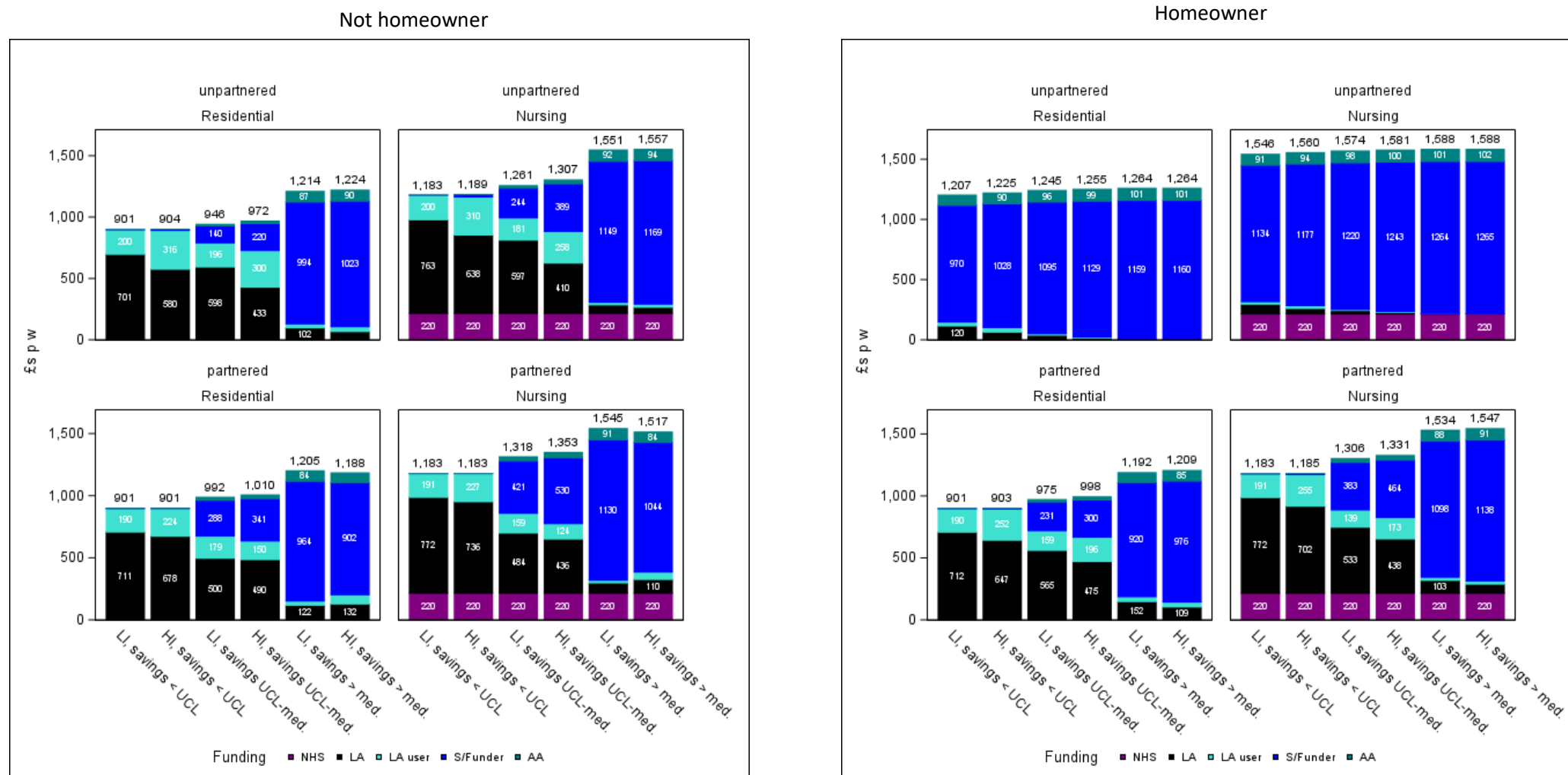
While the pattern of funding mix under the current system varies in ways which would be expected given the form of the mean test, some points stand out:

- User contributions for LA-funded care home residents can be substantial, even for those who are not homeowners, are on low incomes and have savings below the UCL. For example, we estimate that unpartnered non-homeowners with savings below the UCL and incomes in the lowest 40% of the income distribution pay on average £200 per week in user charges for care in a care home, effectively towards the DLC components of the fee (if they are not amongst the small number who are fully funded by the NHS). The figure for otherwise similar older people with higher incomes is

over £300. User contributions are less for partnered people in care homes and for people receiving community care. Nonetheless, older people receiving high intensity community care can face considerable user charges even when they are entitled to some LA funding.

- For those with wealth below the UCL, income level affects user contributions, but the 'cliff-edges' created by the capital thresholds mean that wealth is generally much more important than income in determining the mix of funding sources.
- For community care, the funding mix is far less variable between homeowners and non-homeowners and between partnered and non-partnered people because, under the current means test, the value of the home is always disregarded in the means test. Moreover, the operation of the 'minimum income guarantee' for community care protects a much larger share of income than does its equivalent – the 'personal expenses allowance' – in care homes.

Figure 4: Funding sources, residential or nursing home care excluding NHS fully funded, average absolute amounts by residential or nursing care, homeownership, partnership and income/non-housing wealth group



Notes: LI=low income (quintiles 1&2), HI=higher income (quintiles 3-5); 'nursing' **excludes** fully NHS funded

Figure 5: Funding sources, residential and nursing home care combined, including NHS fully funded care, average absolute amounts by homeownership, partnership and income/non-housing wealth group

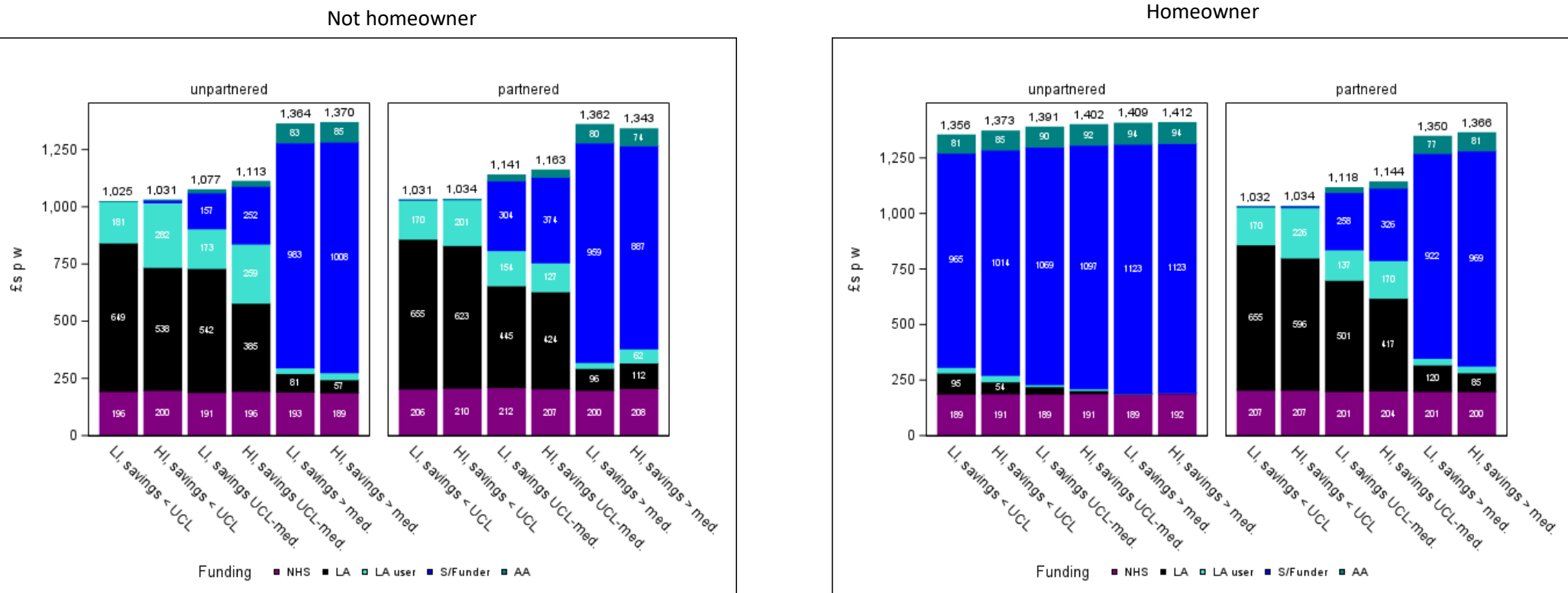


Figure 6: Funding sources, community care excluding Direct Payments, average absolute amounts by level of care, homeownership, partnership and income/non-housing wealth group

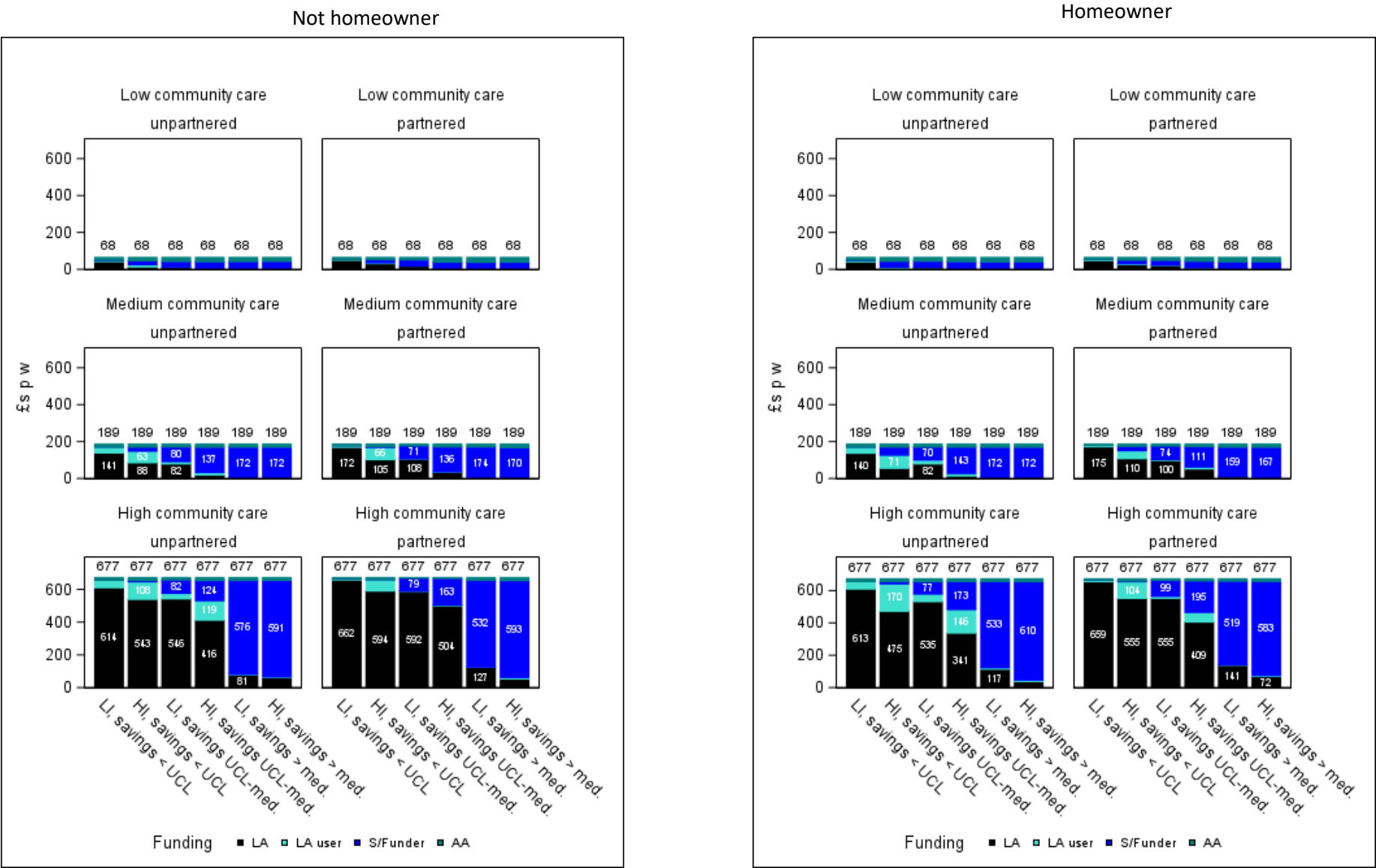
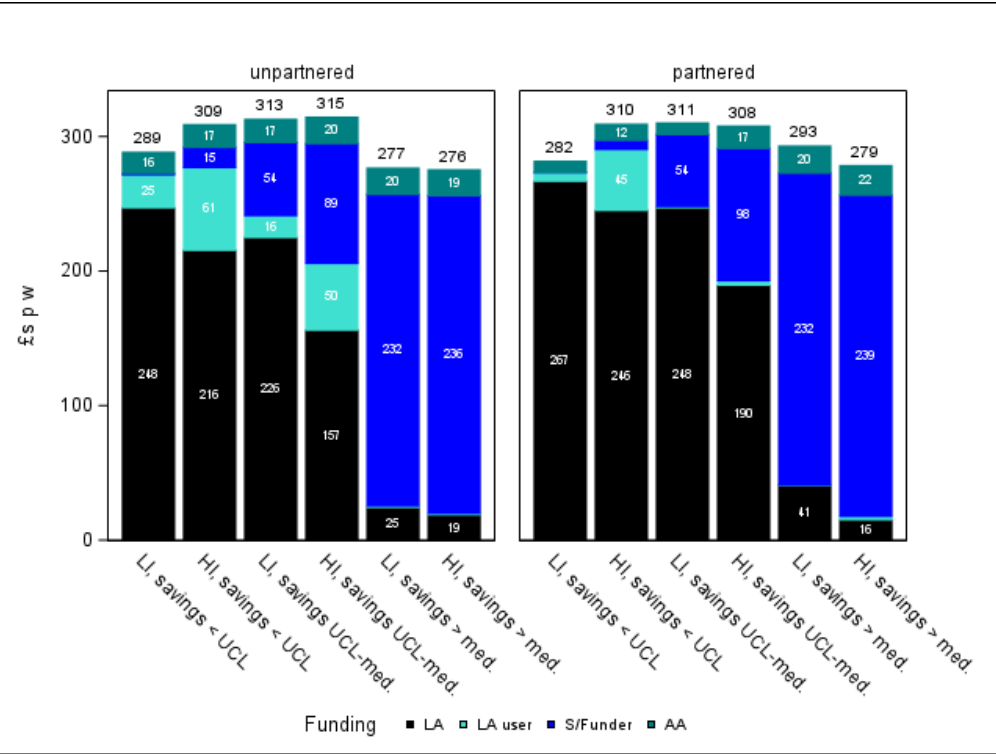
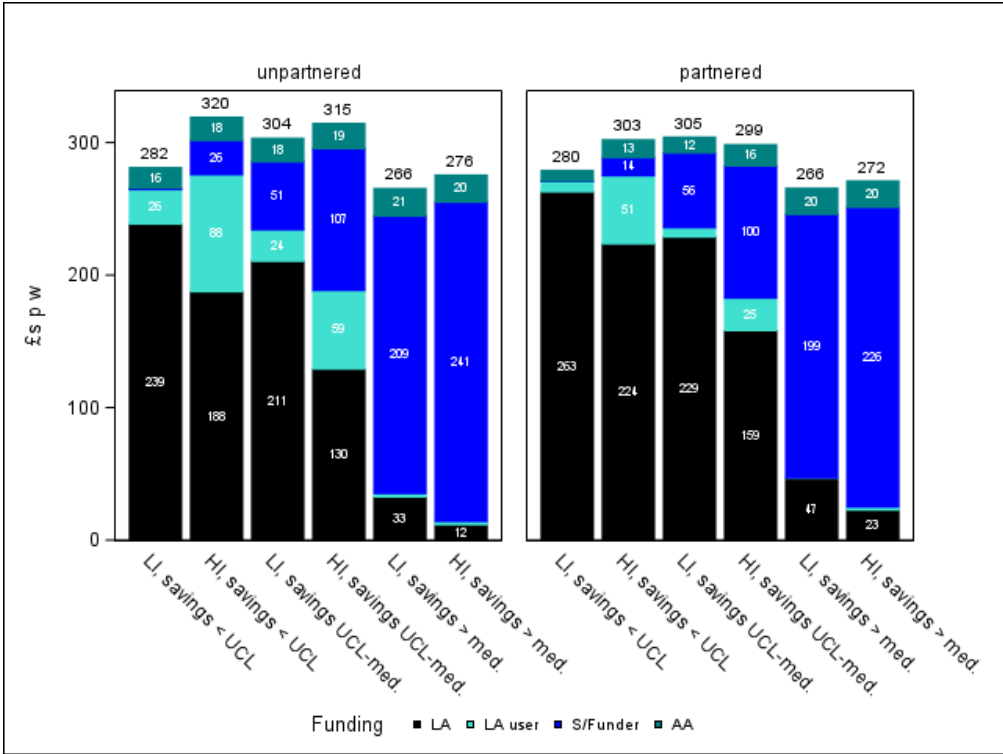


Figure 7: Funding sources, all levels of community care including Direct Payments, average absolute amounts, homeownership, partnership and income/non-housing wealth group

Not homeowner

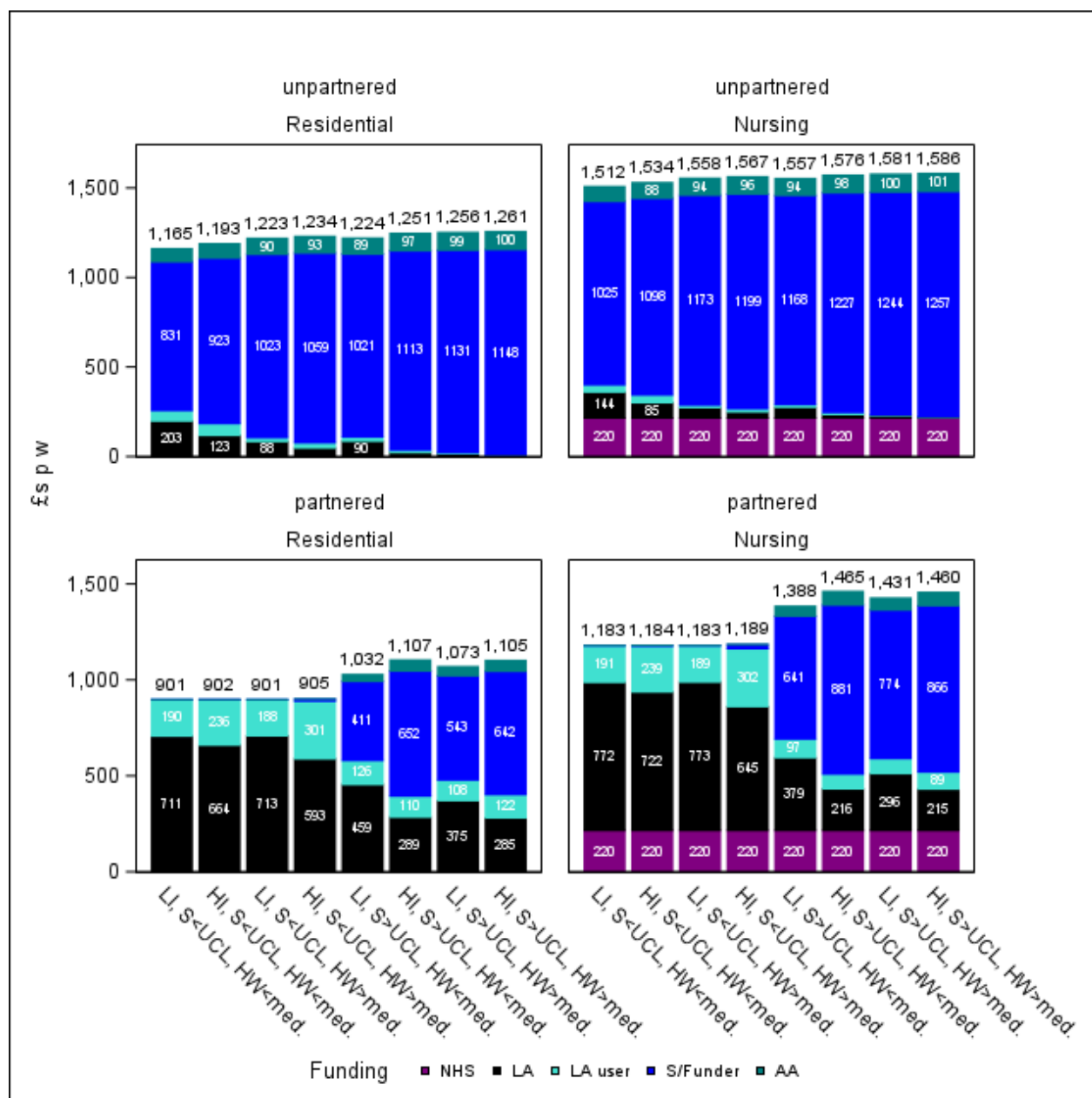


Homeowner



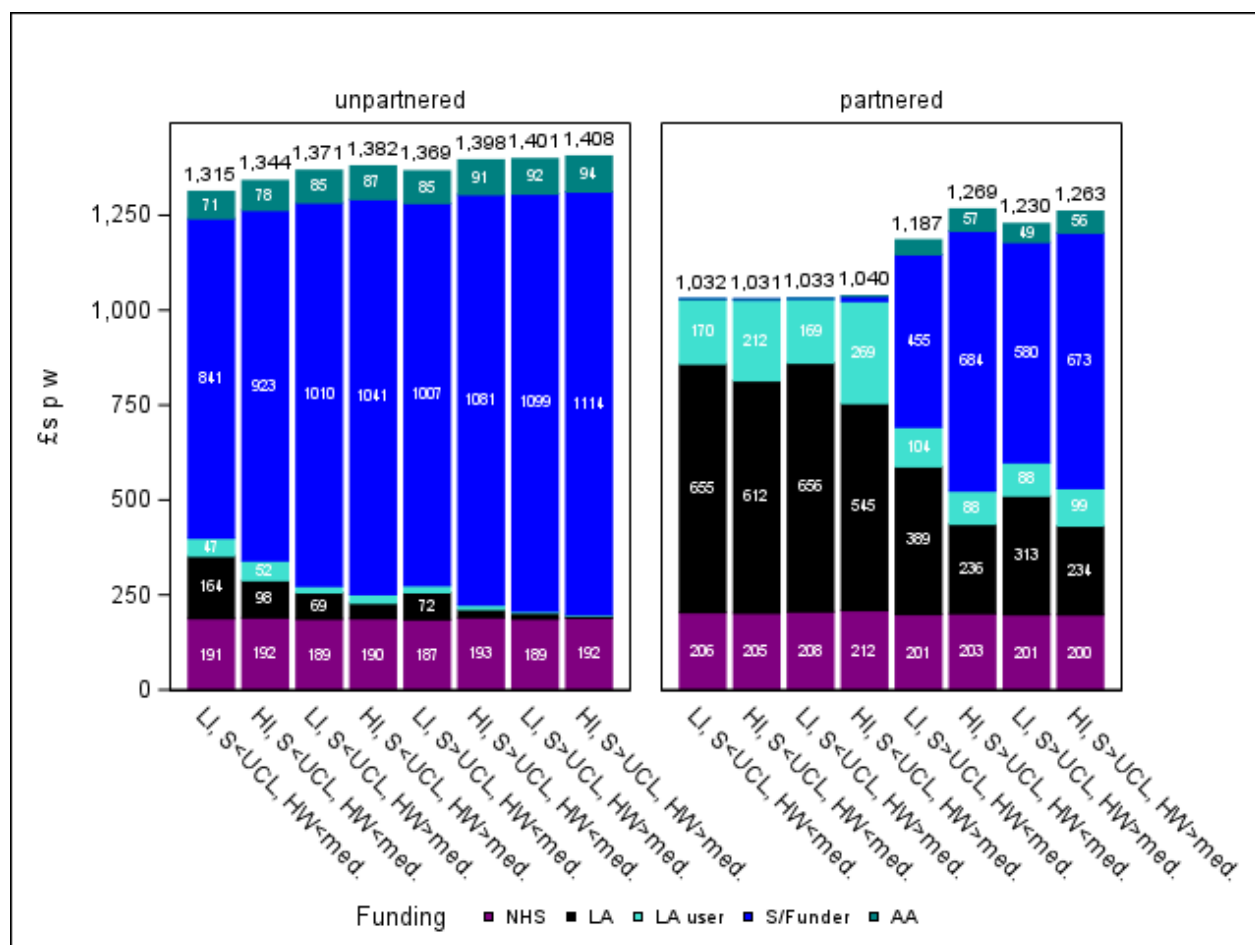
Notes: LI=low income (quintiles 1&2), HI=higher income (quintiles 3-5)

Figure 8: Funding sources, residential or nursing home care excluding NHS fully funded, average absolute amounts by residential or nursing care, homeowners by partnership and income/wealth group



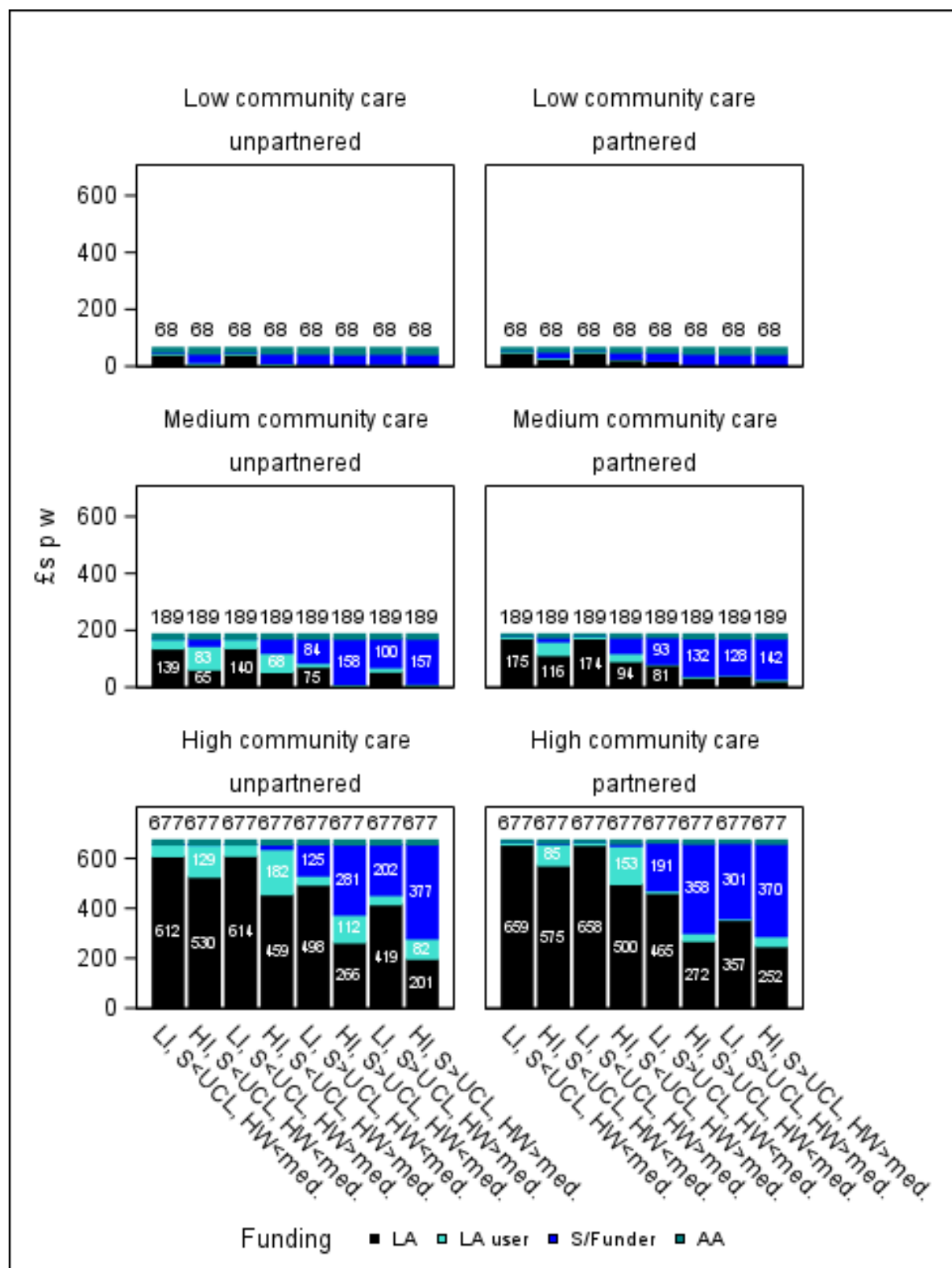
Notes: LI=low income (quintiles 1&2), HI=higher income (quintiles 3-5), S=savings (non-housing wealth), HW=housing wealth; 'nursing' **excludes** fully NHS funded

Figure 9: Funding sources, residential and nursing home care combined, including NHS fully funded care, average absolute amounts homeowners by partnership and income/wealth group



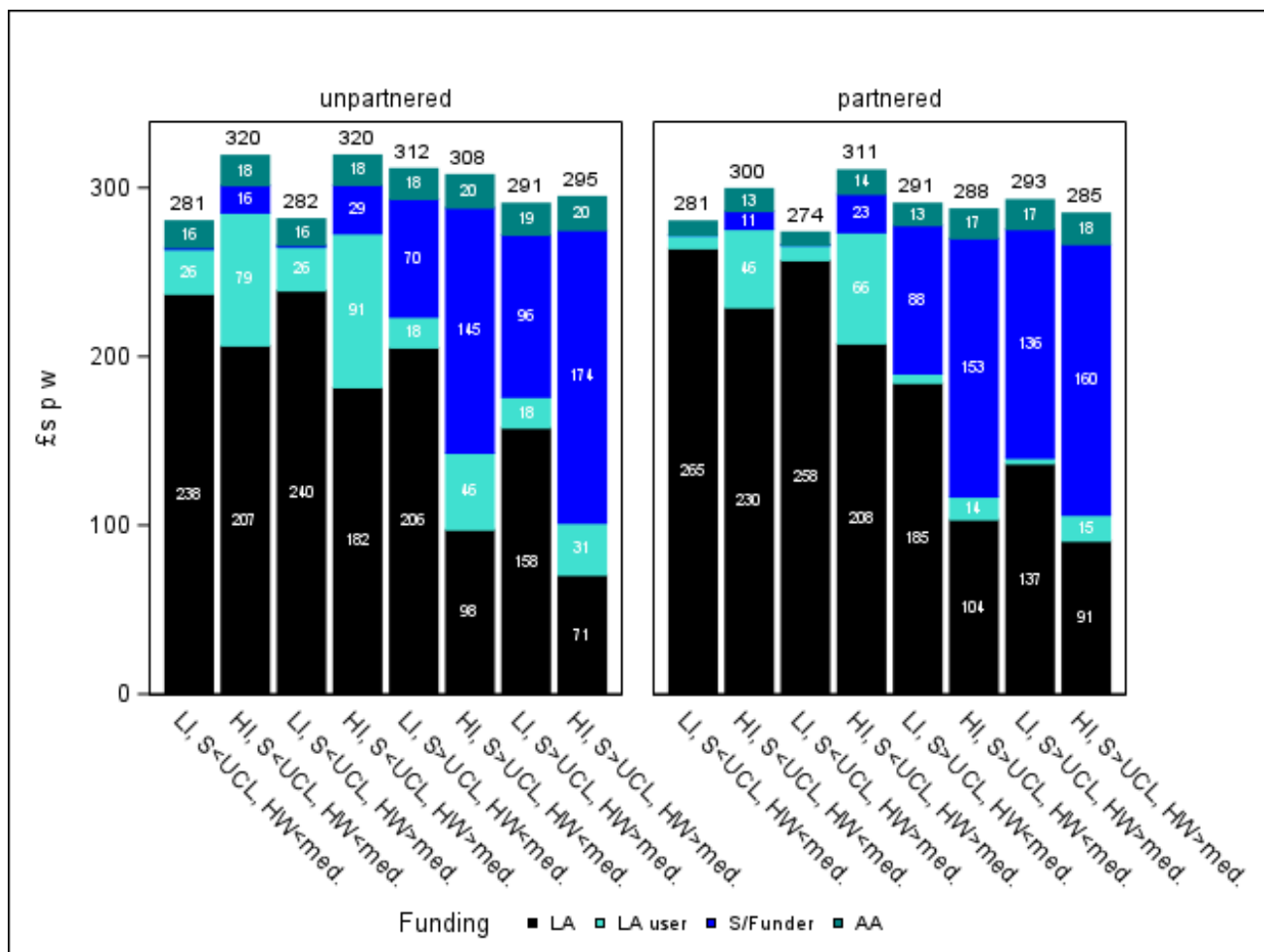
Notes: LI=low income (quintiles 1&2), HI=higher income (quintiles 3-5), S=savings (non-housing wealth), HW=housing wealth

Figure 10: Funding sources, community care excluding Direct Payments, average absolute amounts by level of care, homeowners by partnership and income/wealth group



Notes: LI=low income (quintiles 1&2), HI=higher income (quintiles 3-5), S=savings (non-housing wealth), HW=housing wealth

Figure 11: Funding sources, community care including Direct Payments, average absolute amounts, homeowners by partnership and income/wealth group



Notes: LI=low income (quintiles 1&2), HI=higher income (quintiles 3-5), S=savings (non-housing wealth), HW=housing wealth

6. Impact of previously planned reforms

In this section we update previous analysis (Hu et al., 2025) of the reforms that were planned by the 2019-2024 Conservative UK government, initially for implementation in 2023, subsequently postponed to 2025 but not implemented following the election in 2024 of a Labour government.

The lifetime cap on care costs planned by the Conservative Government followed the general structure of that recommended by the 2011 Commission on Funding Care and Support (CFCS) and this forms the basis for the lifetime cap examined here. There would be a cap on an individual's contribution to eligible care costs, but not daily living costs (DLC) in care homes (accommodation, food, heating, etc.). Prior to reaching this cap, LA help with care costs (in both care homes and in the community) and help with DLC in care homes would remain means tested. Once the cap was reached, eligible care costs would be met by the LA without a means test but help with DLC would remain means tested. The introduction of the cap would be accompanied by increases in the capital thresholds used in the means test (before and after reaching the cap). For those living in the community, eligible care costs are the costs of LA-assessed care needs. For those in care homes,

eligible care costs are the difference between the LA fee rate and DLC. Thus, self-funding care home residents who have reached the cap, would still need to meet DLC and any difference between the self-funder fee rate and the LA rate.

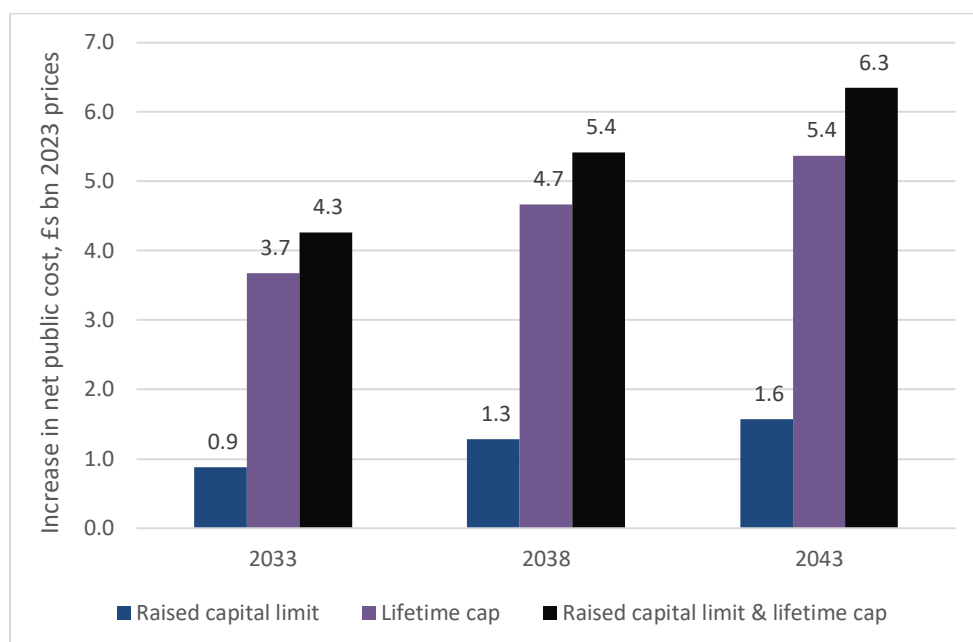
Our projection modelling looks at three reformed scenarios as follows:

- Increases in capital limits without a lifetime cap: Universal upper and lower capital limits which are £100,000 and £20,000 in 2023 prices.
- A lifetime cap without increases in capital limits: A lifetime cap of £86,000 and DLC of £227 per week in 2023 prices, progress towards the cap based on the minimum of eligible care costs and the user's contribution towards them.
- A lifetime cap and increases in capital limits: Combining the two reformed scenarios above, which is the reform originally planned by the 2019-2024 Conservative UK government.

For all three scenarios we assume that all those newly eligible for LA funding take-up their entitlement and that as under the current system, care home residents who receive any funding from their LA towards their fees cease to receive Attendance Allowance or Disability Living Allowance/Personal Independence Payment after four weeks. This generates savings in public expenditure to be offset against the cost of extended eligibility for LA funding. Lifetime caps and daily living costs are converted to 2023 prices (the base year for our projections) according to movements in average earnings. The higher upper and lower capital limits are converted to 2023 prices using the GDP deflator.

Figure 12 shows the effects of reforms on future net public expenditure on long-term care (in 2023 prices). An increase in the means test capital limits is projected to result in net public expenditure being higher by £0.9 billion in 2033 and £1.6 billion in 2043, respectively, in comparison to the current funding system. These amounts represent increases of 4% and 5.2% of what we project for 2033 with no change in the funding system. Implementing a lifetime cap of £86,000 will result in net public expenditure being higher by £3.7 billion (16.5%) in 2033 and £5.4 billion (17.6%) in 2043, respectively. If both the lifetime cap and the raised capital limits are implemented, net public expenditure is projected to be £4.3 billion (19.2%) higher in 2033 and £6.3 billion (20.8%) higher in 2043, respectively, than under the current funding system.

Figure 12: Projected increases from reforms in net public cost of long-term care for older people, 2033- 2043, England



Note: Net public cost includes LA (net of user charges) and NHS expenditure and the cost of disability benefits paid to self-funding care home residents.

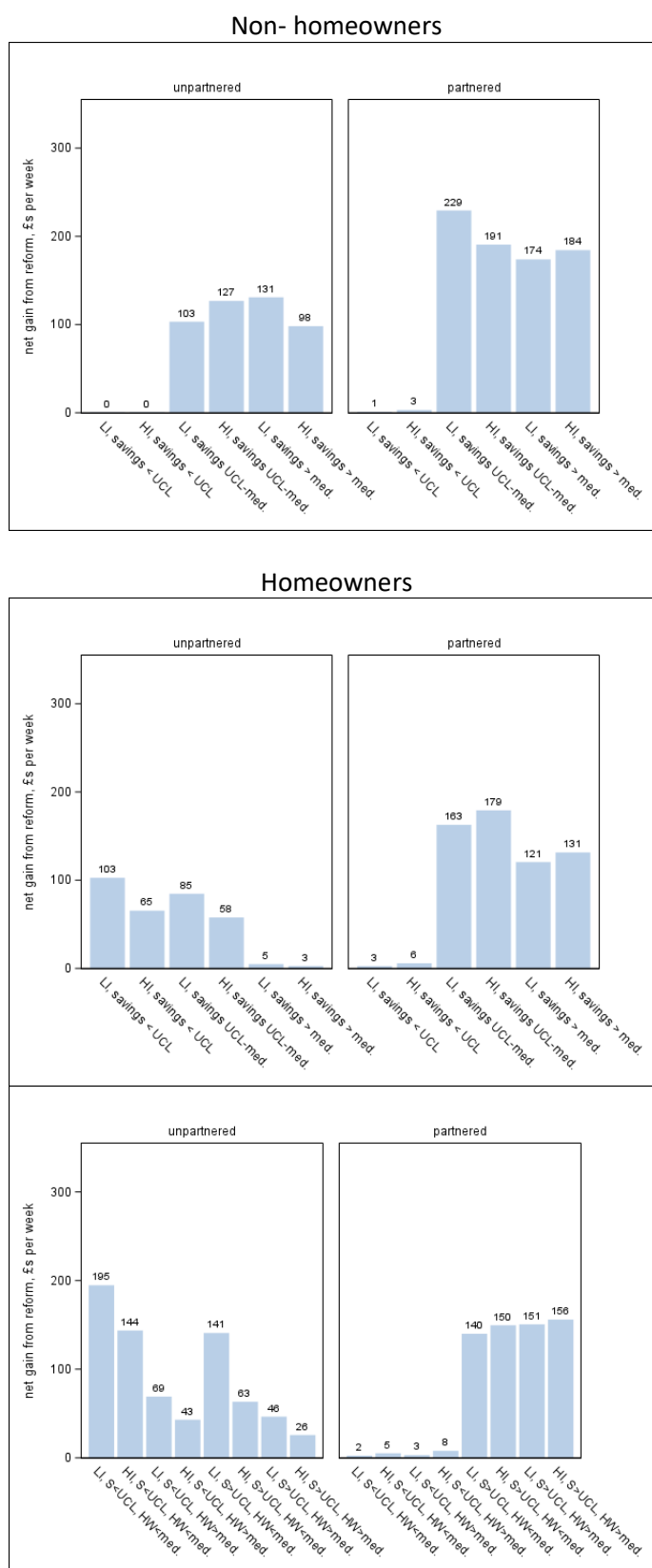
Figure 13 to Figure 15 show, respectively, average weekly gains in 2023 from raised capital limits, from a lifetime cap and from the two combined, for older care home residents according to their income and wealth using the classifications developed in Section 4. The charts also distinguish whether a resident has a partner and their homeownership status before care home admission. The graphs show:

- As would be expected, amongst non-homeowners, raising the capital limits brings benefits only to those with non-housing wealth above the UCL. However, it is beneficial to homeowners with savings below the UCL and particularly those with housing wealth below the median level (for those with savings above the UCL), since they reach the UCL sooner, and hence become entitled to LA help unless they have relatively high incomes. For unpartnered care home residents gains for all who have savings above the UCL range from just under £100 per week (higher incomes, savings above the median) to £131 (lower incomes, savings above the median) Amongst partnered residents who are non-homeowners, gains are higher at £229 per week, for those on low incomes with savings between the UCL and the median (Figure 13)
- In general, a lifetime cap of the magnitude examined here is most beneficial to those at the higher ends of the income and wealth distributions. Nonetheless gains from such a cap would be substantial for unpartnered home-owners with non-housing wealth below the UCL and/or on low incomes. (Figure 14)
- Combining the two reforms, amongst non-homeowners the benefits are largest for those with higher levels of savings and incomes, while those on low incomes (lowest 40% of the income distribution) and savings below the UCL gain little (Figure 15). On average we estimate that care home residents who are unpartnered non-homeowners would gain over £220 per week if they have savings greater than the median level for those with savings above the UCL, compared with only £4 a week for those with low incomes and savings below the UCL. The pattern is similar for

partnered non-homeowners although the gains amongst those with savings above the UCL are somewhat higher than their unpartnered counterparts.

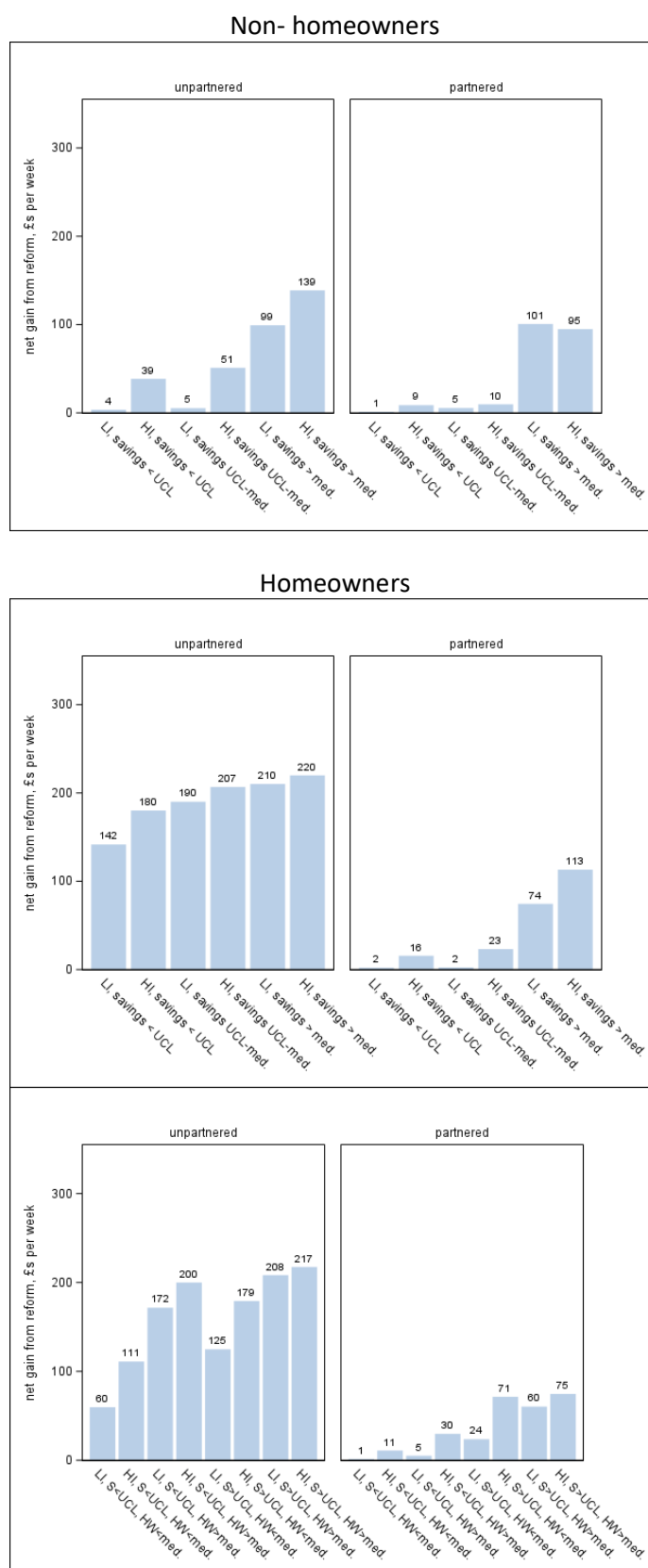
- Amongst homeowners there are substantial benefits from the combined reforms for all groups of unpartnered care home residents. For them, the variations across income and wealth groups are not very marked but it is striking that at over £250 per week, the highest average weekly gains are for those with low incomes, non-housing wealth below the UCL and housing wealth below the median. Amongst partnered homeowners the picture is similar to that for non-homeowners because housing wealth is disregarded in the current means test for both groups. (Figure 15)

Figure 13: Gains from raised capital limits, older care home residents, £s per week, 2023 prices



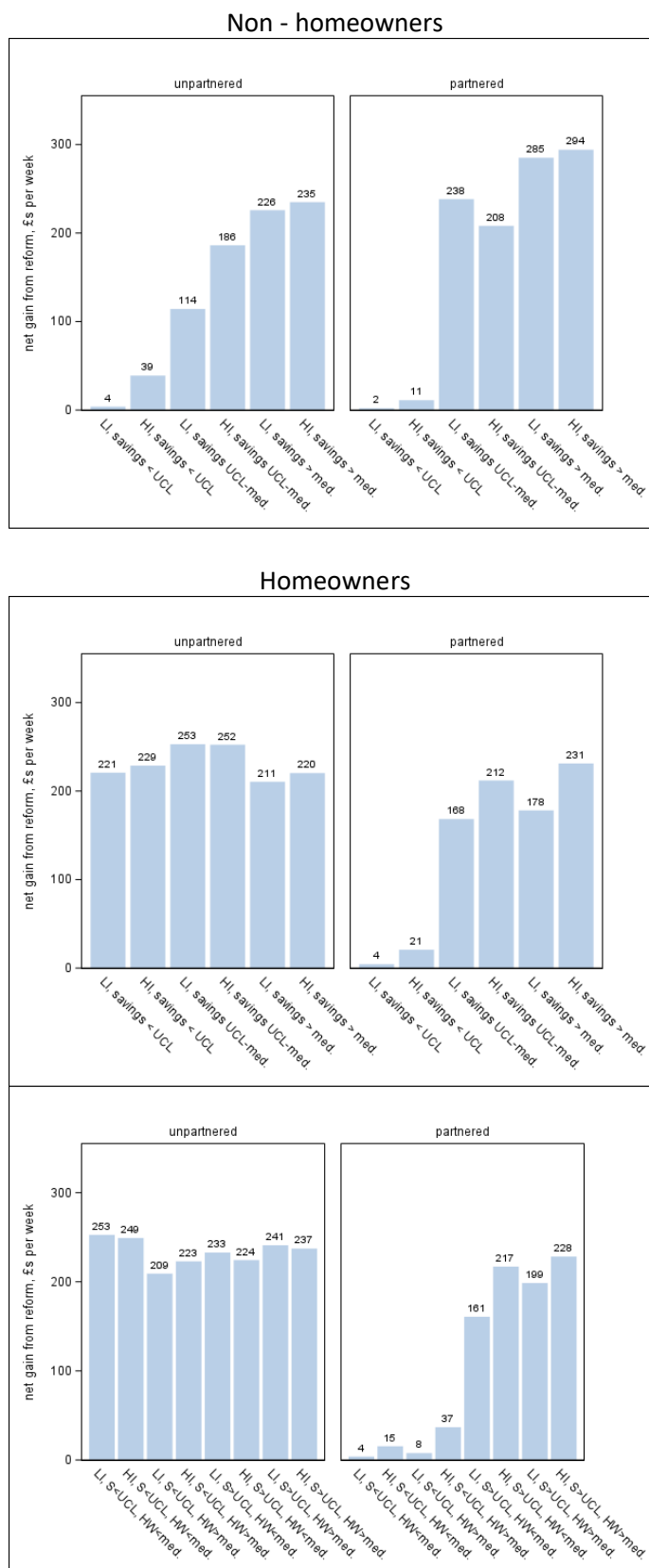
Notes: LI=low income (quintiles 1&2), HI=higher income (quintiles 3-5), S=savings (non-housing wealth), HW=housing wealth

Figure 14: Gains from a lifetime cap, older care home residents, £s per week, 2023 prices



Notes: LI=low income (quintiles 1&2), HI=higher income (quintiles 3-5), S=savings (non-housing wealth), HW=housing wealth

Figure 15: Gains from raised capital limits and a lifetime cap, older care home residents, £s per week, 2023 prices

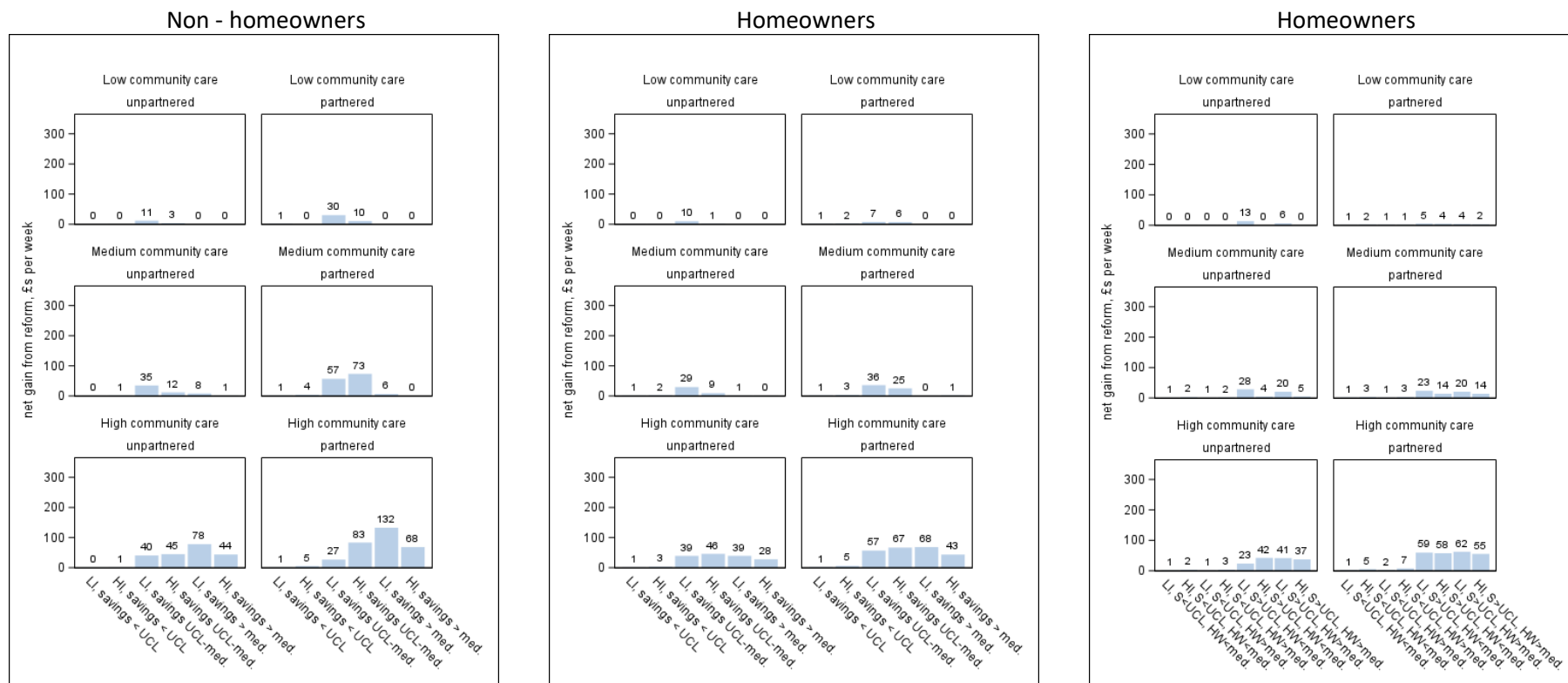


Notes: LI=low income (quintiles 1&2), HI=higher income (quintiles 3-5), S=savings (non-housing wealth), HW=housing wealth

Figure 16 to Figure 18 show the distribution of gains from the previously planned reforms and their components for older recipients of community care. As for care home residents, the graphs distinguish those with and without partners and homeownership status. They also show three different intensities of community care. From these figures we see that:

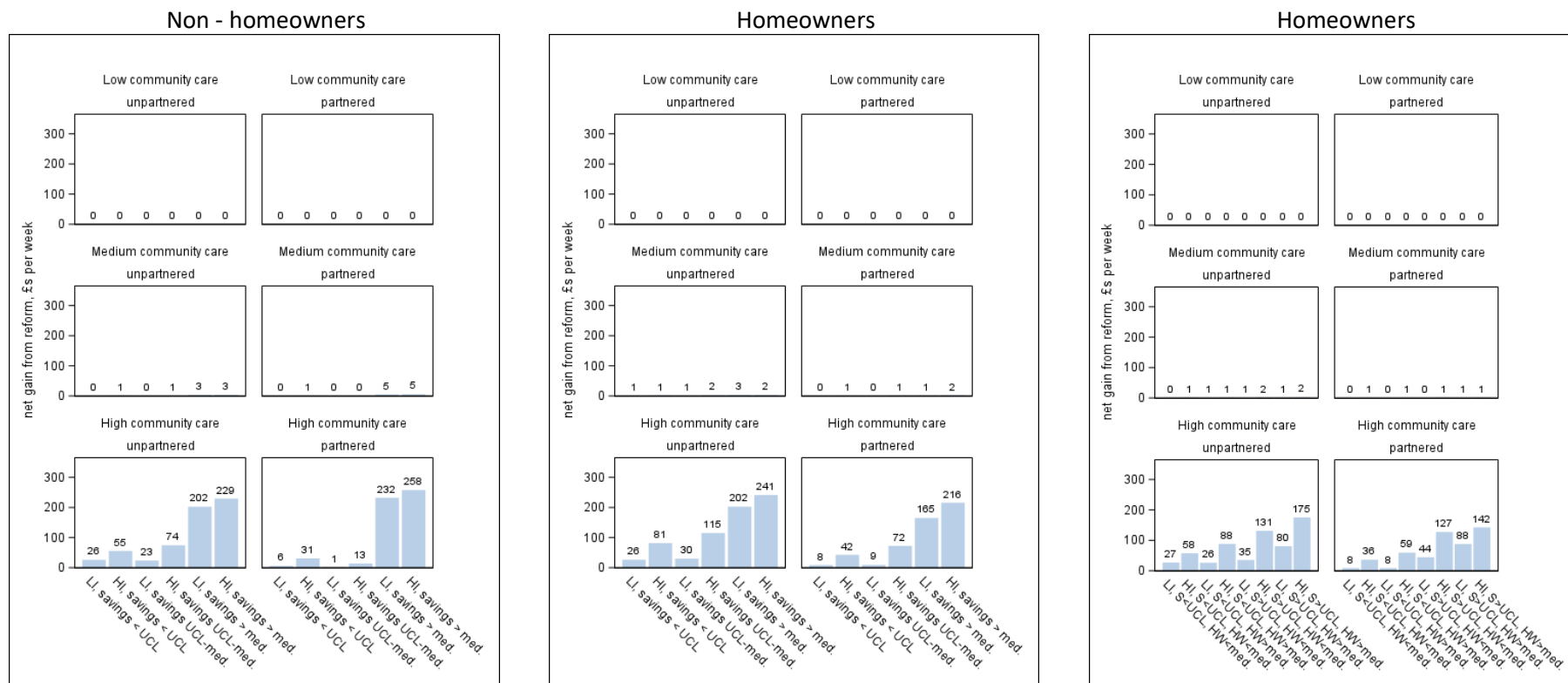
- Gains from each component of the reforms are concentrated amongst those receiving the highest level of community care. They face the highest costs and so are most likely under the current system to need to draw on their savings to fund their care, whether as self-funders or through LA user charges. They are also most likely to reach a lifetime cap set as a monetary amount as here. Those receiving only low levels of domiciliary care are more likely to be able to fund their care costs from income and are unlikely to reach the cap.
- Unlike amongst care home residents, gains are similar for homeowners and non-homeowners because housing wealth is disregarded in the current means test for community care.
- By definition the raised capital limits benefit only those with non-housing wealth above the UCL (Figure 16) but gains from a cap are substantially larger for those with higher levels of non-housing wealth (Figure 17). Combining the two components, amongst community care recipients, the overall reform would bring the greatest financial benefits to those receiving the highest level of care and with savings above the median level (Figure 18). Amongst community care recipients receiving the highest level of care, those, with savings above the median level, the overall reform would bring financial benefits of over £200 per week, reaching over £270 per week for partnered non homeowners.

Figure 16: Gains from raised capital limits, older recipients of community care by level of care, £s per week, 2023 prices



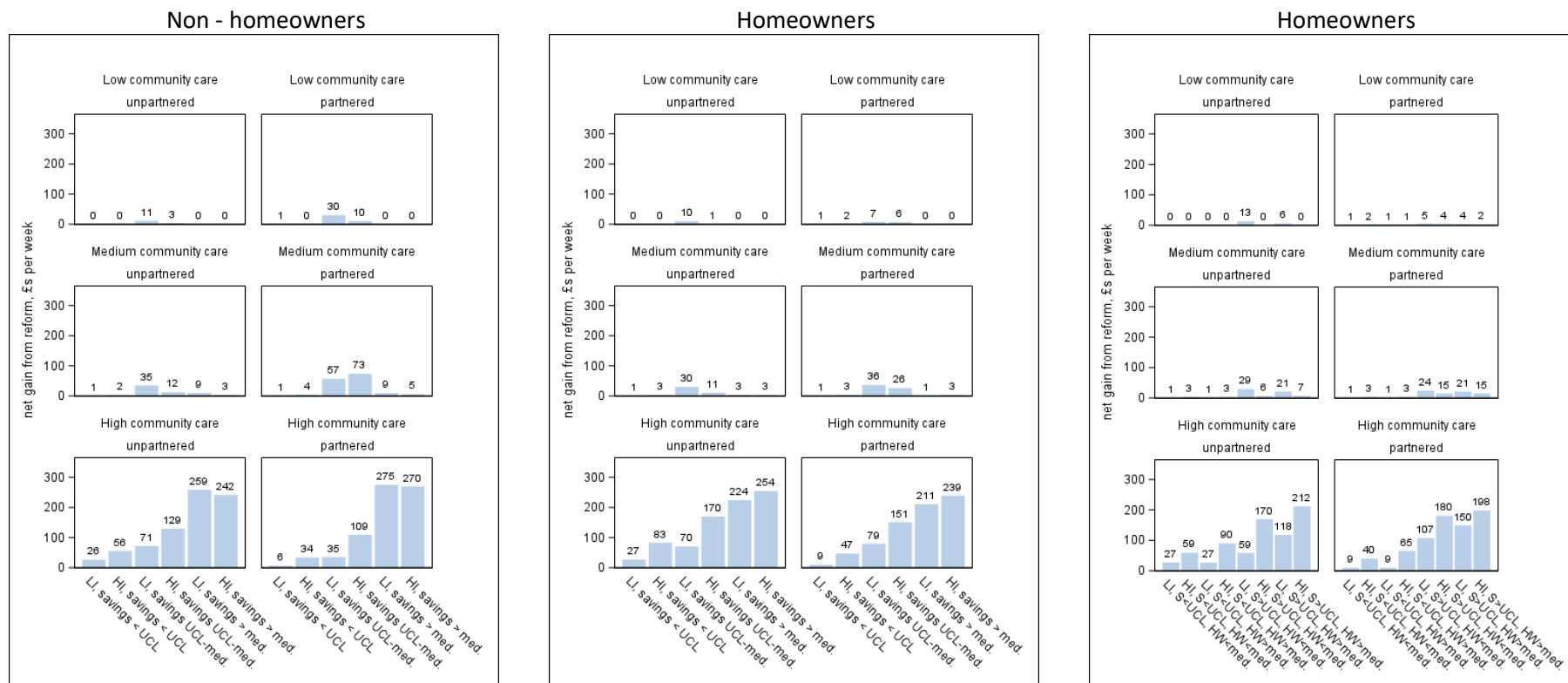
Notes: LI=low income (quintiles 1&2), HI=higher income (quintiles 3-5), S=savings (non-housing wealth), HW=housing wealth

Figure 17: Gains from a lifetime cap, older recipients of community care, by level of care, £s per week, 2023 prices



Notes: LI=low income (quintiles 1&2), HI=higher income (quintiles 3-5), S=savings (non-housing wealth), HW=housing wealth

Figure 18: Gains from raised capital limits and a lifetime cap, older recipients of community care by level of care, £s per week, 2023 prices



Notes: LI=low income (quintiles 1&2), HI=higher income (quintiles 3-5), S=savings (non-housing wealth), HW=housing wealth

7. Conclusion

In England, access to publicly funded long-term care is via a test of income and capital. For people who own their own homes, its value is included in capital if they are assessed as needing to move into a care home, unless a partner or other qualifying person continues to live in their property. Older people in particular are affected by the means test with many of them having to fund all or part of any care they need in later life. Despite much debate of the appropriateness of the means test and many reviews and recommendations for reforms, it has remained structurally similar for many years. This debate continues and recommendations of the independent commission led by Baroness Casey, are expected in 2027. In this paper we have reported the first phase of a study whose aims are to provide analysis which can be used by those contributing to the design of changes to this funding system. To that end we first investigated the relationships between income, savings and housing wealth amongst older people in England, and how these relationships differ according to homeownership and partnership, two key factors in the operation of the current means test. This allowed us to derive a classification of income and wealth to be used in analysing the mix of funding sources for long-term care for older under the current means test and under the most recently planned, but not implemented, reforms. Those reforms would have relaxed the capital tests in the means test and placed a lifetime ceiling on how much an individual was required to contribute to their care costs. The most relevant points from our analysis include:

- While older non-homeowners generally have markedly lower levels of income and savings than homeowners, substantial proportions of unpartnered low-income older people do own their homes and as a result are precluded from state help with their care costs under the current means test.
- User contributions for those who do receive some state help with their care cost can be substantial under the current system, even for those who are not homeowners, are on low incomes and have savings below the threshold which renders them ineligible for any state help with their care costs.
- While both income and wealth affect entitlements to state help with care costs, the ‘cliff-edges’ in the capital test mean that wealth is generally more critical than income in determining the division of costs between the individual and the state.
- As with any means test reforms that make the means test less stringent, the most recently planned reforms would have tended to benefit the better off. But they would have brought substantial financial gains to unpartnered low income homeowners with modest levels of housing wealth and both components of the intended reforms would have been important to achieve this.

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Appendix One

Supplementary tables and figures

Table A 1: Composition of older population by partnership and homeownership

	General older population	Older care recipients
unpartnered non homeowner	16%	35%
unpartnered homeowner	27%	40%
all unpartnered	43%	76%
partnered non homeowner	7%	5%
partnered homeowner	50%	19%
all partnered	57%	24%
all non homeowners	23%	40%
all homeowners	77%	60%

Table A 2: Distribution of older people by income, partnership and homeownership

	Quintile 1 (low)	Q2	Q3	Q4	Quintile 5 (high)	
unpartnered non homeowner	47%	36%	10%	5%	2%	100%
unpartnered homeowner	16%	15%	25%	21%	23%	100%
all unpartnered	28%	23%	19%	15%	15%	100%
partnered non homeowner	51%	34%	9%	5%	1%	100%
partnered homeowner	9%	15%	22%	26%	27%	100%
all partnered	14%	18%	20%	24%	24%	100%
all non homeowners	49%	35%	10%	5%	2%	100%
all homeowners	12%	15%	23%	25%	25%	100%
All older people	20%	20%	20%	20%	20%	100%

Note: Quintiles are based on 65+ equivalised income distribution after housing costs and excluding disability-related income

Table A 3: Distribution of older people by non-housing wealth, partnership and homeownership

		Quartile conditional on > UCL						
		below LCL	LCL-UCL	Q1 (low)	Q2	Q3	Q4 (high)	
unpartnered non homeowner		83%	3%	6%	3%	3%	2%	100%
unpartnered homeowner		42%	6%	15%	12%	12%	14%	100%
all unpartnered		57%	5%	11%	8%	9%	9%	100%
partnered non homeowner		81%	10%	3%	4%	1%	1%	100%
partnered homeowner		35%	13%	11%	14%	14%	13%	100%
all partnered		40%	13%	10%	13%	12%	12%	100%
all non homeowners		83%	5%	5%	3%	2%	2%	100%
all homeowners		37%	11%	13%	13%	13%	13%	100%
All older people		47%	9%	11%	11%	11%	11%	100%

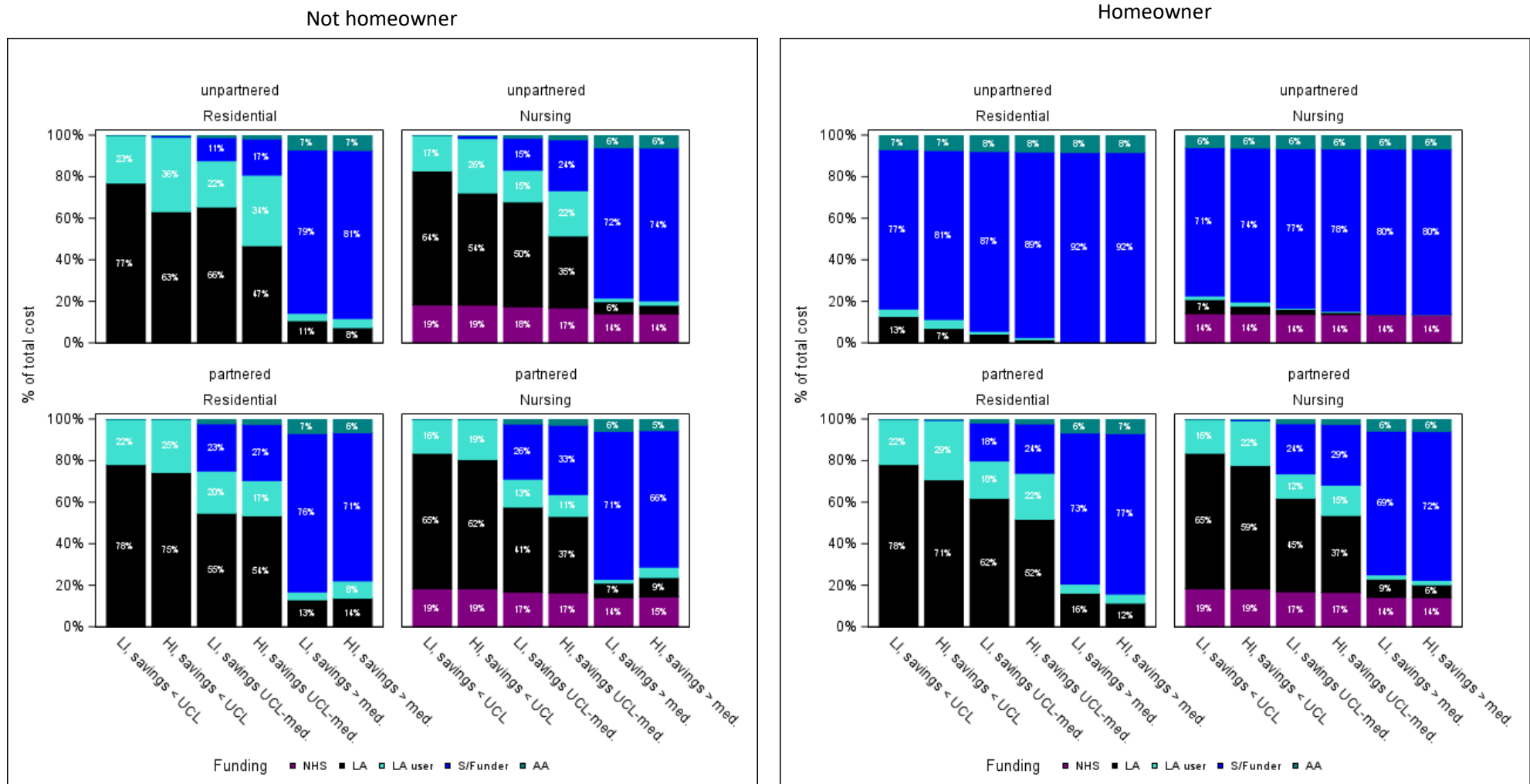
Note: For those with partners, each partner is assigned half of their estimated joint non-housing wealth

Table A 4: Distribution of older homeowners by housing wealth and partnership

	Quartile 1 (low)	Q2	Q3	Quartile 4 (high)	
unpartnered homeowner	2%	19%	33%	47%	100%
partnered homeowner	38%	28%	21%	13%	100%
all homeowners	25%	25%	25%	25%	100%

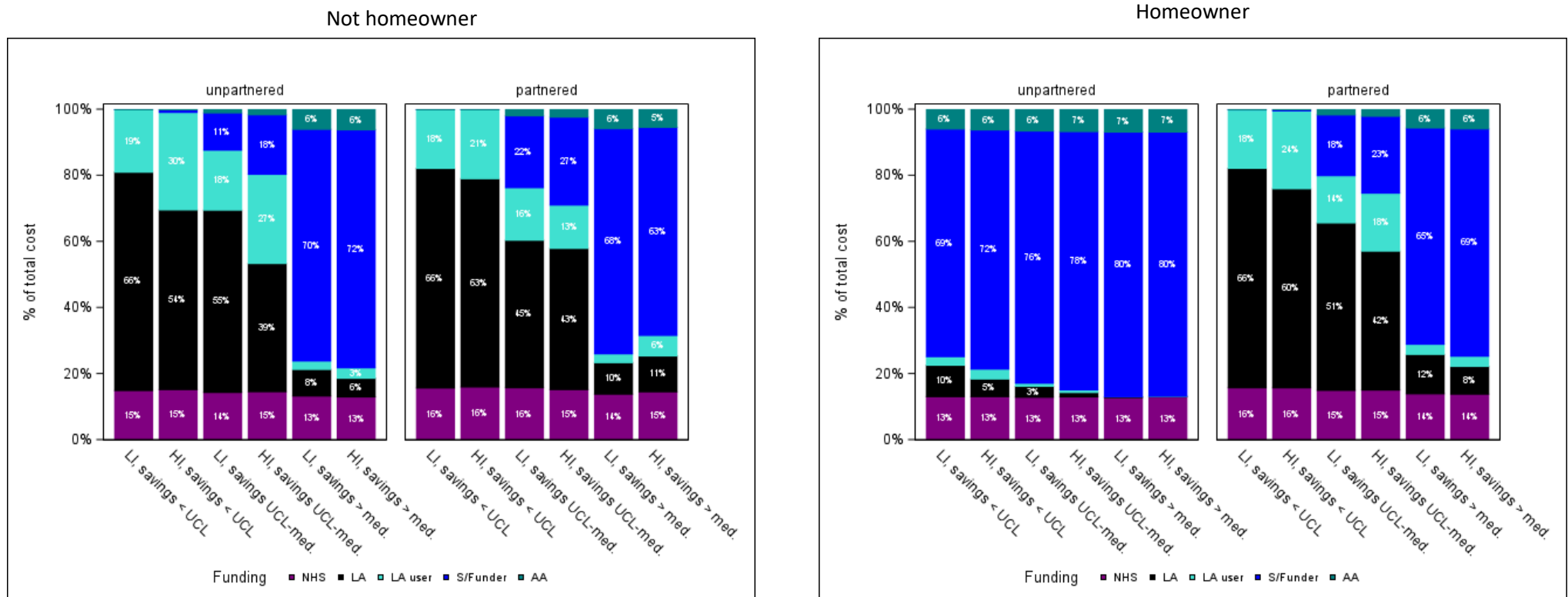
Note: For those with partners, each partner is assigned half of the estimated value of their property which is why partnered homeowners appear to have lower housing wealth than unpartnered homeowners.

Figure A 1: Funding sources, residential or nursing home care excluding NHS fully funded, average proportionate amounts by residential or nursing care, homeownership, partnership and income/non-housing wealth group



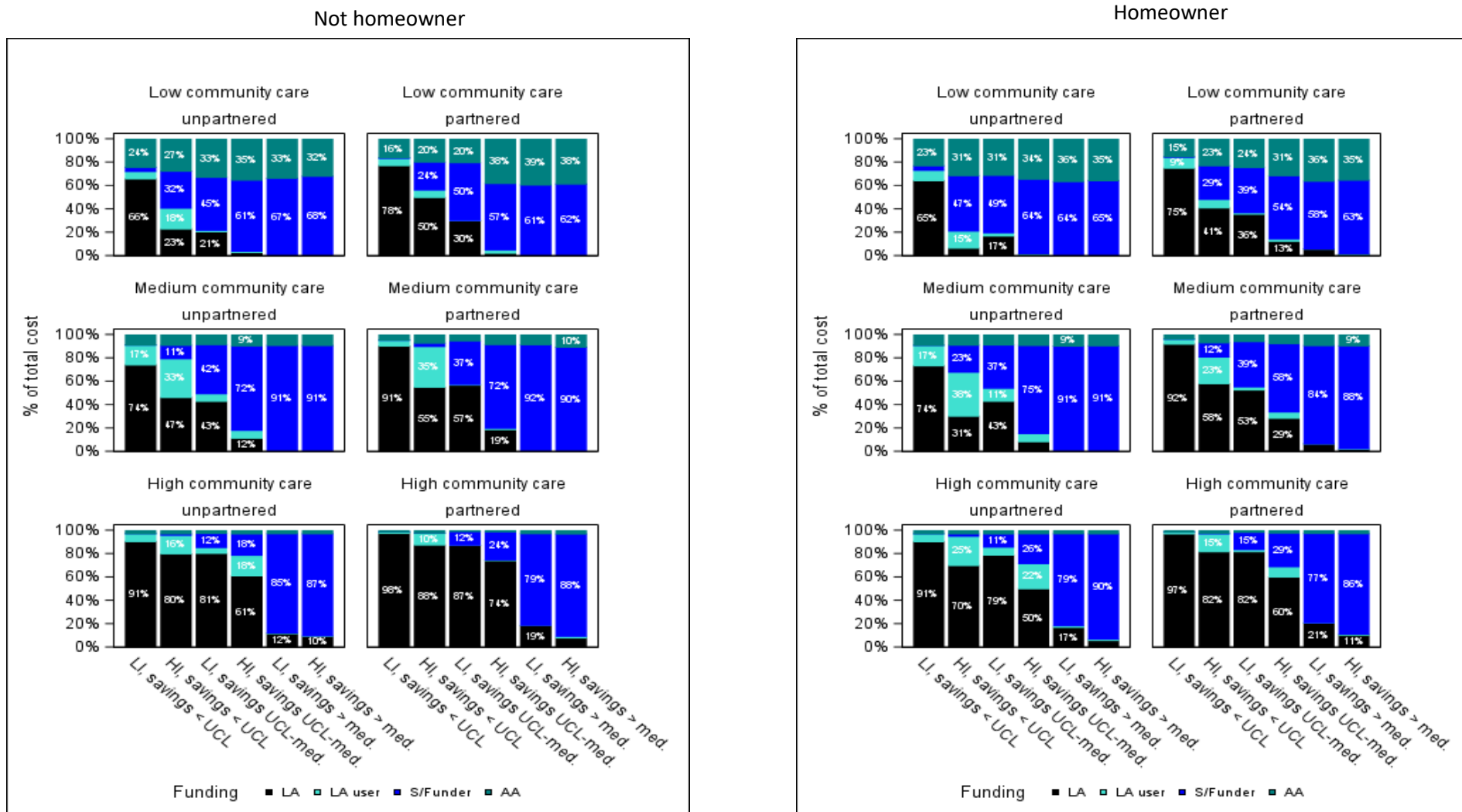
Notes: LI=low income (quintiles 1&2), HI=higher income (quintiles 3-5); 'nursing' **excludes** fully NHS funded

Figure A 2: Funding sources, residential and nursing home care combined, including NHS fully funded care, average proportionate amounts by homeownership, partnership and income/non-housing wealth group



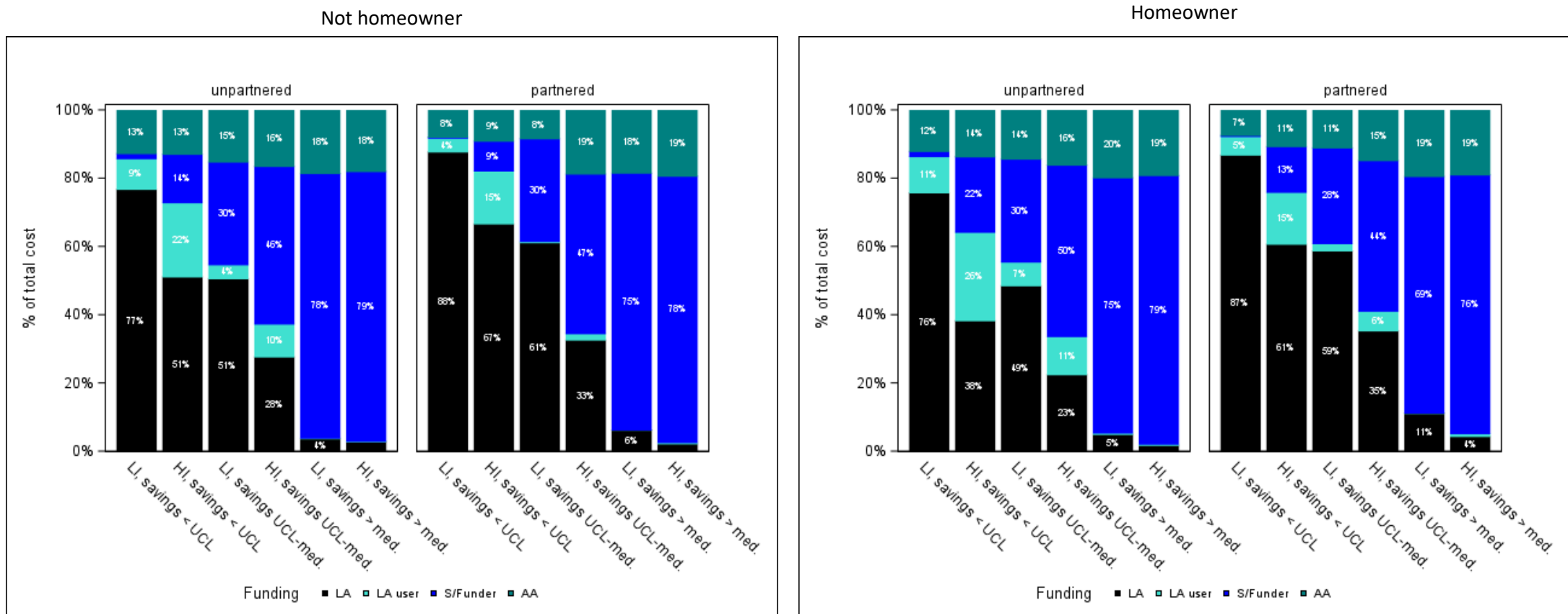
Notes: LI=low income (quintiles 1&2), HI=higher income (quintiles 3-5)

Figure A 3: Funding sources, community care excluding Direct Payments, average proportionate amounts by level of care, homeownership, partnership and income/non-housing wealth group



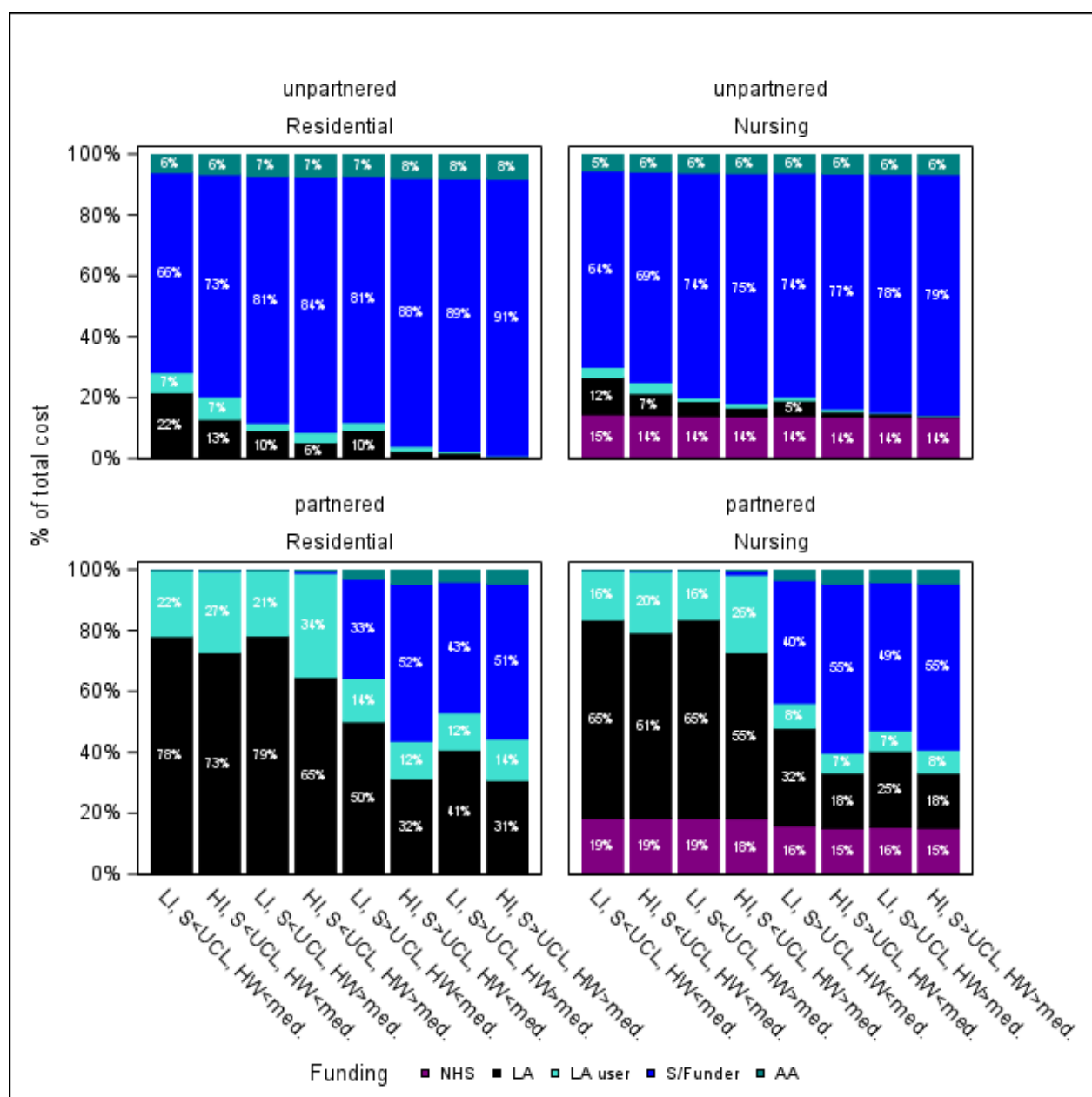
Notes: LI=low income (quintiles 1&2), HI=higher income (quintiles 3-5)

Figure A 4: Funding sources, all levels of community care including Direct Payments, average proportionate amounts, homeownership, partnership and income/non-housing wealth group



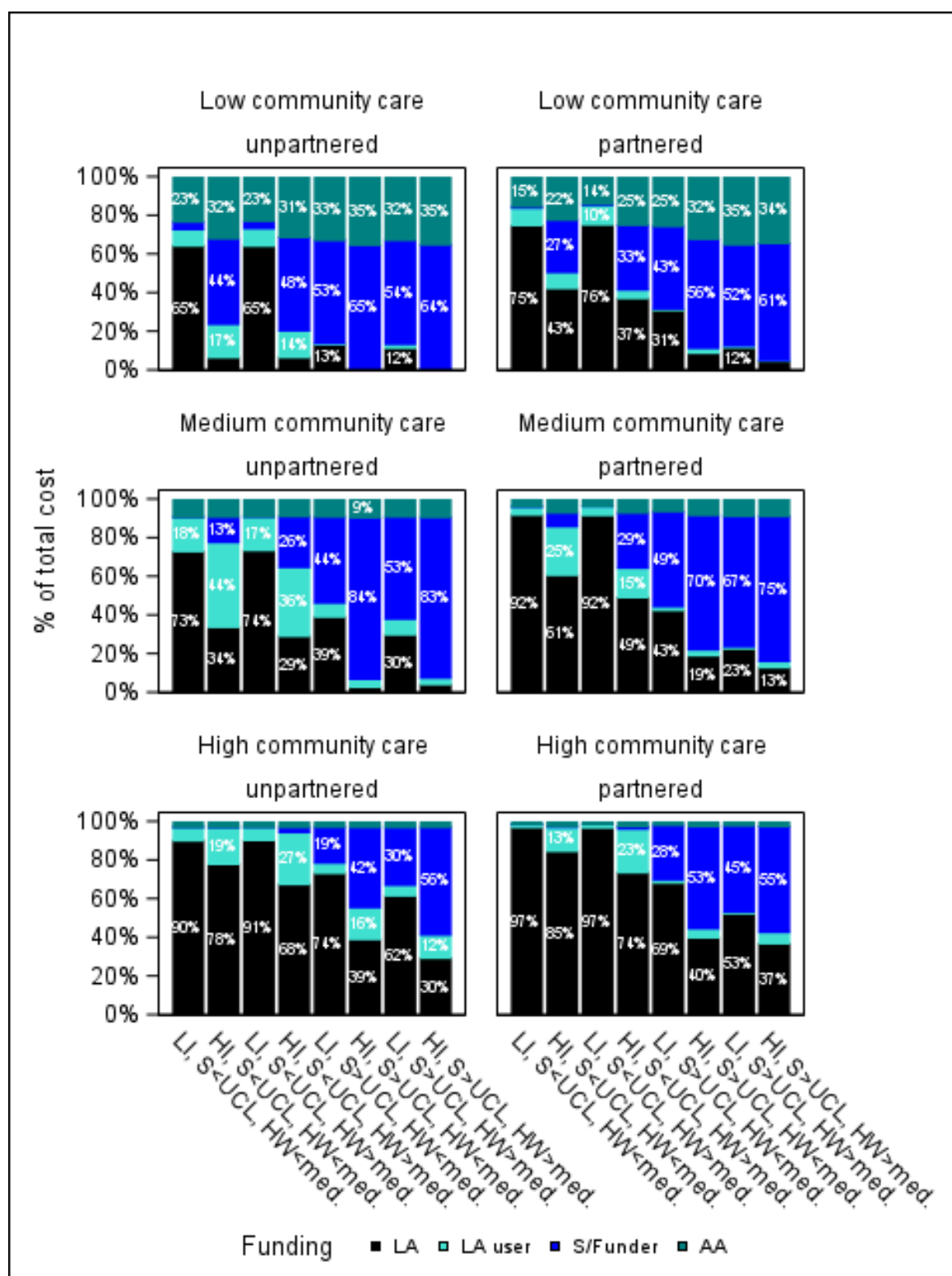
Notes: LI=low income (quintiles 1&2), HI=higher income (quintiles 3-5)

Figure A 5: Funding sources, residential or nursing home care excluding NHS fully funded, average proportionate amounts by residential or nursing care, homeowners by partnership and income/wealth group



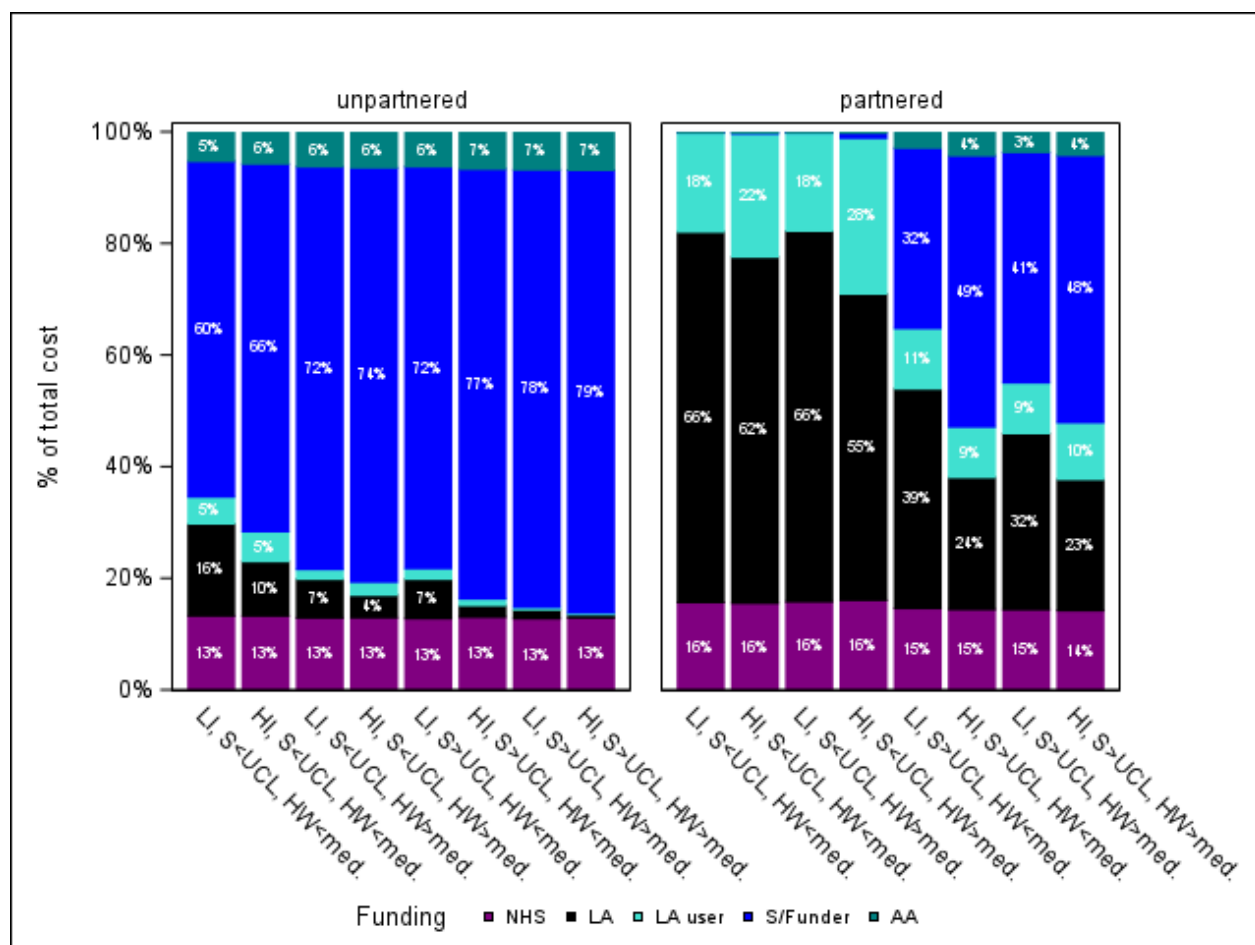
Notes: LI=low income (quintiles 1&2), HI=higher income (quintiles 3-5), S=savings (non-housing wealth), HW=housing wealth; 'nursing' **excludes** fully NHS funded

Figure A 6: Funding sources, community care excluding Direct Payments, average proportionate amounts by level of care, homeowners by partnership and income/wealth group



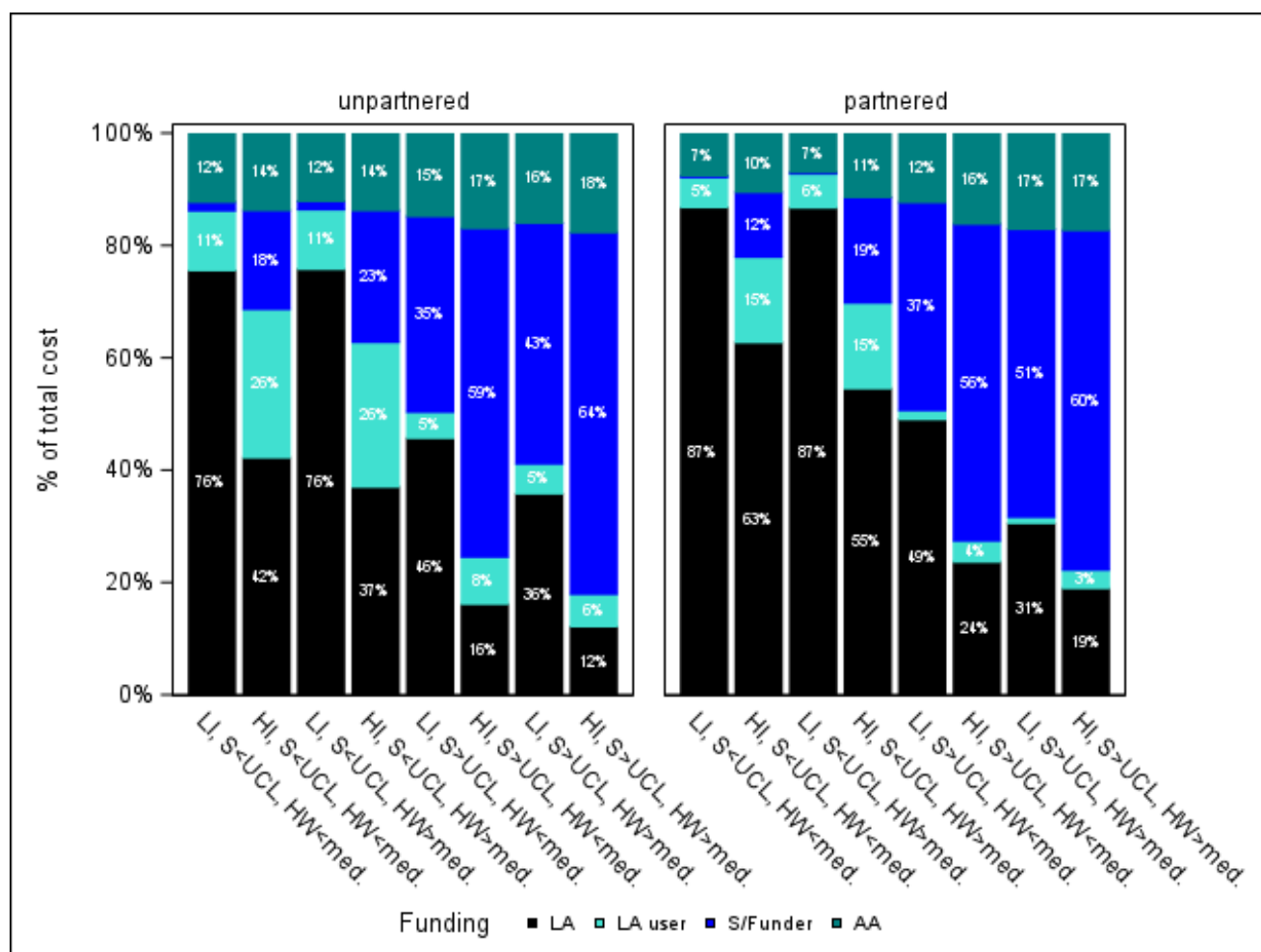
Notes: LI=low income (quintiles 1&2), HI=higher income (quintiles 3-5), S=savings (non-housing wealth), HW=housing wealth

Figure A 7: Funding sources, residential and nursing home care combined, including NHS fully funded care, average proportionate amounts homeowners by partnership and income/wealth group



Notes: LI=low income (quintiles 1&2), HI=higher income (quintiles 3-5), S=savings (non-housing wealth), HW=housing wealth

Figure A 8: Funding sources, community care including Direct Payments, average proportionate amounts, homeowners by partnership and income/wealth group



Notes: LI=low income (quintiles 1&2), HI=higher income (quintiles 3-5), S=savings (non-housing wealth), HW=housing wealth

Appendix Two

Further details of the simulation models

The CPEC long-term care projections model for older people model consists of five main parts. The first part estimates the numbers of older people with different levels of disability by age group, gender, household type, education and housing tenure. The second part estimates the levels of long-term care services required, by attaching a probability of receiving health and social care services to each cell. The third part of the model estimates total health and social services expenditure, and, in the fourth part, total expenditure is allocated to the various sources of funding. Finally, a fifth part relates to the social care workforce.

To enable the aggregate expenditure projections produced by the CPEC model to be split between public and private expenditure, the CARESIM model projects trends in:

- The proportion of older people by age group, gender, and household composition who (a) own their home and (b) left full-time education aged 16+ years,
- The proportion of older service users, by type of care package, who are required to fund their own care privately under the provisions of the current means test,
- The proportion of the gross weekly costs of publicly funded care, by type of care package, which older service users are required to meet in user charges.

To produce these last two sets of proportions, projections of the number and characteristics of older service users from the CPEC model are used as weights so that the CARESIM sample of people aged 65+ is rendered representative of the projected population of older service users. The weights are applied to the sample drawn from the FRS in the base year. For future years, CARESIM 'ages' individual members of the FRS sample and then applies the weights from the CPEC model.

CARESIM does not predict which sample members will need care. Applying the weights from the older people's macrosimulation model renders the sample representative in terms of demographic characteristics (age, gender, marital status, homeownership, and educational level), of the population projected by that model to be receiving different types of care.

The main economic and demographic assumptions used here are summarised in Box A1 below.

Box A1: Economic and demographic assumptions

- The number of people by age and gender changes in line with the Office for National Statistics (ONS) 2022-based principal population projections.
- Prevalence rates of disability in old age by age group (65-69, 70-74, 75-79, 80-84, 85+) and gender remain unchanged, as reported in the Health Survey for England 2011 to 2019.
- Homeownership rates and educational rates for older people change in line with projections produced by the CARESIM model.
- The proportions of people receiving unpaid care, formal community care services, care in a care home and disability benefits remain constant for each sub-group by age, disability and other needs-related characteristics.
- Health and social care unit costs rise in real terms in line with Office for Budget Responsibility (OBR, 2024) assumptions for future trends in productivity, except that non-labour non-capital costs remain constant in real terms and an uplift in unit costs is included for the years to 2025 to take account of the rises in employers national insurance contributions (ENICs) and the national living wage (NLW).
- The current social care funding system (i.e., the structure of the means testing rules) will remain unchanged, albeit thresholds for means testing are updated in the projection years.
- Real Gross Domestic Product (GDP) rises in line with OBR projections published in October 2024 (OBR, 2024).
- The supply of formal care will adjust in line with demand, and demand will be no more constrained by supply in the future than in the base year.
- Monetary values are expressed in base year prices (i.e., 2023/24) using known or forecast movements in the GDP deflator.
- The proportion of older care recipients whose care is privately funded and the proportion of the costs of publicly funded care met by older service users through user charges vary in line with projections from the CARESIM model.
- Monetary parameters within the long-term care and social security systems are assumed to maintain their values relative to known or forecast movements in the CPI with some exceptions, e.g. the triple lock for state pensions.

