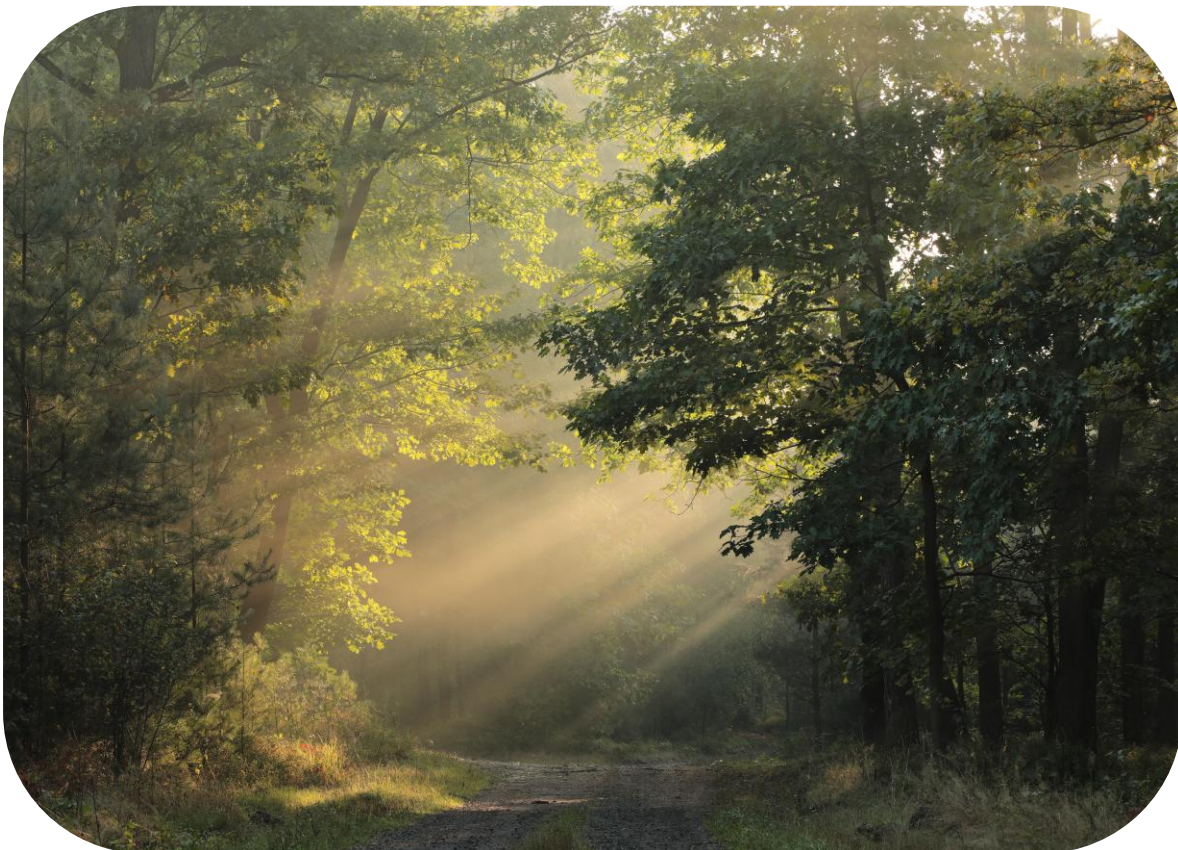


LCP on point



Opt-out Automatic Enrolment - a way out of the social care funding maze?

October 2026



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Executive Summary

As the population ages, more and more of us will need help with our daily lives of a type which is not provided by the National Health Service. But the costs of this ‘social care’ do not fall evenly.

As the population ages, more and more of us will need help with our daily lives of a type which is not provided by the National Health Service. But the costs of this ‘social care’ do not fall evenly. Someone who dies suddenly early in retirement may face little or no care costs, whereas someone who spends years in later life in a care home with dementia could easily run up a six figure bill – a bill which could eat up the value of their family home and other lifetime savings. It makes no sense for individuals to try to save for these largely unpredictable costs and, in any case, it is infeasible for most people to save at these levels on top of their pension provision, which is itself often inadequate.

The solution to this problem clearly lies in the pooling of this risk across society. But the private insurance market – in the UK and around the world – has found it largely impossible to come up with products. Open-ended future costs of social care, potentially decades down the line, are hugely difficult to predict and essentially uninsurable.

For that reason, we make the case in this paper for a “social insurance” model for England.¹

This would be delivered by building on the hugely successful policy of ‘automatic enrolment’ into workplace pensions, a policy which has increased the number of pension savers in the UK by more than 11 million since it started in 2012.

In our proposal, all taxpayers aged forty and above would be automatically enrolled into paying a premium, using the mechanism of an extra 1p on the basic rate of income tax. The maximum premium would come to a little over £30 per month.

Payment of this premium would qualify the individual for a discount on their contribution to their future care costs, a discount which would rise each year as they paid more in. Someone with 25 years in the system would be fully exempt from the requirement to contribute towards their personal care costs, thereby protecting their lifetime savings from catastrophic care costs.

However, as with automatic enrolment, this premium would be entirely voluntary. People would be free to opt out if they did not value this protection against future care costs.

¹ Given that Scotland has already adopted its own approach, this paper sets out a framework that could be applied in the first instance to England, though the devolved governments of Wales and Northern Ireland may wish to adopt a similar approach.

Indeed, we have assumed significant opt-outs, such as amongst those currently living in rented accommodation who may not have significant assets at risk in retirement.

We summarise below the similarities and differences between automatic enrolment for pensions and our proposed automatic enrolment for social care in England.

	For Pensions	For Social Care
What age group is enrolled?	22 to State Pension Age	All aged 40 and over
Who is enrolled?	Employees, earning £10,000 pa or more	Anyone with taxable income above the personal allowance, currently £12,570
What do they pay?	4% of 'qualifying earnings'	1% of basic rate tax band
Who does the enrolling?	Employers	Government
What do they get?	Steady build-up of a pension pot	Steady build-up of rights to free social care

But we come up with a startling conclusion. Based on what we believe are credible assumptions, this model helps to reduce the future care costs of millions of people whilst generating substantial up-front revenue for the government for years to come.

Some of this extra revenue could be used immediately to relax the tight capital rules which today debar those with even modest amounts of savings from any public funding towards their care costs.

Up-front revenue could also be prioritised for prevention: improving cardiometabolic health in mid-life, supporting effective obesity treatment where appropriate and helping unpaid carers and older people to maintain independence at home. This would give those paying into the scheme more immediate benefit, while reducing avoidable demand for both health and social care and potentially strengthening the scheme's long-term financial sustainability.

At a time when the new Prime Minister has indicated that he is willing to 'use political capital'² to find a solution to the problem of funding social care, and has initiated cross-party talks to this end, the time could not be better for fresh thinking on an issue which has been the subject of dozens of reviews over the last three decades.

There are many practical issues of implementation which would need to be considered, which we discuss later.

² See: www.theguardian.com

But as we have discussed these ideas with people from a range of perspectives, we have been struck by the enthusiasm for the basic principle of opt-out automatic enrolment as a means of helping us as a society to escape from the largely random and arbitrary risk of catastrophic social care bills later in life.

01 *The problem and case for reform*

How social care funding grew as an issue

When the post-War welfare state was designed, it was described as providing welfare ‘from cradle to grave’. In particular, care of older people was seen as primarily an NHS function. Life expectancy in post-War Britain was such that most people died well before the frailty of old age set in. The minority who lived long lives and needed additional care could be looked after in long-stay NHS hospitals or might be cared for by other family members.

Social care – help with daily life but not requiring medical expertise – was not an integral part of that original design. Where social care was required, those who could not afford it and had no family members to provide it might turn to a local authority for support. But any such support would only be available on a means-tested basis.

Four major trends since then have contributed to a growing issue around the funding and supply of social care.

These are:

- A dramatic improvement in life expectancy, with far more people now reaching old age and coping with frailty and in need of help
- The closure of long-stay NHS wards for the elderly
- Changing patterns of family life and employment, with far more women – the traditional care givers – now in paid employment
- The dramatic increase in homeownership, with around 70% of all retirees now owning the home in which they live

The resultant system sees hundreds of thousands of people in Britain today in need of social care but many of them unable to access state support beyond one specific social security benefit, namely Attendance Allowance.

These people may be deemed not to have needs sufficiently serious to qualify for local authority provision and/or they may be deemed to have too much by way of assets – including the value of the family home where relevant³ – to qualify for public funds.

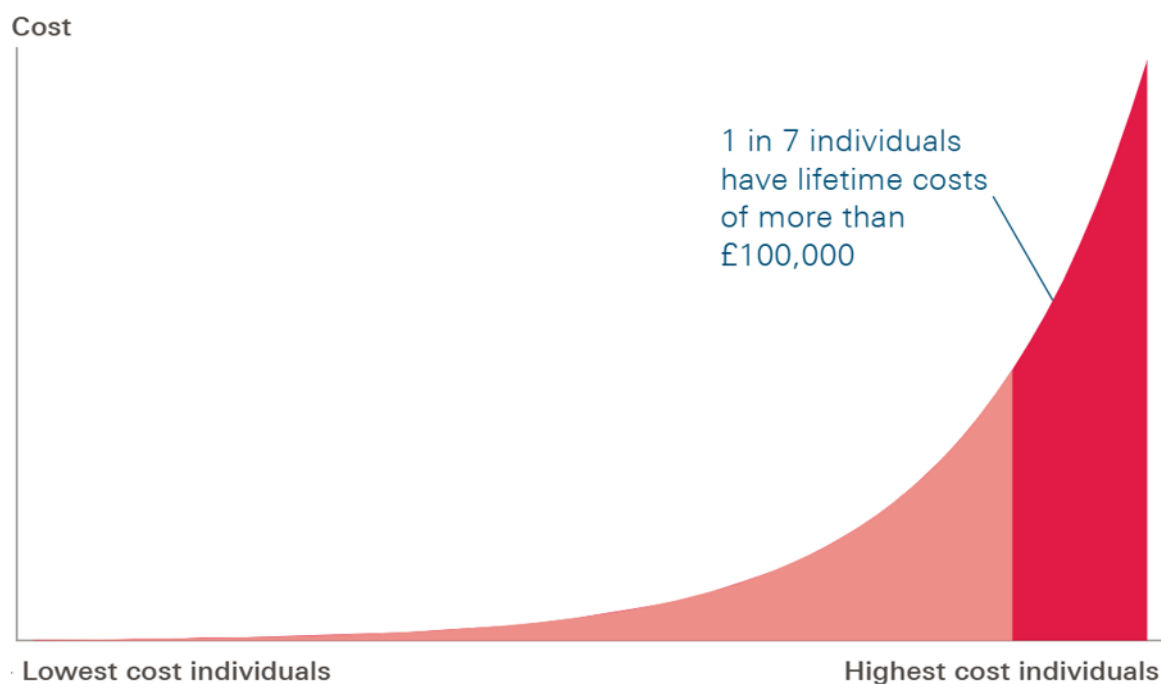
For those who do not qualify for public funds, there is a risk that they will rapidly run down their own lifetime savings, given the very high cost of care and of residential care in particular.

³ Where one member of a couple needs social care and the other is living in their family home, the value of that home is excluded from any capital test. But for a single person or surviving widow/widower, the value of the family home is counted if they are no longer living in it.

Whereas some people still die before they incur any care costs at all, others can have a prolonged period in later life where their care costs rack up, potentially ravaging the value of their savings. The 2011 Dilnot Commission on social care describes these as ‘catastrophic’ care costs.

This variation is summarised in the following chart, drawn from a 2024 Health Commission report, which itself is an updated version of a similar chart in the Dilnot Commission report

Future lifetime costs by individual



Source: [Social care funding reform in England | The Health Foundation](#)

As the chart shows, many people will have low lifetime care costs, but a minority will face exceptionally high costs. Around 1 in 7 are expected to have to find more than £100,000 in total.

As things stand, there is no real way for individuals to ‘pool’ this risk. Private insurance products for care costs are very limited, and the main product – the ‘immediate needs’ annuity – exists only to pool costs amongst those who already know they are likely to spend a period in residential care. There is no wider mechanism by which individuals can put in a premium which would pay out if they were the ‘unlucky’ one who ended up facing huge cumulative lifetime care costs which destroyed the value of their savings.

Official reviews and Commissions on social care

Issues around care funding, alongside wider questions about the quality and nature of social care and the social care workforce, have prompted a series of commissions and reviews stretching back more than a quarter of a century.

A notable example was the Royal Commission on Long-Term Care of the Elderly, which reported in 1999.

Its remit was:

“to look into how best to provide sustainable long-term funding for good quality care of the elderly and how the costs should be shared between taxpayers and the individual.”

The Commission’s main recommendation was for a system of taxpayer funded free personal care, though with individuals still responsible for their own normal living costs and housing costs. This recommendation was not taken up by the Government of the day.

There have been many further studies since then⁴, most notably the Dilnot Commission, set up by the Coalition Government and which reported in July 2011⁵.

The Dilnot Commission’s main recommendations were:

- A ‘lifetime cap’ on accumulated personal care costs, above which taxpayer funding would kick in
- An immediate increase to the capital limits which apply to those currently in the system, allowing people to hold more capital before they would be disqualified from public funding

The Dilnot proposals were initially welcomed by the Coalition Government and were included in the Care Act 2014, though not implemented at that stage. The plans were left on the shelf until they were picked up again by the Conservative administration of 2019-2024, with a view to implementation in October 2025. But this plan was immediately shelved by the incoming Labour Government in July 2024⁶.

In January 2025, the Government asked Baroness Casey to undertake a fresh review, with an interim report on ‘critical’ issues in the care system to be produced in 2026 and a final report in 2028.

⁴ According to the Prime Minister, there have been 22 reviews of social care since the Royal Commission: [Prime Minister’s speech on social care - 29 July 2026 - GOV.UK](#)

⁵ See: [Deposited paper DEP2011-1118 - Deposited papers - UK Parliament](#)

⁶ See: <https://www.gov.uk/government/speeches/chancellor-statement-on-public-spending-inheritance>

When Andy Burnham MP took over from Sir Keir Starmer MP as Prime Minister in summer 2026, he indicated that finding a resolution to the social care challenge was a priority and one on which he was 'prepared to spend political capital'⁷.

To this end, he asked the Casey Commission to bring forward its recommendations to 2027 and convened cross party talks to seek to establish a consensus on this issue⁸.

The purpose of this paper

This paper sets out a way of tackling the issue of 'catastrophic' care costs, which we believe has the potential to combine political feasibility with an effective solution which could be implemented relatively quickly. The proposal we advance, based around an opt-out automatic enrolment model, would provide a way for individuals to pool with others the risk of care costs wiping out their lifetime savings.

We start by setting out the thinking behind the model we are advocating. We then describe in more detail the design for an opt-out social care premium, collected through the income tax system. We show how this will quickly start to build up protection of family wealth when faced with high and enduring care costs. Next, we set out how some of the up-front funding generated by this proposal could be used to provide an immediate easement of current capital rules, as well as funding for preventative measures to help reduce the extent of need of social care support in later life.

In the Appendix, we provide a short summary, for context, of approaches to social care funding which have been adopted in other countries. We also provide sensitivity analysis showing how our central modelling results would be affected if key assumptions were to be varied.

We are sharing this analysis with all interested parties, including government and opposition parties and the Casey Commission. We are grateful to all of those who we have already discussed this paper with, but all comments and views expressed remain those of the authors.

⁷ See: www.theguardian.com

⁸ See: [Prime Minister's speech on social care - 29 July 2026 - GOV.UK](https://www.gov.uk/government/speeches/prime-minister-s-speech-on-social-care-29-july-2026)

02 *Designing a new social care contract*

The UK of the 2040s, where large numbers of people are likely to be living with frailty in later old age, bears little relation to that of the 1940s when the modern welfare state was designed. And this suggests that there is a need to reconsider whether the 1940s model, which still largely shapes the health and care system, is any longer appropriate, with particular reference to the place of social care.

One potential development of the 1940s model, where the National Health Service was designed to cover health needs ‘from cradle to grave’, would be to regard social care as an extension of the NHS. In this model, there would be no distinction (and no arbitrary dividing lines) between ‘health’ care and ‘social’ care. Both would be covered in full by the state, free at the point of use.

Such a proposal would however be extremely expensive. In 2024, the Health Foundation wrote that:

“Introducing an NHS-style model of universal and comprehensive care could cost around £17bn in additional funding by 2035/36”⁹.

Given current pressures on public spending and the extent of government borrowing and debt, it is hard to see such a comprehensive option being favoured. Previous attempts to introduce ‘free personal care’, such as the 1999 Royal Commission report referred to earlier, have gathered dust on the shelf, largely on cost grounds.

There is also an argument that such a model would, in any case, take the role of the state too far. An important component of the cost of residential care is what are sometimes called ‘hotel’ costs – board and lodging costs which (to varying degrees) we all expect to cover in later life. It is not clear why these should be free to those in long-term residential care (as opposed to short-term NHS stays), when those living in their own homes have to pay their own way.

In addition, those who do not own their own home – a growing group of the UK population – are unlikely to have significant assets in retirement and would generally already be entitled to means-tested help with social care costs. Across-the-board taxation to fund a ‘national care service’ would increase costs to renters – many of whom are on lower incomes – to help protect the assets of homeowners, an outcome which might be regarded as regressive.

⁹ See: [Social care funding reform in England | The Health Foundation](#)

At the other end of the policy scale, it could be argued that individuals should make their own provision, with social care simply being another cost for which individuals should save, or against which they should insure, and with a means-tested safety-net for those who are unable to do so.

There are, however, two major problems with this approach:

- Given the highly variable nature of lifetime social care costs, with some people having zero costs and others facing catastrophically high costs, it is very unclear how much people should save to cater for such extremely different potential outcomes; where risks are hugely unequal, it is more likely that insurance (where risks are pooled) is a more efficient solution rather than saving.
- As discussed earlier, the private insurance market, with limited exceptions, provides very little in the way of insurance products to protect against catastrophic care costs. From the perspective of the insurance provider, they are seeking to price a risk which may not fall due for decades to come, is of an indeterminate length and whose cost is highly uncertain. There is also great uncertainty about the future policy environment and what, if anything, might be covered by the state in future years. Against this backdrop, the market for private long-term care insurance products has never really taken off.

But there may be a third way, which combines the risk-pooling with a politically feasible funding source. This is social insurance, delivered through the mechanism of an 'opt-out' automatic enrolment scheme.

By social insurance we simply mean that all citizens (or those over a certain age) would be automatically enrolled into paying in to a common pool. Payments in would be broadly related to ability to pay. Those who incurred care costs would then draw on the pool. For modest average premiums, those who have contributed would be protected against the risk of 'catastrophic' care costs.

Some countries, such as Japan¹⁰, have opted instead for mandatory contributions. In this case, those aged 40 and over pay a mandatory levy to help towards the costs of social care.

There are several reasons why directly importing this approach to the UK might be problematic:

- The Labour Party manifesto included a pledge not to increase the headline rates of the major direct taxes – Income Tax and National Insurance Contributions; even if labelled with another name, any mandatory increase in taxation during this Parliament is likely to be regarded as a breach of this pledge; in addition, other political parties engaged in recently commenced all-party talks on social care have indicated their opposition to solutions based on across-the-board tax rises.

¹⁰ See Appendix 1 for a discussion of approaches to social care funding taken in other countries

- If the increase was via the National Insurance system, which is the current way in which the risks of unemployment, sickness and old age are pooled, this would raise serious intergenerational issues. This is because NICs are currently levied only on those under state pension age.
- A tax rise on those of working age to fund the care of the elderly might be regarded as further favouring a group which has already benefited from a range of other government policies, notably generous indexation of the state pension.

However, there may be a way to deal with these three issues. This would be to make the new contribution voluntary. Individuals would be automatically enrolled into the system but would be free to opt out.

This is the approach which has been adopted with great success in the sphere of workplace pensions. Starting in 2012, employers in the UK have been progressively required to enrol employees into a workplace pension but with the right of workers to opt out. Defying original government assumptions of a 25% opt-out rate¹¹, the opt-out rate has turned out to be not much more than 10%¹², and over 11 million more people are now saving into such pensions compared with before the start of the policy¹³.

We suggest in this paper that a similar approach could be taken to building up rights to free social care.

Given the point above about intergenerational fairness, we suggest a new social care premium which would be levied on all those aged 40 or over, including pensioners. This would be collected via the income tax collection mechanism, with an illustrative starting rate of 1p on the basic rate of income tax. By only levying the charge on the basic rate band, this would cap the maximum potential premium. Based on current tax bands in the UK (excluding Scotland), the maximum figure would be just over £31 per month.

Unlike income tax, this would be optional. As no-one would be obliged to pay, this could not be regarded as a breach of the Labour manifesto commitment not to raise direct taxes. But it would use a highly effective collection mechanism, coupled with a relatively progressive tax base, to generate substantial funds for social care.

A key question would be whether people would opt out or not.

¹¹ See: [Department for Work and Pensions report](#), paragraph 2.57

¹² See: <https://www.gov.uk/government/statistics/workplace-pension-participation-and-savings-trends-2009-to-2025/workplace-pension-participation-and-savings-trends-of-employees-2009-to-2025>

¹³ See: https://assets.publishing.service.gov.uk/media/6a073f6cf7c2e79c33db903d/Second_Pensions_Commission_Report_standard.pdf, p8

For the purposes of this paper, we assume that:

- Renters, who constitute around 40% of those in their early 40s, would all opt out as they are likely to have little in the way of assets to protect from care costs in later life.
- A proportion of homeowners would opt out, though declining with age (as care costs become much more real and tangible as you get older); for pensions we have seen an overall opt-out rate of little more than 10% based on a default contribution of 4% of qualifying earnings; in this case we are talking about a (much smaller) illustrative 1% social care contribution; however, we make a conservative assumption of a 20% average opt-out rate (with higher opt-outs for those in their 40s and 50s and lower opt-outs for those in their 70s and 80s). But we expect the power of inertia to remain a key factor in preventing large-scale opt-outs¹⁴.

One major advantage of this proposition is that those with most to lose from catastrophic care costs – those with the greatest wealth – would be most likely to value this form of insurance. And, if we assume that wealth and income are generally strongly correlated, this means that those with the highest incomes are least likely to opt out. This in turn makes the revenue base of the policy relatively resilient even if larger numbers on lower incomes choose to opt out.

In terms of what people get out for paying a contribution, we propose that the benefits should be on a sliding scale. Specifically, we suggest that anyone who pays into this scheme for one year should qualify for a 4% discount on any personal contribution they might be expected to make to their care costs in old age. Those with two years in the system would get 8% off and so forth, until those with 25 years would qualify for fully free personal care.

Such a scheme would obviously take time to mature, but it has the advantage that contributors start to benefit from the first complete year of contributions. With every extra year that they pay in, the exposure of their assets to potentially catastrophic costs is diminished.

This is illustrated in Table 1, which takes the case of someone who starts to need domiciliary care, using an average unit cost of £14,600 per year. The table shows the contribution to be made by an individual if they have assets over the current capital limit of £23,250, and how much they would gain if they had 5/10/15/20/25 years of contributions.

¹⁴ For evidence from the US on the power of inertia when automatic enrolment was applied to 401(k) pension arrangements, see: https://www.nber.org/system/files/working_papers/w7682/w7682.pdf

Table 1. Savings from new automatic enrolment scheme by number of years contributed

Years of contributions	Gross cost (per year)	Annual saving
(No scheme)	£14,600	n/a
5	£14,600	£2,920
10	£14,600	£5,840
15	£14,600	£8,760
20	£14,600	£11,680
25	£14,600	£14,600

The maximum annual premium is currently £377 (being 1% of the basic rate income tax band), so someone who paid in for 25 years would have paid in a maximum of £9,425 over their lifetime. This would generate a saving in the above example of £14,600 for each year that they needed care – substantially more than they had paid in. Of course, others who paid in might face little or no care costs in later life and would get out less than they pay in.

There is a further question as to what should be done for those currently in or approaching the social care system and with little realistic prospect of building up a meaningful record of contributions.

We propose that, as a downpayment on the new system, there should be an immediate and significant relaxation of the existing ‘capital limits’ which govern social care funding in England, similar in principle to that proposed by the Dilnot Commission, though not as generous¹⁵. At present, individuals in England are ineligible for help with social care costs if their assets (including the family home if it is no longer needed) exceed an upper limit of just £23,250. If their capital exceeds a lower limit of £14,250, but is lower than the upper limit, an income is ‘imputed’ from the capital in excess of the lower limit, but they may still be eligible for help.

Instead, we propose a substantial increase in the upper capital limit to £100,000 and an increase in the lower limit to £25,000. We provisionally estimate that the cost of such a change would be around £1 billion but are awaiting updated estimates.

From a fiscal perspective, the major advantage of this proposal is that millions of people, including many of working age, start paying contributions now, but only draw down on their new rights potentially in decades to come. In the interim period, this additional revenue can be used to make immediate improvements. The full benefits of the new regime take time to mature, but the public can see a significant gain immediately.

¹⁵ The Dilnot Commission proposed an upper capital limit of £100,000 but this was in 2011 which would now be the equivalent of more like £150,000. For our purposes we need to strike a balance between immediate improvements for those who have not had time to pay in, and a fair deal for those who have contributed, potentially for many years.

We also believe that some of this upfront revenue could be used for what could loosely be described as ‘preventative’ measures. By this we mean measures which could reduce the length of time during which people needed social care, and potentially the intensity of the care that was needed.

For example (and as discussed more fully in Section 5), up front revenue could be used to develop interventions which could potentially delay the onset of dementia. If successful, this would be of benefit not just to the individual concerned, both personally and financially, but also to the state as the total cost of social care needed for the individual would be lower. In short, the ‘new contract’ with the state includes giving a new priority to preventative measures and not merely picking up the pieces when things go wrong.

In the next section, we present some modelling to show how an opt-out automatic enrolment system of this sort might work and whether the sums would add up.

03 *Modelling an opt-out automatic enrolment system – a core model*

As set out in the previous section, we propose an ‘opt-out’ automatic enrolment scheme to apply in England with the following features:

- Applying to all taxpayers aged 40 or over
- Based on a ‘premium’ equivalent to 1% on the basic rate of income tax
- Individuals would be entirely free to opt out of paying this premium
- Each year you pay in, you get 4% off your financial contribution to social care costs. After 25 years of paying in, you will need no contribution toward your core social care costs.

In addition, it is envisaged that, as part of the package, there would be an immediate increase in the capital thresholds for social care, with the lower limit rising to £25,000 and the upper limit to £100,000.

In this section, we look at the potential revenue and costs for such a policy.

a) Potential revenue

To estimate the potential revenue from this new premium, we need the following data and assumptions¹⁶:

- **Number of taxpayers and taxable income (at the basic rate) by age**, allowing us to exclude those aged under 40 and focus just on the basic rate band, and to include those living in England only. For this we use the Survey of Personal Incomes (SPI) micro data, for which 2022-23 is the latest available year. We uprate this to 2026-27 values by scaling the amount of taxable income by the published ‘ready reckoner’ estimates of the yield of 1p on income tax in 2022-23 and 2026-27¹⁷, before reflatting to 2028-29 prices for comparability with care cost estimates.
- **Proportion of people who are renters by age**: We assume that it will only be those who have assets to protect who will be interested in social insurance for care costs; on the basis that most renters will have very limited assets in retirement, we assume 100% opt out amongst this group, which we apply based on the rate of renting in different age groups; this is derived from the latest English Housing Survey¹⁸.

¹⁶ We test the sensitivity of our results to variations in these assumptions in Appendix 2.

¹⁷ We use ‘full year’ revenues from [Direct effects of illustrative tax changes bulletin \(June 2025\) - GOV.UK](#) and [\[ARCHIVED CONTENT\] Direct effects of illustrative tax changes bulletin \(June 2021\) - GOV.UK](#)

¹⁸ [FA1201 age of household reference person by tenure.ods](#)

- **Assumed opt-out rates amongst home-owners:** we do not know how many people would opt out of a voluntary social insurance premium based on 1% on the basic rate of tax. The only obvious benchmark is that the 4% default pension contribution under automatic enrolment is associated with an opt-out rate of just over 10%. On the basis that some people may opt out of social insurance for care because they do not think it will be relevant to them (whereas most people think they may be old and need a pension), we assume, for illustration, a 20% opt-out rate for homeowners on average. As shown later, within this overall average, we assume that the oldest (who are closest to needing care) will be less likely to opt out, whilst those furthest away will be more likely to opt out. The weighted average across all taxpayers and tenure types is an assumed opt-out rate of around 42%, roughly four times the opt-out rate of those automatically enrolled into workplace pensions.
- **Income tax share from England:** We assume that as Scotland has its own system of free personal care, the extra social care premium collected via the income tax system would not apply in Scotland. We also assume that the devolved governments of Wales and Northern Ireland would need to decide whether to use this mechanism, so for now we only include income tax revenues from England.

The resultant assumptions and calculations of revenue are summarised in Table 2.

Table 2. Estimation of potential yield from new social care premium in England¹⁹

Age band	No. of taxpayers (m)	1% yield per person per year (if 100% take-up)	% renters (all opt out)	Assumed further opt out (homeowners)	Combined opt-out rate (renters and homeowners)	Total revenue
40-44	3.1m	£328	40%	30%	58%	£432m
45-54	5.9m	£331	33%	25%	50%	£980m
55-64	5.3m	£296	31%	20%	45%	£859m
65-74	4.4m	£217	20%	15%	32%	£643m
75 & over	4.2m	£177	19%	10%	27%	£546m
Total					42%	£3,460m

For the rest of our modelling, we assume that both revenues from the new premium and costs of care will rise simply because of inflation²⁰. To simplify the analysis, we therefore strip out purely inflationary increases in costs/revenues and keep everything in 2028-29 prices (as this is the first year in which the discounts could start to apply).

¹⁹ Note: For consistency, all cost and revenue figures are expressed in 2028/29 prices.

²⁰ We deal with rising costs owing to demographic pressures separately.

However, we do note that the yield from a 1p increase in income tax has been extremely buoyant in recent years.

In part, this is because of the repeated freezing of the starting point of income tax, meaning that more and more people are being brought into income tax and the proportion of their income which is taxed is going up. That policy is set to continue until at least 2030, which suggests that even if care costs were to rise faster than inflation, there is a strong chance that the revenue base would also rise to keep pace. We discuss this point further in Appendix 2.

In terms of the potential number of people building up discounts on their future social care costs, based on the opt-out rates shown in Table 2, we estimate that just over 13m people would be paying in, and potentially benefiting from the scheme.

b) Potential costs – reductions in personal contributions to social care costs

Under our proposed scheme, those who had paid the new premium for one year would have a reduction of 4% in their personal contribution to their care costs. After two years this would rise to 8% and so on until, after 25 years of contributions, they were fully covered. In this section we estimate the likely cost of this new provision.

To estimate the likely cost per person of the new easement, we need to know:

- How many older people receiving residential care and domiciliary care are ‘self-funders’. There are a range of data sources which we could use, and the Scottish experience provides some pointers as well. But for a consistent approach, we use a recent projection published by leading academic experts in the area²¹ which suggests that by 2028²² the number of older people self-funding residential care will be around 159,000 and the number self-funding care in their own home will be around 146,000.
- It is however interesting to compare these numbers with the Scottish experience of ‘free’ personal care to date. Since the size of the residential care home population is difficult to expand, increased demand for care after it became free is likely to be seen in the use of ‘free’ domiciliary care. Official Scottish figures²³ suggest that 4.8% of the Scottish population over the age of 65 now get Free Personal Care in their own home. Applying this percentage to the population of England and Wales would give a figure over 580,000 total users of domiciliary care, compared with around 420,000 (including publicly funded cases) forecast by the Health Foundation. Given that in our model the progression to free personal care is only complete after 25 years in our model, we would not expect a surge in demand on the scale implied by the Scottish rate of use. But we do undertake sensitivity analysis in the Appendix to test how far a much higher take-up rate of domiciliary care

²¹ Hu, B., Hancock, R., Wittenberg, R., Mayorga Camus, J. & Pauschardt, J. (2026). Projections of adult social care demand and expenditure in England, 2023 to 2043. Care Policy and Evaluation Centre: London, UK.

²² We assume that if the proposed policy were to be implemented in 2027-28, then 2028-29 would be the first year in which someone would first qualify for a discount on their social care costs.

²³ See: <https://www.health.org.uk/reports-and-analysis/briefings/social-care-funding-reform-in-england>

would affect the overall finances of the scheme.

- For the cost per person, we are able to look at data from Scotland, where a policy of free personal care is already in place²⁴. For those in residential care, there is a standard ‘tariff’ rate of £260.30 per week (in 2026/27) towards personal care costs, whilst for domiciliary care, the average contribution from the public purse was reported to be around £238.46 per week in 2024/25²⁵. We use the GDP deflator to take both figures up to 2028/29 prices and take a weighted average to give a unit cost across both sectors of £265.75 per week or £13,819 per year.
- Once the new system is up and running, the people who will qualify for the easement will be those who have paid in at least one year under the new system. This therefore excludes those who a) have not paid income tax since the scheme started and b) those who opted out. However, we assume that the self-funding population will overwhelmingly overlap with the taxpaying population, so the only current self-funders who will not qualify are those who have opted out. We have assumed that this will be around 10% for those likely to call on the scheme in the early years.

Table 3 shows how these assumptions combine to give us a year-by-year cost assumption. To simplify the presentation, we have combined residential and domiciliary care, so the number of self-funders is the combined total for the two sectors, and the unit cost is a weighted average cost across both.

Table 3. Year-by-year costs of opt-out automatic enrolment scheme for social care

	No of self-funders	% not opted out	Unit cost	Cost reduction	Exchequer cost
2028-29	305,000	90%	£13,819	4%	£152m
2029-30	305,000	90%	£13,819	8%	£303m
2030-31	305,000	90%	£13,819	12%	£455m
2031-32	305,000	90%	£13,819	16%	£607m
2032-33	305,000	90%	£13,819	20%	£759m
2033-34	305,000	90%	£13,819	24%	£910m
2034-35	305,000	90%	£13,819	28%	£1,062m
2035-36	305,000	90%	£13,819	32%	£1,214m

As Table 3 shows, the cost of the scheme grows steadily as people have more years in which to build up a reduction in their contribution to care costs. However, even after eight years of the policy, the Exchequer cost is substantially below the premium income shown in the previous section.

²⁴ See: <https://www.gov.scot/publications/free-personal-and-nursing-care-scotland-2024-25/>

²⁵ See: <https://www.parliament.scot/chamber-and-committees/committees/committee-reports/hscs/2026/2/24/hscss062026r10?#dp61479>

²⁶ See: [Free personal and nursing care: statistics - gov.scot](#)

As noted above, we ignore inflation in both costs and revenues, presenting all figures in current terms.

But there will be a second upward pressure on costs which will arise from demographic pressures. The expected growth in the number of older pensioners in the coming years is likely to lead to increased demand for social care services, which would need to be covered by the new scheme.

To give an order of magnitude on potential costs, we return to the Health Foundation projections which formed the basis of our estimates for 2028. The same publication provides projections of the number of self-funders in a) domiciliary care and b) residential care over the next 15 years. The results are a projected growth of around 2.5% pa in domiciliary care numbers and 2.75% pa in residential care numbers. We therefore use these as the basis for assessing potential demographic-led cost pressures.

The results are shown in Table 4.

Table 4. Year-by-year costing of new scheme, including demographic pressures

Year	Exchequer cost
2028-29	£152m
2029-30	£311m
2030-31	£479m
2031-32	£656m
2032-33	£842m
2033-34	£1,037m
2034-35	£1,241m
2035-36	£1,456m

Compared with the baseline with no demographic pressure, this version increases cost in year 8 by around 20%. This shows that it is important to factor in demographic pressures into any modelling, and so it is these figures, including expected demographic change, which we use in the rest of this paper.

c) Potential costs – immediate increase in capital limits

Under the current system in England, those with capital in excess of £23,250 are not eligible for taxpayer help with the costs of social care. Those with capital between £14,250 and £23,250 may be eligible, but an income is imputed from their capital, at a rate of £1 per £250 in excess of the lower capital limit. Anyone with capital below £14,250 has it ignored completely.

This regime means that even relatively small amounts of capital make people ineligible for help, and they can exhaust most of their savings before state assistance kicks in.

The Dilnot review, in addition to suggesting a lifetime cap on care costs, also proposed an immediate easement of the capital rules. Such an approach gives immediate benefit to those who would not benefit from any longer-term reform.

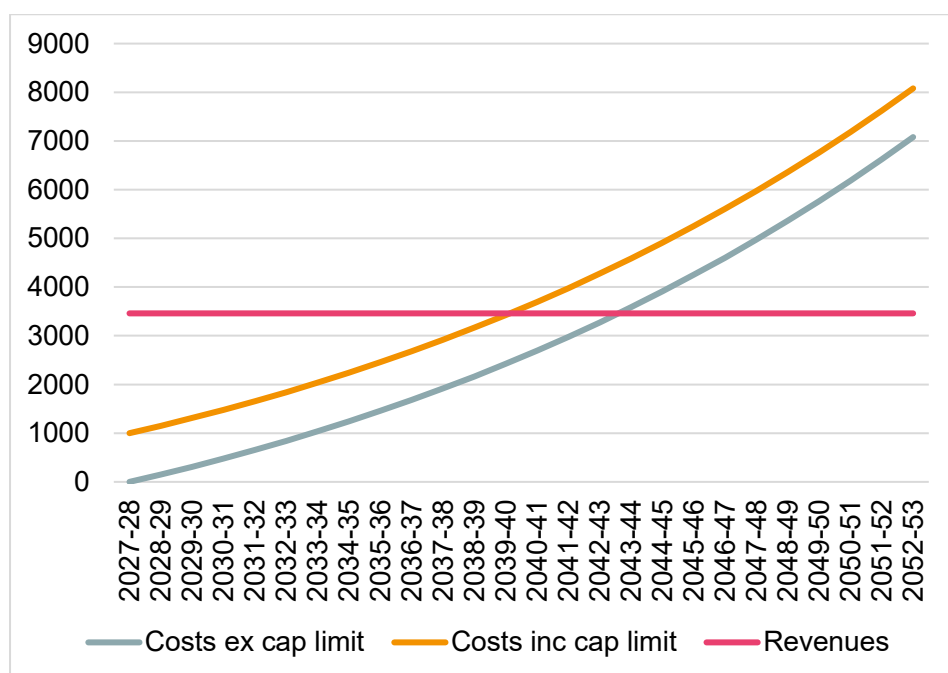
We suggest something similar, proposing the immediate introduction of a substantially increased Upper Capital Limit of £100,000 and a raised Lower Capital Limit of £25,000. Our provisional estimate is that this will cost around £1 billion in the first year, though we are awaiting updated official estimates.

d) The combined profile of revenues and expenditure

Having constructed a profile of revenues from the opt-out social insurance premium and of costs from the new discount scheme and from the immediate increase in capital limits, we can see the balance between revenues and costs as the scheme matures.

This is shown in Figure 1, and now we run on until the first people are receiving 100% cover, having had the opportunity to pay in to the system for 25 years.

Figure 1. Costs and revenues (£m, 2028/29 prices) – first 25 years with / without capital limit



What is striking about Figure 1 is that the policy generates net revenue to the Exchequer until the end of the 2030s, even once account has been taken of likely demographic pressures. This revenue presents huge opportunities to do more in the field of 'prevention' which could reduce overall demand for social care in the long run and thereby reduce the net costs of the scheme whilst also benefiting the individuals concerned.

Eventually, of course, the scheme starts to cost more money than it raises, though it would be fair to say that the costings become increasingly uncertain the further into the future we go. In terms of dealing with this, one obvious solution would be to increase the opt-out social care premium if needed. But another would be to use the time between now and then to implement preventative measures which could mitigate the otherwise rapidly rising cost of social care. If such measures were successful, they could significantly alter the long-term financial balance of the package as a whole.

04 Modelling an opt-out automatic enrolment system – issues for further consideration

The purpose of this paper is to set out a high-level solution to the challenge of funding social care for older people in a fairer way. But many questions would need to be answered before such a system could be implemented in practice. In this section we note a number of important issues which would need to be addressed.

a) What counts as social care?

When taking out any insurance policy, there needs to be a clear definition of what is and is not covered. When it comes to a house burning down or a car being written off, the risk is pretty clear. But in the case of social care costs, there are many more grey areas.

There seems to be general acceptance that any element of costs which represent ‘hotel costs’ would not be covered. All of us who live long enough can be expected to feed ourselves, heat our homes etc., and there is no obvious need to ‘pool’ the risk of having to meet such costs.

We also assume that, at the other end of the scale, genuine ‘nursing’ costs would continue to be covered in England by the ‘free nursing care’ contribution which nursing homes receive from the government.

The balance of fees is likely to cover personal care costs and a decision would need to be made as to what the scope of insurance cover would be.

We assume that ‘core’ costs would be covered, where someone needs help with things like:

- Getting up in the morning and going to bed in the evening
- Help to prepare meals, and help with eating them
- Assistance with washing, bathing and using the toilet

There would, as now, continue to be a ‘needs’ test, so that only those who demonstrated that they actually needed this type of help would qualify.

But beyond this, a decision would need to be made about what further support might be covered. For example, if someone could not easily clean their own home, would help with this be covered? This is not directly ‘care for the person’, but clearly the inability to keep a home clean could have a significantly adverse impact and would probably need to be covered.

On the other hand, some things which are important to quality of life, but not within the narrow definition of 'care' might not be covered.

For example, there is no doubt that being able to get out of the house and socialise, visit the shops, go to the cinema etc., would all improve someone's quality of life. But it is probably unlikely that the cost of paying someone to help make these things possible would be likely to be included in the costs covered.

It is beyond the scope of this paper to come up with a detailed list of what would and would not be included, and this would to some extent be a political decision. But what we have done is show, in the Appendix, how the costs of the scheme could rise substantially if a very broad definition of personal care was used, as distinct from the rather narrow definition we have assumed, based in turn on the Scottish model.

b) The role of Attendance Allowance (AA)

There is already a very significant taxpayer contribution to the costs of care in the form of Attendance Allowance, and careful thought would need to be given to how this system could be reformed once a social insurance scheme was up and running.

Attendance Allowance is a social security benefit available on a non-means-tested basis to anyone over pension age who needs significant care during the day, at night or both. Those who need care only in the day (or only in the night) get the lower rate of benefit, and those who need care both day and night get the higher rate. These are currently, respectively, just under £4,000 per year and just under £6,000 per year.

Attendance Allowance currently costs around £9.2 billion per year and is paid to around 1.85 million people.

Under the current system, the main beneficiaries of AA are those who fund their own care costs. Where people are publicly funded – for example in a care home – any AA that they receive is knocked off the funding they receive from a local authority, so whether they get AA or not makes no difference. But where people are paying for their own care, a payment of £4,000-£6,000 per person can make a valuable contribution to costs.

In Scotland, those who receive free personal care in their own home can receive the Scottish version of AA (Pension Age Disability Payment) on top, but entitlement ceases after 28 days in residential care.

Where the Government has proposed reform of social care funding in the past, it has assumed that once care becomes free (for example, for those in excess of the ‘Dilnot’ lifetime care cap, or those who become state funded following an increase in capital limits), AA would be withdrawn²⁷.

In the case of our proposed social insurance scheme, any impact on AA would need to be more gradual. There is no overnight change to eligibility for most people – simply a gradual percentage reduction in their personal contribution to their care costs. It would clearly be hard to persuade people to insure against care costs if the first thing that happened having insured was that they lost access to thousands of pounds of state support which those who were uninsured would continue to get.

On the other hand, once people start being entitled to 100% rebates on their care costs, it is hard to see why they should receive thousands of pounds a year in Attendance Allowance towards those same care costs.

It may be that AA could be operated on a gradually sliding scale, with somewhat lower help to those with lower net care costs, and this would generate some further savings which could be reinvested in the system. But governments should be wary of going too far and undermining the incentive to insure in the first place. We have therefore not so far scored any savings on AA as part of our costings.

c) The potential for opt in – especially amongst non-taxpaying retirees

One drawback of our proposed social insurance scheme is that it takes time to mature. At a rate of 4% discount per year of contributions, no-one would qualify for a full rebate until they had paid in for 25 years, so some time in the early 2050s.

If the scheme proved popular, there might be some appetite for two forms of ‘opt-in’ behaviour:

- Individuals who were not taxpayers opting to pay a premium in any case;
- Individuals who were taxpayers but could not build up full cover in time being able to buy ‘additional years’, again at a set premium.

The idea of voluntary social insurance is a feature of the current National Insurance system, whereby those who do not earn enough to pay NI Contributions can opt to pay voluntary contributions at a set rate. This might be, for example, to help build up entitlement to a full state pension.

²⁷ See, for example, the 2022 Impact Assessment for Social Care Charging Reform [Impact Assessment template](#), which counts as a benefit on p4; “Financial benefits to government due to a reduction in benefits allowances payable (Net Present Value £1.28 billion) as some benefits, such as Attendance Allowance, are only available when not receiving state support.

In the case of care insurance, whilst there are attractions in helping people to build up cover more rapidly, there are clearly risks – most notably the risk of individuals ‘selecting against’ the scheme.

To give an extreme example, if I were to discover that I would shortly need expensive residential care, I might try to ‘buy back’ as many years as I could in order to qualify for something approaching a 100% discount on my care contribution.

There would be a high risk that the price of doing so could be small relative to the amount saved in care contributions, thereby undermining the finances of the scheme.

To try to avoid this, a more modest proposal would be to allow people to opt in to year-by-year contributions (at a set premium), but not to top up in bulk. This could mean, for example, that someone who was early retired and a non-taxpayer when the scheme came in could opt to pay voluntary contributions and gradually build up cover. Those who already knew they had imminent care needs would not have time to build up significant cover, reducing the risk of adverse selection.

d) Minimum premiums?

We have proposed that the premiums for this scheme would be collected via the income tax collection mechanism and would be based on the equivalent of 1p on the basic rate of income tax.

However, if adopted in precisely this way, there would no doubt be some people with low levels of taxable income who could receive exceptional value for money compared to those who might be contributing hundreds of pounds each year for the same cover.

To some extent, an element of cross-subsidy is a design feature of any social insurance system and is not fundamentally unfair.

But there could be concerns about the fairness of the system if:

- a) Some people’s premiums literally amounted to pennies because their taxable income was only just above the tax threshold.
- b) People, such as the self-employed, were able to manipulate their income for tax purposes so that they earned just enough to pay tax and get insurance cover, but still pay relatively little into the system.

If these concerns proved significant, one option would be to have a minimum monthly premium to qualify for cover.

The maximum premium, based on 1% of the full width of the basic rate band, is currently just over £30 per month²⁸. So, an appropriate minimum contribution could be set at £10 per month, meaning a multiple of no more than three times between the lowest and highest contributors.

There are however downsides to such a proposal.

The first is that this is administratively messy.

Whether or not someone's 1% contribution amounted to £10 per month or not would depend on their total taxable income from all sources and would not be known finally until the end of the tax year. It would be messy to have to refund contributions of under £10 per month, and there is also a risk that this could happen every year if someone was on a persistent low income (such as a retiree) and did not opt out.

The second problem is that this approach could rule out those who have relatively low incomes but significant wealth at risk of care costs. An example might be the 'cash poor, asset rich' widow, who had a modest taxable income but significant wealth tied up in the family home.

A minimum premium of £10 per month would in practice exclude anyone with taxable income of £12,000 over the threshold, so a total income of £24,570, which would rule out a significant number of pensioners.

This could also create a cliff edge where someone whose state and private pension income falls just below the minimum is unable to obtain cover – and remain at risk of catastrophic care costs – whilst someone just above could gradually build up full cover.

It may be that a rather low 'de minimis' to avoid trivial contributions generating cover would be appropriate, but this is a design decision which would need to be made by the government of the day taking account of operational considerations and the risk of complicating the simplicity of what is proposed.

e) Administration

Implementing a major change like this would undoubtedly involve significant changes to HMRC systems.

These would include:

- Operating a different income tax rate in England (though there is, of course, precedent in doing this for Scotland)

²⁸ This is simply the gap between the starting point for higher rate tax at £50,270, and the level of the personal allowance, currently £12,570, taxed at 1%, which is £377 per year or £31.42 per month.

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- Communicating and operating an opt-out mechanism, ensuring that those who did not want to pay into the system did not do so
 - Creating new records of years of paying into the system, akin to the current system of storing 'qualifying years' towards the state pension

Early work would be needed on setting up administrative systems, in parallel with the development of the relevant legislation, so that the new system could be implemented without undue delay.

For simplicity we have assumed that the new contributions would start flowing next year (2027-28) and the first people would start benefiting from savings in 2028-29, but in practice it would be likely to take longer than this, both to complete the necessary legislation and regulations and to set up the required administrative infrastructure.

04 Prevention: changing future need and the size of the funding problem

One great advantage of the model we have advanced in this paper is that it provides significant up-front revenue, as millions of today's workers pay in for something which will typically not pay out for some decades. Some of this revenue could be used to improve the current system, including through the immediate relaxation of capital limits discussed earlier. However, it also provides an opportunity to invest in preventing, delaying or reducing future needs for health and social care.

This matters for two reasons. First, it improves the intergenerational character of the proposed new contract. Many of those paying the new premium in their forties, fifties and early sixties may be decades away from needing social care themselves. But they could see more immediate benefits if some of the revenue generated by the scheme were used to improve health, reduce avoidable illness and help people to remain independent for longer. The new contract would therefore not simply ask people in mid-life to contribute now in return for a potential benefit in later old age. It would also put a new priority on improving their chances of reaching later life in better health.

Second, well-targeted prevention has the potential to reduce the future demand for both healthcare and social care. The purpose would not be to suggest that all future care needs can be avoided. Ageing, frailty, dementia and disability will remain realities for many people, and there will always be a need for high-quality support when people can no longer manage without it. However, there is strong reason to believe that some need can be prevented, postponed or at least reduce severity and care needs. Even modest reductions in the period during which people need intensive support, or in the number of people moving prematurely into residential care, could improve people's quality of life and reduce pressure on public services.

For this reason, prevention should be a prioritised use of some of the early revenues from the scheme, alongside other pressures and priorities of the day. In this paper we are not prescribing specific legislative preventive measures; but instead, we provide illustrative examples to highlight the proposed approach and outcomes.

Reducing cardiometabolic risk in mid-life

The first opportunity is to make greater progress in preventing and managing cardiometabolic disease. High blood pressure, high cholesterol and raised blood glucose are major drivers of cardiovascular disease, including premature heart attack and stroke. These conditions are not only important causes of premature death and NHS activity; they can also lead to long periods of disability, reduced independence and a greater need for support in later life.

There is also a wider link between cardiovascular health and dementia. Better prevention and management of vascular risk factors will not prevent all forms of dementia, but it has the potential to reduce vascular dementia and to delay or reduce some of the disability associated with cognitive decline. Previous work has shown that a failure to sustain progress against cardiovascular disease could have significant consequences for both healthcare and social-care costs in the decades ahead. Reversing that trend is therefore relevant not only to NHS priorities but also to the long-term affordability of social care.

Some of the up-front revenue from the new social insurance scheme could be used to support a renewed focus on identifying and managing cardiovascular risk in the middle years of life. The precise mechanism would be for government and the NHS to determine. It could include more effective community-based diagnosis; greater use of pharmacies, primary care and neighbourhood services; better follow-up for people found to have raised blood pressure, cholesterol or blood glucose; and more support to sustain long-term adherence to treatment and lifestyle change.

The relevance to this paper is clear. These are interventions which could benefit the very cohort asked to contribute to the new scheme. A person in their forties, fifties or sixties who has their cardiovascular risk identified and managed more effectively may avoid an acute health event within a relatively short period. Over time, the same action may also reduce their risk of living for many years with disability, frailty or dementia-related care needs. This is therefore an example of prevention which offers a more immediate return to contributors whilst helping to reduce the size of the future care funding problem.

Making prevention investable: targeted support for obesity treatment

A second example is the opportunity to use time-limited funding to support access to effective new treatments for obesity, alongside wider weight-management support. Obesity is associated with a wide range of health conditions, including cardiovascular disease, type 2 diabetes, musculoskeletal problems and some forms of cancer. It can also reduce mobility and independence, affecting people's ability to remain in work, to care for others and ultimately to live independently in later life.

New medicines for obesity, including current GLP-1-based medicines, have the potential to become an important part of the response for those who meet appropriate clinical eligibility criteria. The number of people who might benefit however is far greater than the number who can currently access such treatment. While there are several factors driving this such as system readiness, budget impact (ie short term affordability to the system) is the primary barrier.

This is an example of why prevention should be seen as an investment rather than simply as an additional call on public spending.

There may be circumstances in which a period of up-front funding can help to expand access to interventions with the potential to reduce future healthcare use (and costs), support employment and reduce the risk of later disability.

The rationale would be particularly strong where the funding need is time-limited, because prices, clinical pathways and wider availability are likely to evolve over time as the first GLP-1s become generic.

One possible route would be to use a proportion of prevention funding to support targeted access through Integrated Health Organisations (IHOs). The IHO model is intended to give local systems greater responsibility for the health outcomes of a defined population, with incentives to invest in prevention where this reduces avoidable activity elsewhere in the system. This could provide an appropriate setting for risk-sharing arrangements with manufacturers and providers, so that public funding is linked, where possible, to agreed outcomes and real-world evidence of benefit.

Rather than creating an open-ended funding commitment or running clinical services itself, the scheme could provide time-limited pump-priming support for the NHS and IHOs to expand cost-effective obesity treatment, demonstrating whether prevention can improve health, employment and later-life independence while reducing future demand.

Supporting independence at home: unpaid carers and avoiding premature residential care

The third opportunity is to invest in keeping people independent at home for longer, where this is safe and consistent with their wishes. For many people, the point at which they move from living at home with some support into residential care is a major turning point in their lives. It can also be a major turning point in the costs they face, particularly where residential care is required for a prolonged period.

It would be unrealistic to suggest that all admissions to residential care can or should be avoided. For some people, residential care will be the right setting to meet complex needs and provide safety, dignity and companionship. For others however, admission may follow a deterioration which could have been prevented such as a fall, a hospital stay, a crisis in unpaid caring arrangements or the absence of relatively modest practical support. There is therefore a strong case for investing in interventions which help people remain safely in their own homes and communities for longer.

A key part of this must be better support for unpaid carers. Friends and family members provide care on a vast scale, often alongside paid work, ill-health or responsibilities of their own. When an unpaid carer is unable to help, the consequences can be serious both for them and for the person they support.

A care arrangement which has been sustained for years can collapse quickly, leading to hospital admission, emergency formal care or a move into residential accommodation.

The support required will differ between households and we are not suggesting a single national model is prescribed. However, prevention funding could be used to test and expand approaches which provide carers with practical advice, local support networks, training, rapid help during a crisis, short breaks, help to navigate services and greater flexibility to combine caring with employment. There may also be scope for targeted support with particularly difficult care needs which can otherwise become the point at which an informal caring arrangement is no longer sustainable.

Alongside this, prevention funding could support interventions designed to maintain mobility, function and safety at home. These might include falls prevention, strength and balance programmes, reablement, occupational-therapy-led assessment, housing adaptations, assistive technology and rapid support after a fall or hospital discharge. The objective should be framed in terms of outcomes: reducing avoidable deterioration and postponing the point at which an individual needs to enter residential care.

There is also a case for much better analysis of 'care pathways', looking at things like the steps which led up to an admission into a residential care home and whether earlier interventions such as occupational therapy or re-enablement services could have helped to delay or prevent the need for this particularly expensive type of care.

This is an area where the potential fiscal effects could be material. Residential care is generally much more expensive than support delivered in someone's own home. If a package of practical interventions enabled even a proportion of people with dementia, frailty or complex needs to remain at home for an additional year or two, the gross cost of residential care could be deferred achieving better outcomes for individuals and families, combined with reduced pressure on both the NHS and the social care system.

Prevention is not a diversion from social care reform; it is part of making reform durable. Using a proportion of early scheme revenues to improve health in mid-life and sustain independence in later life would give contributors more immediate value, reduce avoidable pressure on the NHS and care system and potentially extend the fiscal headroom available to provide protection against catastrophic care costs in the future.

05 Conclusions

There have been many attempts to tackle the issue of social care funding in the last 30 years, but none has so far managed to secure sufficient political commitment to result in a fundamental change in the system. Our aim in this paper has been to test out a new approach which might be more politically acceptable whilst dealing with the central issue of the unpooled risk of catastrophic care costs in later life.

The paper has not aimed to provide a comprehensive blueprint but instead to set out a core model to test whether the sums add up. More detailed design features could follow if and when there is consensus on the basic framework.

Our modelling has shown that the numbers do ‘add up’.

We show that, even with substantial opt-out, the optional 1p on the basic rate of income tax could raise enough to cover both an immediate improvement to the means-testing system and an investment in preventative measures. And it would enable over 13 million people, at relatively modest cost, to start building up protection against the risk of huge care costs wiping out the value of their lifetime savings.

We offer this proposal to people of all political persuasions, within and outside government, as a potential solution to a growing problem which creates a real sense of unfairness to those who are most affected. We hope that the idea will be taken forward and developed and may finally help to resolve the impasse over the fairer funding of social care for older people.

Appendix 1. Funding approaches in other countries

International approaches to funding social care vary in both how revenue is raised and the extent of protection offered to individuals. The examples in Table A1 combine tax funding, compulsory social insurance, needs-based entitlement and user contributions in different ways. Broadly, they range from dedicated social-insurance systems to mixed insurance and public-funding arrangements and tax-funded models.

Despite these differences, the systems share several design features. Access to support is based on assessed care need, but no system meets the full cost of care. Most entitlements are set at defined amounts or involve co-payments, which, together with eligibility thresholds based on care need, help contain public expenditure. Some systems also cap personal contributions to limit individuals' exposure. Accommodation and other living costs in residential care are generally treated separately from the core care entitlement. The Netherlands is the main exception, including them within the insured package. What individuals pay is usually related to their income, assets or wider financial circumstances, with further support available for those unable to meet the remaining costs. The form of the entitlement can also differ by care setting, as in Scotland, where the public contribution towards personal care is a flat weekly rate in care homes but not at home.

None of these systems provides a direct precedent for the opt-out model proposed in this paper. The contributory schemes considered are compulsory, and while they, like the proposed scheme, base entitlement on assessed need, none links the level of protection to the length of an individual's contribution record. Each nonetheless highlights design choices relevant to the model's development, including how contributions are raised, how the entitlement is defined and which costs remain the responsibility of the individual.

Table A1. International approaches to funding social care

Geography	Core funding model	Revenue-raising mechanism	Entitlement & coverage	User contributions & residual costs	Relevance to policy design for England
Germany	Mandatory pay-as-you-go social long-term care insurance (<i>Pflegeversicherung</i>), introduced in 1995 as a distinct pillar of social insurance.	Earnings-related contributions are generally shared between employees and employers, with pensioners also contributing. Rates vary with family circumstances and contributions are capped at an income ceiling.	Needs-assessed, graded benefits across domiciliary and residential care, provided through cash or services. Benefit levels are set nationally for each grade of need and are defined amounts rather than full reimbursement of care costs.	Individuals meet any care costs above the value of their benefit, as well as accommodation, food and investment costs in residential care; social assistance is available for those unable to meet these costs.	Provides an example of a dedicated, earnings-related social-insurance contribution extending into retirement, with contributions shared across employees, employers and pensioners. It also illustrates an approach in which insurance provides defined benefits rather than full reimbursement of care costs.
Japan	Mandatory pay-as-you-go public long-term care insurance, introduced in 2000.	Around half of long-term care insurance funding comes from public revenues and half from mandatory premiums paid by people aged 40+. People aged 40-64 pay premiums through their health-insurance arrangements, generally shared with employers, while those aged 65+ pay locally determined premiums, typically collected directly from pensions.	Needs-assessed entitlement to domiciliary, community and residential care. People aged 65+ qualify according to care need, while those aged 40-64 are eligible only when care needs arise from specified age-related diseases.	Users generally pay 10% of covered service costs, rising to 20% or 30% for higher-income users. In residential care, accommodation, food and other daily living costs are paid separately, with protections for lower-income users and those facing high care costs.	Especially relevant to a proposition for England in which contributions begin around age 40 and continue into retirement. It provides a clear example of establishing a contributory social-insurance relationship well before most people need care, although participation is mandatory rather than opt-out.

Netherlands	Mixed compulsory social-insurance/public-funding model. The <i>Long-term Care Act (Wlz)</i> , introduced in 2015 to replace a broader scheme in place since 1968, provides dedicated compulsory insurance for people with intensive, enduring care needs; less intensive care and support is covered through separate health-insurance and publicly funded local arrangements.	Wlz is financed through an income-related national insurance premium alongside government funding. Other care and support is financed separately through compulsory health insurance and public budgets.	Needs-assessed entitlement for people with intensive, ongoing care needs requiring 24-hour care. Care may be provided in a residential or domiciliary setting.	Adults receiving Wlz care pay an income- and asset-related personal contribution towards the cost of their care, with the amount varying according to personal circumstances and care setting and subject to a maximum. For residential Wlz care, accommodation, meals and standard living costs are included within the insured package.	Useful example of broad compulsory risk pooling, with long-term care insurance focused on people with the most intensive care needs and less intensive support funded through other routes. It also provides a relatively comprehensive package of care for those who qualify, with income- and asset-related user contributions. Less directly analogous to an opt-out contribution than Germany or Japan.
France	Publicly funded, non-contributory model. The <i>Allocation personnalisée d'autonomie (APA)</i> , introduced in 2002, is the main needs-based long-term care benefit for older	APA is funded through departmental public budgets and national solidarity financing, rather than through a dedicated individual long-term care premium.	APA is available to people aged 60+ with an assessed loss of autonomy. In domiciliary care, support is based on an assessed care plan and level of dependency. In residential care, APA contributes towards	Users contribute towards their APA care plan according to income, from nothing on low incomes to 90% of its cost on higher incomes, and plans are capped by dependency level. In residential	Provides a contrast to contributory insurance models: a needs-based long-term care benefit financed through public revenues rather than a dedicated individual premium, with user contributions varying

	people with loss of autonomy.		dependency-related care costs.	care, accommodation costs are met by residents, with means-tested social assistance available as a last resort. Adult children may be required to contribute, and the assistance can be recovered from the resident's estate after death.	according to financial resources.
Scotland	Tax-funded model, as in England. <i>Free personal care</i> was introduced in 2002 for people aged 65 and over and extended to all adults in 2019.	No dedicated long-term care insurance premium or contribution.	Unlike England, Scotland provides a universal, needs-assessed entitlement to free personal care for eligible adults, regardless of income or capital, across domiciliary and residential care. For self-funding care-home residents, this is delivered through a nationally set weekly payment towards care-home fees; domiciliary personal care is provided according to assessed need, without an	Individuals contribute towards remaining chargeable care-home costs, subject to a financial assessment, and towards non-personal care at home. In 2026/27, Scotland's residential-care capital limits are £22,750 (lower) and £36,750 (upper), compared with £14,250 and £23,250 in England; these thresholds determine the level of local-authority support	Illustrates how a tax-funded system can provide a universal entitlement to free personal care while retaining means-tested contributions towards other care-home costs, and how the form of an entitlement can differ by care setting. Unlike a contributory social-insurance approach, it does not create an individual contributory entitlement or dedicated social-insurance fund.

			equivalent national flat-rate payment.	towards eligible care-home costs.	
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Appendix 2. Sensitivity analysis

The impact of a major reform like this on public spending and on revenues over a period of decades is inevitably uncertain. Throughout this paper we have tried to use plausible 'best estimate' assumptions, erring on the side of caution as appropriate. But it is important to understand how far a change in one of the key assumptions could affect the overall package.

In this section we undertake analysis of the sensitivity of the overall cost/revenue balance to an adverse variation in each of four major elements of the package.

These are:

- What if more people opt out of paying the premium than we have assumed?
- What if demographic pressures increase the cost of the proposal more than assumed?
- What if the cost of providing social care (and hence the discount available under the social insurance scheme) is higher than assumed?
- What if the move towards lower cost / free personal care generates increased demand, as in Scotland?

We consider each in turn.

1. Worse opt-out rates

In the base case we assumed that all renters opt out. We have also assumed a 20% opt-out rate for homeowners aged 55-64, with a higher opt-out rate for younger homeowners and lower opt-out rates for older homeowners. The 20% rate is loosely informed by the 10% opt-out rate for workplace pensions, with an assumption that opt-out for social care would be somewhat higher as fewer people may value social care insurance (which they may not need) compared with a pension.

But it is important to consider whether the funding of the scheme would be materially affected by a plausible higher rate of opt-out. So, we look at a scenario where the 55-64 age group has a 30% opt-out rate amongst homeowners, with opt-out rising to 50% for those in their early 40s. Table A2 summarises the opt-out rates assumed in our base case, and a potential 'worse case' scenario.

Table A2. Opt-out rates in base case and ‘worse case’ scenario

	Base Case (Homeowner opt out)	‘Worse Case’ (Homeowner opt-out)	Base Case (Overall opt-out)	‘Worse Case’ (Overall opt-out)
40-44	30%	50%	58%	70%
45-54	25%	40%	50%	67%
55-64	20%	30%	45%	52%
65-74	15%	20%	32%	36%
75+	10%	10%	27%	27%

Figure A1 shows how this would affect the finances of the scheme.

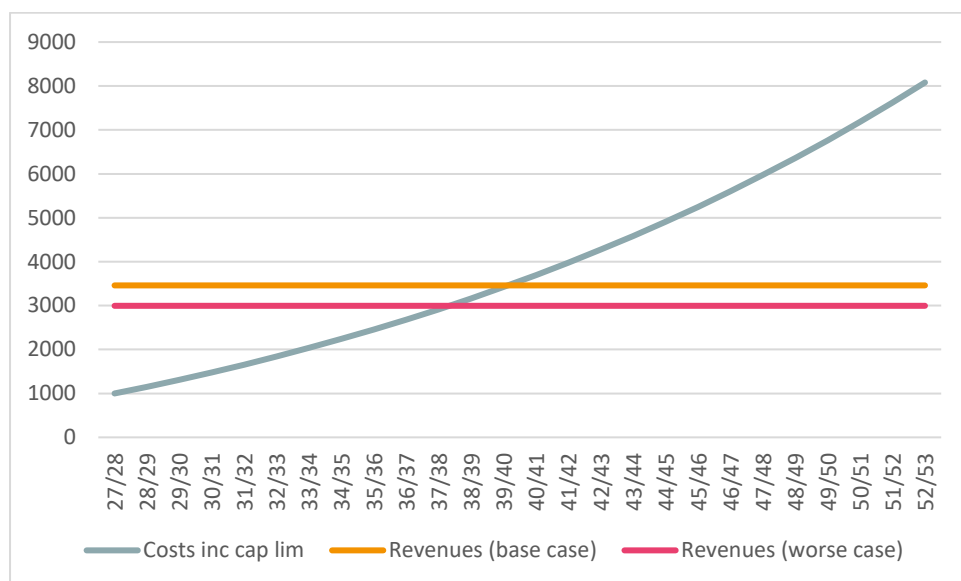
Key points are:

- We estimate that this pattern of opt out would reduce revenues by around £0.5bn pa²⁹.
- The ‘breakeven’ date (where revenues remain above costs) is reached two years sooner, in around 2037-38 rather than 2039-40.

However, despite this much higher opt out rate, the plan generates an additional £2 billion in the first year, and over £1 billion per year until the mid 2030s, over and above the cost of the relaxation of the capital limits. This should be sufficient to fund some of the preventative measures outlined in this paper.

²⁹ In principle a higher opt-out rate would gradually also reduce the costs of the scheme because fewer people would have paid contributions. However, we have not cut the opt-out rate assumed for those closest to needing care, so the impact of this would take many years to feed through and has therefore not been included for simplicity.

Figure A1. Costs / revenues (£m, 2028/29 prices) with a) base case and b) worse case opt-out rates



2. Higher demographic pressures

We have already factored in a growth of around 2.5% pa in demand for domiciliary care and 2.75% pa in demand for residential care. But how would our numbers change if demographic pressures proved greater?

Our expectation is that if demand were even higher than we have assumed, this would be mostly felt in the domiciliary sector, where there is more flexibility to expand services. Recent history shows that capacity for residential care for the elderly has been remarkably static, so in this section we assume that the excess demand pressure feeds through purely into further increases in domiciliary care numbers.

One basis for a higher growth estimate would be recent workforce statistics³⁰ which suggest that the number of posts (including vacancies) in domiciliary care has risen by a rate of around 5.5% per year for the last six years. We therefore model costs on the basis that demand for domiciliary care rises at this rate in the coming years, rather than the 2.5% we have so far assumed.

Our modelling has reflected the likely increase in demand for social care arising from an ageing population over the coming two decades. We have assumed a fixed stock of residential care beds and that any increased demand will come through in the form of increased use of domiciliary care, rising at 5.5% per year in line with recent trends.

³⁰ See: <https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/workforceintelligence/resources/Reports/National/Summary-of-domiciliary-care-services-2025.pdf?>

The impact of this on the costs of our proposal relative to revenues is shown in Figure A2.

Figure A2. Costs/ revenues (£m, 2028/29 prices) with a) baseline demographic pressures and b) additional expansion of residential care places

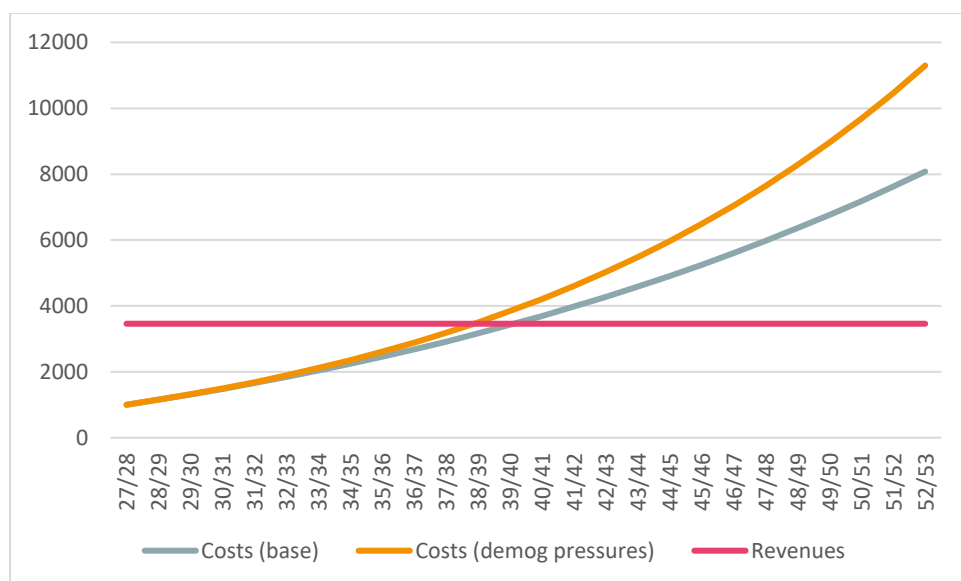


Figure A2 shows very clearly that the impact of the greater than expected growth in demand for domiciliary care arising from demographic pressures in the coming decades starts to have a material impact in later years. In the early years, those who have paid in are only getting a discount of 4%/8%/12% and so on out of their total personal care costs; the impact of a small increase in volumes, on which a small percentage of cost can be recovered is marginal. But the combination of a greater-than-expected number of elderly frail people who progressively move towards 100% of their costs being paid would put financial strain on the system. This chart highlights the importance of not simply repeating history and converting demographic pressures into proportionate increases in care use, but instead trying to tackle underlying causes and reduce need / demand at the same time.

3. Higher unit cost (broad definition of social care)

As discussed earlier, a crucial issue is what exactly is included in 'social care'. The Scottish government's version of 'free personal care' takes a relatively restrictive view as to what is included, and it is the unit costs from this scheme which have fed into our projections.

But it seems plausible that the definitions of personal care used in the taxpayer-funded Scottish system have been drawn very tightly for budgetary reasons. And people paying in to an English system over a 25-year period might expect more comprehensive coverage. This might be the case if, say, there was a risk that people might opt out of the premium on the basis that they would still potentially be left in retirement to use their assets to pay both 'hotel costs' and 'other' social care costs not covered by the scheme's strict definition.

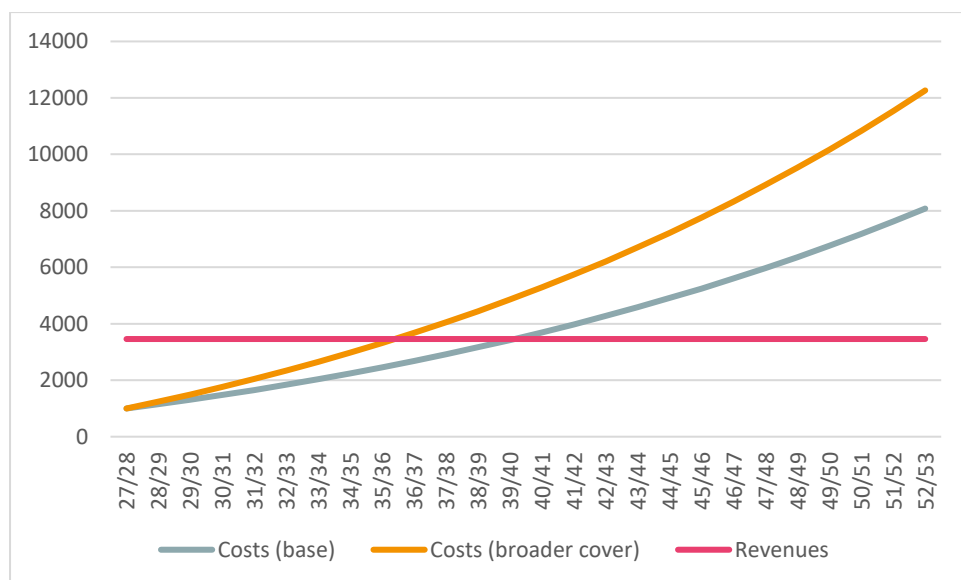
In Scotland, we see that spending on domiciliary care is (obviously) based on a needs test, and that the outturn spending figures should broadly match actual expenditure on core personal care costs. But in residential care there is a standard tariff rate, which appears to be well below typical care costs, and could leave individuals with a cumulative shortfall which threatened to seriously erode their savings. A large shortfall of this sort could undermine the credibility of an insurance-based system if adopted in England.

So, what if it was felt necessary to pay a higher ‘tariff’ rate in care homes, and/or to cover a broader range of care costs in domiciliary care?

To give a sense of orders of magnitude, we can use an estimate from specialists LaingBuisson who put the full costs of care staff in care homes at around £359 per week in a report based on data for 2022³¹. If we uprate this to 2028-29 using the GDP deflator this would give us a figure of £430 compared with the rate of around £270 we have used so far. If we also assume a broader coverage on domiciliary care that keeps the *relative* cost of domiciliary and residential care the same, this would imply a domiciliary care figure of £415 compared with the £261 per week we have used so far.

The results of using these higher figures are shown in Figure A3.

Figure A3. Costs/ revenues (£m, 2028/29 prices) with a) baseline definition of personal care and b) broader definition of personal care



Not surprisingly, effectively adding around 60% to the expected average cost for those who benefit from this new scheme has a very dramatic impact on the cost profile of the scheme.

³¹ See: <https://www.careengland.org.uk/wp-content/uploads/2023/10/LB-Fair-Cost-of-Care-Analysis-Final-Report-Sep-2023.pdf>

Whilst it remains fiscally positive in the early years, breakeven occurs after about nine years rather than around thirteen years as in the base model. Net costs then rise substantially.

This chart is a reminder that, ultimately, the key driver of cost for the whole proposition is the breadth of care costs that the new scheme will cover. It may be that a less restrictive definition of care costs will be required to make the scheme attractive, but a viable scheme is unlikely to be exhaustive in coverage.

4. Higher demand as the net cost of care reduces

In Scotland, free personal care was in effect switched on 'overnight'. Not surprisingly, where something suddenly becomes free, demand can be expected to go up. But aside from general demographic pressures in the coming years, we have not so far factored in any demand impact of our proposed social insurance scheme for England. So, what would happen to the finances of the scheme if the move in the direction of 'free' care led to a surge in demand?

One buffer against a surge in demand is that, unlike the Scottish scheme, our social insurance proposal only comes in very gradually. For example, after five years up and running, the largest discount would be 20%, and hence people would still be on the hook for 80% of their care costs. This is likely to significantly reduce the risk of 'induced demand' as net costs fall.

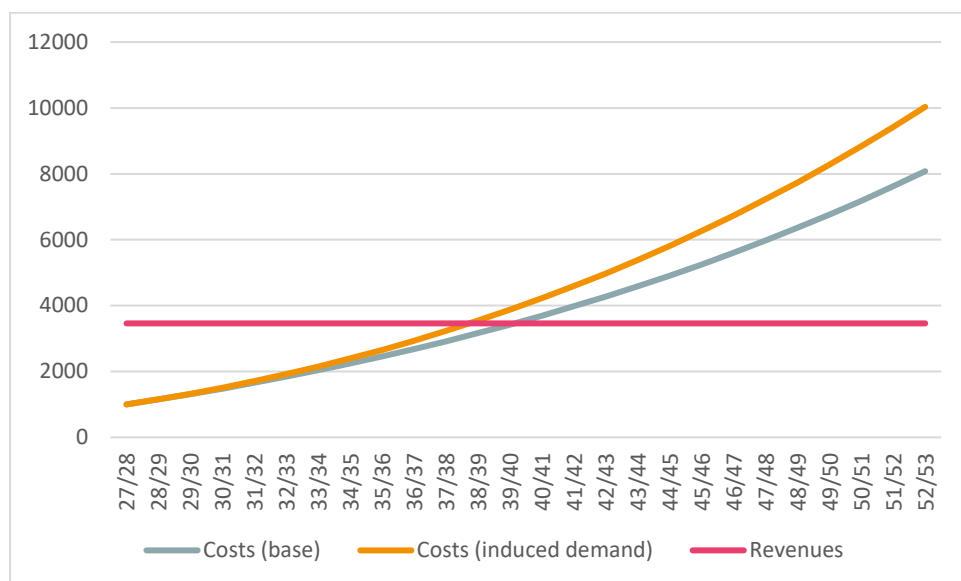
However, as an experiment, we consider a scenario where, after 25 years running the scheme, personal care is free and demand has risen to Scottish levels.

The Scottish government estimates that around 4.8% of the Scottish population aged 65+ is now getting free personal care in their own home, and so this might be a plausible end level of demand.

Based on the current population over 65 in England and Wales, this would imply around 580,000 users of domiciliary care in total. This compares with a Health Foundation estimate (used earlier) of around 420,000 total users in 2028, of which around 1 in 3 is currently self-funding. We assume that the rise in demand is proportionate to the percentage discount people have built up hence is linear between now and twenty five years' hence.

We therefore model the impact of an extra 160,000 users over the next 25 years, or an extra 6,400 per year. The results are shown in Figure A4.

Figure A4. Costs/ revenues (£m, 2028/29 prices) with a) baseline level of demand and b) progressively higher ‘induced’ demand as net cost of care falls



In the early years of the reform, induced demand is low because individuals are still responsible for the large majority of their care costs. But the impact of induced demand is assumed to rise steadily, and in this case, we see that it brings forward the likely breakeven date by around two years. However, compared with other factors which could upset the finances of the scheme, the potential impact of this factor seems likely to be more modest and gradual.

Summary and comparison

Having tested the sensitivity of the model to four different adverse variations, we can compare the importance of each by looking at how each impacts on the Net Present Value of the proposition over the next 25 years. We use the standard government ‘Green Book’ methodology³² of applying a 3.5% discount rate per year. The results are shown in Table A3.

On the cost side, we include the cost of immediately increasing the capital limits under the current system. We do not include potential expenditure on ‘preventative’ measures, but nor do we include the savings which such ‘preventative’ measures could generate. It is however our strong view that serious investment in prevention in the early years could materially improve the cost profile in the later years of the scheme.

³² See: [Review of discounting in the Green Book: Terms of Reference - GOV.UK](#)

Table A3. Net Present Value (£m) of base model and alternatives

	Net Present Value (2028/29 prices)
Base model	+£1.3bn
• With higher opt-outs	-£9.8bn
• With extra demographic pressure	-£10.1bn
• With broader coverage	-£23.3bn
• With higher 'induced' demand	-£7.8bn

These Net Present Value figures are inevitably highly uncertain, being based on a set of assumptions around future costs and revenues up to the early 2050s. But the relative size of these numbers gives us some indication of where the potential challenges to the model are most likely to come from.

The baseline model broadly comes out even over the first 25 years, with a very slightly NPV of (plus) just over £1.3bn. Most of the other potential downside pressures push this figure into a negative range of roughly -£8bn to -£10bn. But the biggest impact of the factors we have considered³³ would be if a much broader definition of social care was to be adopted, leading to a negative figure for costs over revenues of £23.3bn over the next 25 years. None of these numbers is necessarily politically impossible (indeed, it could be argued that they are all relatively small given the length of time these costs take to build up), but it is important to be aware of the potential downside if our assumptions should prove to be too optimistic.

³³ Noting, of course, that more than one of these factors could come into play at the same time.

Appendix 3. Other notes on costings / revenue estimates

Two other factors affecting the costings / revenue assumptions are worth noting for completeness.

1. Inflation in cost base and inflation in revenue base

A key area to consider is the balance between inflation in care costs (which obviously makes the funding position worse) and inflation in tax revenues (which improves the funding position). For now, we have assumed that these match each other and have therefore stripped them out of the model. But how realistic is that assumption?

In terms of costs, social care is a very labour-intensive activity, so changes in the wages of those who work in the care sector are likely to be a major determinant of overall costs. Although such work is often relatively low paid, policies such as the increase in the National Living Wage have led to above-inflation increases in costs in recent years.

However, our proposed social insurance model is funded by an optional 1% increase in the basic rate of income tax, and the largest single component of the income tax base is earnings from employment. To the extent that an increase in the wages of care workers over time adds to costs, we should expect economy-wide increases in earnings levels to boost revenues. The two might, in principle, tend to move together.

To test this, we have looked at two relevant indicators:

- On costs, the hourly cost in England paid by local authorities to external providers for an hour of home care to those aged 65 or over; this rose from £18.68 in 2020-21 to £25.05 in 2025-26, an increase of 34%³⁴;
- On revenues, the yield from an extra 1% on the basic rate of income tax, according to HM Treasury 'ready reckoners'; on the definition we have chosen, this increased from £5.65bn in 2020/21 to £7.55bn in 2025-26, also an increase of 34%³⁵.

³⁴ See: [Market Sustainability and Improvement Fund \(MSIF\): provider fee reporting 2025 to 2026 - GOV.UK](#), various years, and [Improved Better Care Fund \(iBCF\): provider fee reporting, 2021 to 2022 - GOV.UK](#)

³⁵ See: [Direct effects of illustrative tax changes bulletin \(June 2025\) - GOV.UK](#) and similar publications for earlier years. Note that when income tax is raised there is a 'first year' impact and a 'full year' impact which allows for the time lag in collecting some income tax due in any given year. To get the full impact of the proposed social care levy we have used 'full year' impacts in each case, effectively assuming that all of the revenue from the premium is raised immediately.

There are, of course, a wide range of factors which will determine care costs on the one hand and tax revenues on the other, but there is some a priori reason to think that these two figures might tend to move in broadly the same direction, and our simple analysis of trends in the last five years offers some reassurance on this point. On this basis we are content that, in stripping out both sorts of inflation, we are not fundamentally undermining the credibility of our model.

2. Potential double-counting in the model

One point to note is that there is an element of double counting of costs in these charts, which make them unduly pessimistic.

In the first year of the reform, the existing capital rules are substantially eased, increasing the contribution to care costs from the public purse. Previous government projections have assumed that around 50,000 current self-funders would benefit from this easement each year³⁶.

In modelling the social insurance scheme which kicks in from year two onwards, we could in principle reduce the number of self-funders by the full 50,000 benefiting from the higher capital limit, thereby reducing the projected cost of the social insurance scheme. But we have not factored this into our costings.

One reason for this is that these 50,000 people are, by definition, those who had relatively modest amounts of capital – mainly those between the old upper limit of £23,250 and the new upper limit of £100,000. Without the increase in the capital limit this group would have initially self-funded and run down their capital, but many would – after some months or years – have then fallen under the old limit and qualified for extensive public funding in any case. Excluding them from our costings entirely could have understated the eventual public spend in respect of these people.

On balance, we judged it best to err on the side of caution, leaving them in our base case and thus potentially somewhat overstating the costs of the package as a whole. This gives us extra margin in case any of our other assumptions should prove to be unduly optimistic, as we have discussed in this section.

³⁶ See: [Impact Assessment template](#), Table 9

Contact us



If you would like more information, please contact your usual LCP adviser or one of our specialists below.



Marina Berger
Associate Consultant
Marina.Berger@lcp.com



Robert King
Senior Consultant
Robert.King@lcp.com



Dr Jonathan Pearson-Stuttard
Head of LCP Health
Jonathan.Pearson-Stuttard@lcp.com



Steve Webb
Partner
Steve.Webb@lcp.com

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Lane Clark & Peacock LLP London, UK
Tel: +44 (0)20 7439 2266
enquiries@lcp.uk.com

Lane Clark & Peacock LLP Winchester, UK
Tel: +44 (0)1962 870060
enquiries@lcp.uk.com

Lane Clark & Peacock Ireland Limited
Dublin, Ireland
Tel: +353 (0)1 614 43 93

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