Who should bear the costs of care: state or individual?

Design choices & policy questions: learning from abroad

Camille Oung & Natasha Curry, The Nuffield Trust, October 2026

The original research was supported by Joseph Rowntree Foundation

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Who we are & today's talk

- Nuffield Trust
  - Independent health & care think tank
  - Aim to generate evidence to improve policy & practice
  - International comparisons at the heart of our social care work

- Today's talk
  - Focused on how other countries decide the balance between state and individual responsibility
  - Based on work funded by JRF
  - Prompts questions about the decisions & choices England faces

https://www.nuffieldtrust.org.uk/research/sharing-the-costs-of-social-care-how-other-countries-balance-state-and-individual-contributions https://www.nuffieldtrust.org.uk/news-item/a-new-contract-for-social-care-how-to-strike-the-right-balance-between-state-and-individual-responsibility

JRF
JOSEPH ROWNTREE FOUNDATION

Who gets formal social care in England?

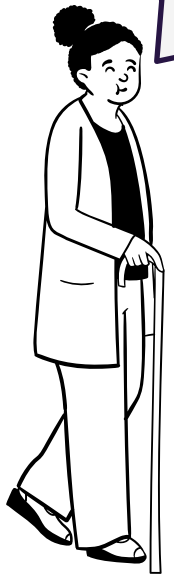
My name is **Georgia** and I have been a wheelchair user since a spinal cord injury in my 20s.
I work part-time and need assistance with transport and work**. I have saved up £24,000** in the hope of one day being able to purchase to a property that can be adapted to my needs.



My name is **Harveen** and this is my husband **Winston**. We **own our home, worth £580,000, and have £60,000 of savings**.
Winston was diagnosed with Alzheimer's and until now I have been his main carer. But I can't cope anymore. I have decided we **both need to move to a care home** so I can be sure we can spend our final years together.



My name is **Asma**. I have lived in my house for over 50 years, and it is now worth **£180,000**.
I'm a widow and live on my state pension, and have **savings of £25,000**.
I recently had a stroke and two falls and need regular **home care**.



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There is some consensus that social care needs fixing…

- Individuals left with very high costs
- Heavy reliance on unpaid carers
- High levels of unmet need
- Increasing reliance on local revenue: Needs threshold varies between councils
- Provider fees reduced: cross-subsidy between self-funders & council-funded individuals
- Workforce challenges: pay, recruitment, retention

Approx one in seven people aged over 65 faces **care costs of more than £100,000** over their lifetime (DHSC modelling 2021)

Est. 1.6m older people have **unmet needs**. (Age UK 2023)

1.2 million unpaid **carers live in poverty** – nearly one in ten (400,000) in deep poverty. (Carers UK 2024)

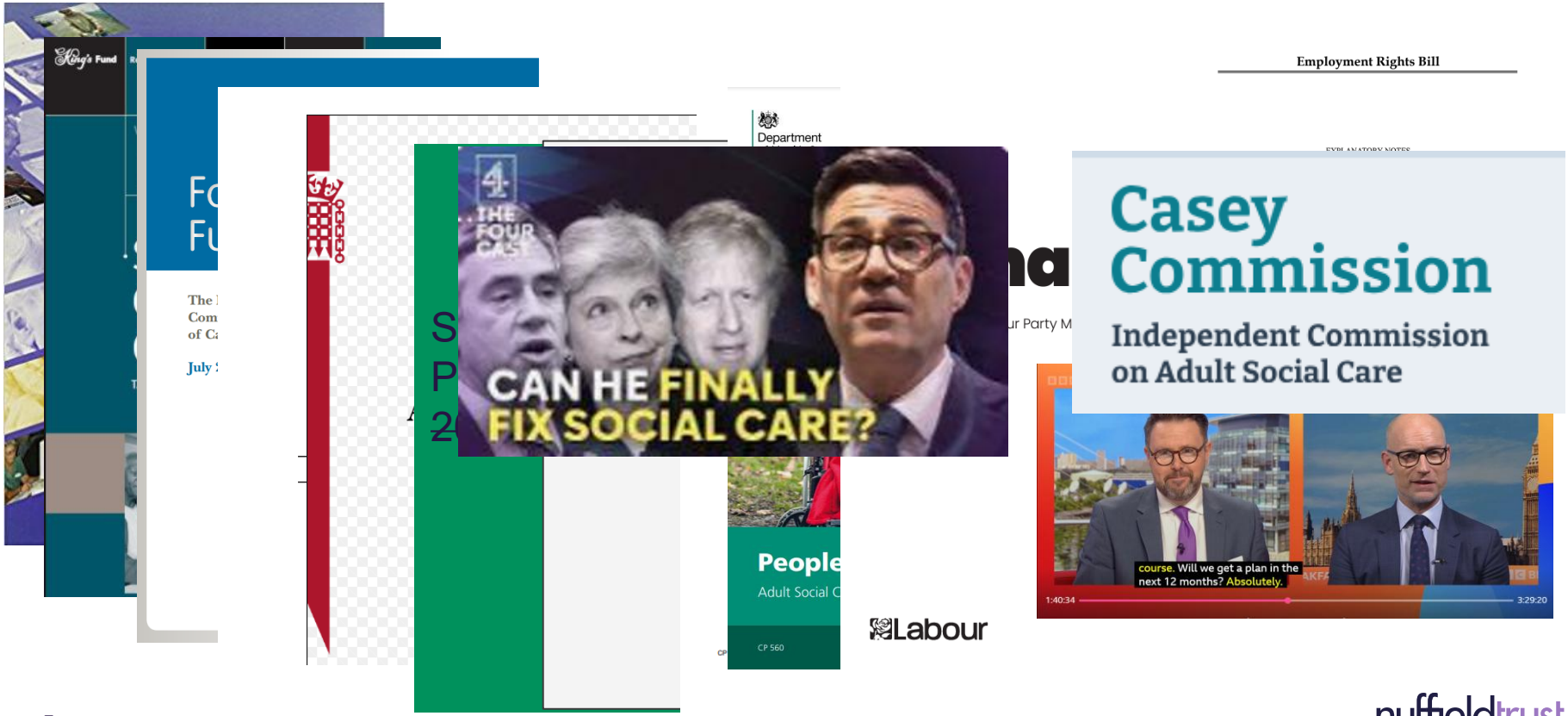
Self-funders can pay 40% more than local authority residents for the same care. (CMA, 2017)

66% of councils reported **providers handing back contracts** in previous 6 months. (ADASS 2026)

Est. 1.5m **disabled** adults have **unmet needs**. (Healthwatch 2024)

96,000 **vacancies** & heavy reliance on **overseas workers**;
Low pay: Median hourly pay: £12.60ph - 39p more than NLW;
Experienced care workers earn only 12p more than new starters. (Skills for Care 2026)

But no consensus over how to fix it…



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Why has reform proved so elusive?

1 **Public awareness**	Low public awareness limits pressure for change.
2 **Politics**	An adversarial political system turns reform into a political risk.
3 **Political will**	Lack of political will — and bravery — stalls difficult choices.
4 **Starting point**	The debate often starts with “How much will it cost?” and “Who pays?”
5 **Missing questions**	Too little exploration of what we want, what we need, who should be prioritised — and what feels fair.

A third (34%) of the public mistakenly think the NHS provides most social care for older people. *





*https://www.health.org.uk/reports-and-analysis/briefings/we-need-to-talk-public-attitudes-to-social-care-and-the-NHS#lf-section-287766-anchor

Where are we now?





What we know

- Andy Burnham is committed to social care reform
- The Casey Commission's timeline will be accelerated
- He has promised a new National Care Service (NCS) 'run on NHS principles'
- Possibly free personal care (FPC) for older people
- Some funding to be provided from changes to the pensions triple lock from 2030
- Likely some action re 'profiteering' in the sector



What we don't know

- What is really meant by an NCS?
- Does NHS principles necessarily mean free at the point of use?
- If FPC would be just for older people? What about working age adults?
- Will the funding be enough?
- What approach will be taken to addressing 'profiteering' concerns?
- How comprehensive & ambitious will the Casey proposals be?

Fundamental questions remain

THE BIG CONVERSATION ON CARE
Help shape a fairer future

1. To what extent should the state be responsible for someone's care costs?
2. How should the state decide who it supports and to what degree?
3. Should the state protect individual's assets?
4. Should the state bear the costs of accommodation/hotel fees in addition to care?

➢How do other countries decide on the balance?



We reviewed 11 countries or regions



Northern Ireland



Scotland



Wales



New Zealand



British Columbia



Australia



France



Catalonia



Denmark

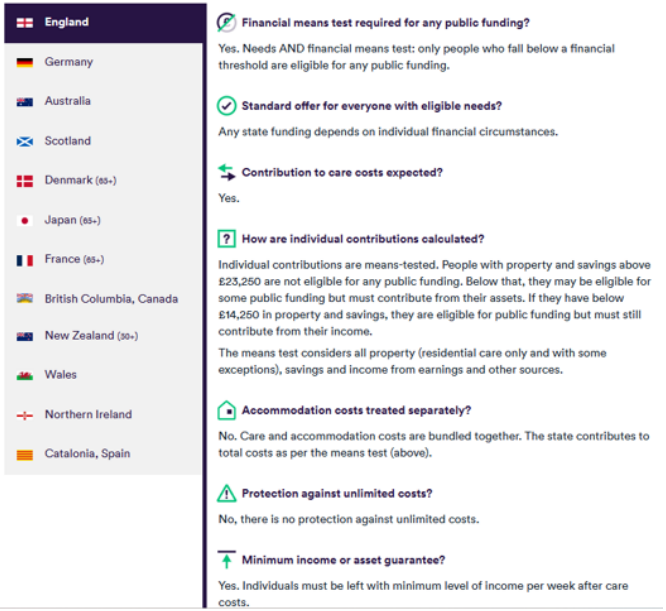


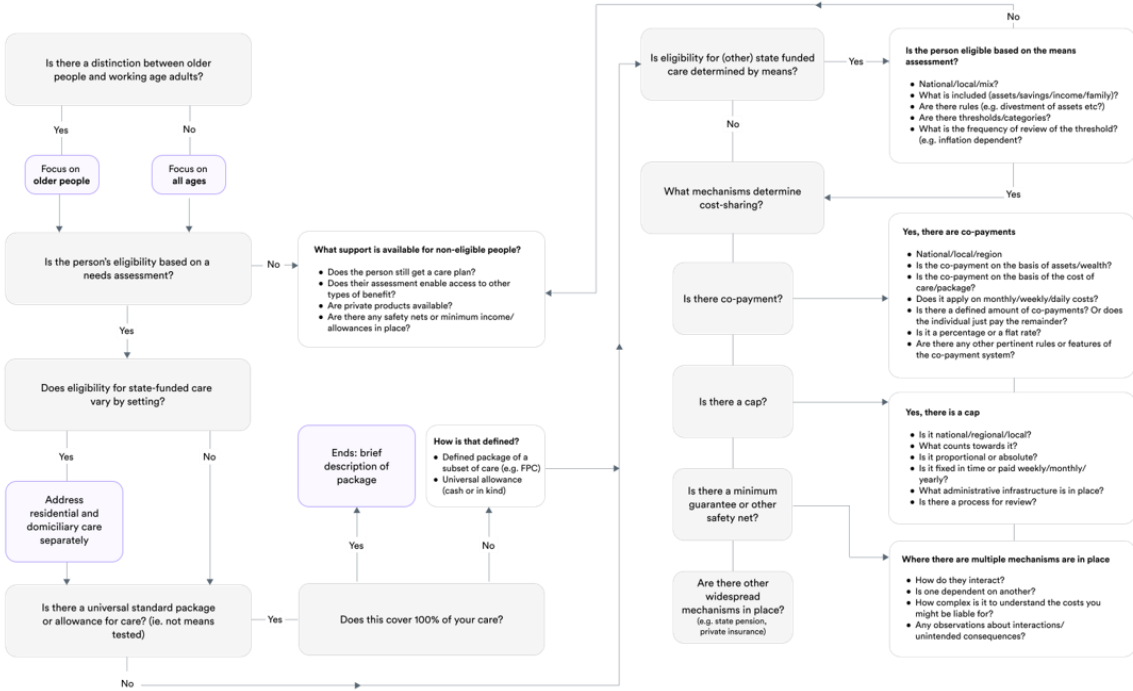
Germany



Japan

Our outputs





https://www.nuffieldtrust.org.uk/news-item/a-new-contract-for-social-care-how-to-strike-the-right-balance-between-state-and-individual-responsibility

https://www.nuffieldtrust.org.uk/research/sharing-the-costs-of-social-care-how-other-countries-balance-state-and-individual-contributions

England is a relative outlier



DENMARK

Everybody can access publicly funded care. There are no user contributions on care costs.



MOST OTHER COUNTRIES

Everyone is entitled to **something**, but it doesn't cover everything and can vary by financial circumstances



NEW ZEALAND (residential), NORTHERN IRELAND (residential), WALES

Access to care is **restricted** based on people's financial circumstances

KEY POINTS

1. Only Denmark offers all care for free
2. Most other countries offer something to everyone
3. Even means-tested systems tend to be more generous

Some countries offer the same to all



GERMANY/JAPAN

Everyone regardless of financial circumstances has access to a **set allowance relative to need** (on a nationally-set scale).



AUSTRALIA

The state provides a **free package of 'clinical and personal' care** to all but other elements of care are means-tested



SCOTLAND

Everyone is eligible for **free personal care**. All other elements of care (wider social care, accommodation in care homes etc) is means-tested as in England.

KEY POINTS

1. These models potentially offer certainty and clarity
2. These models prioritise equality over equity
3. On their own, these approaches risk leaving people exposed to high/unlimited costs

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Some countries vary the offer according to means



FRANCE

Everyone is entitled to **some state-funded care** but the amount **varies** according to someone's financial circumstances (0%-90%).



BRITISH COLUMBIA

Everyone is entitled to **some state-funded care** but people can only be charged for **care costs up to 80% of their income** (note assets are excluded).



AUSTRALIA

Beyond the universal free element, other parts of care are **means-tested**. A complex series of tapers & thresholds are used to avoid sudden cliff-edges



JAPAN

If the individual requires more care than is provided within the universal allowance, **co-payments are means-tested**. Three income (note assets excluded) brackets determine if someone pays 10%, 20% or 30% of costs

KEY POINTS

1. These models prioritise equity: those who have higher wealth pay more
2. On their own, they do not protect against unlimited/high costs
3. These models can be complex and difficult to understand

Complexity!





Income threshold	Rate single person	Rate couple, illness separated (single rate)
Income free area	$36,454.60	$35,726.60
First income threshold	$90,130.04	$89,402.04
Second income threshold	$105,048.00	$105,048.00
Third income threshold	$121,173.20	$121,173.20
Fourth income t		

Asset threshold	Rate
Asset free area	$66,500.00
First asset threshold	$219,858.40
Second asset threshold	$266,000.00
Third asset threshold	$369,366.66
Fourth asset threshold	$552,858.40
Home exemption cap (per person) — the net value of the home above this	$219,858.40

The DAP is calculated by multiplying the room's RAD by the Maximum Permissible Interest Rate (MPIR) set by the Australian Government, and dividing by 365 days.

As of 1 July 2026, the MPIR is 8.51%. For example, the Daily Accommodation Payment for a room with a RAD of $600,000 would be:

$600,000 × 8.51% ÷ 365 = $139.89 per day

« 2° Pour les bénéficiaires dont les ressources mensuelles sont supérieures à 0,725 fois et inférieures ou égales à 2,67 fois le montant mensuel de la majoration pour aide constante d'une tierce personne susvisée, le taux de participation est déterminé en appliquant la formule suivante :

« $T = P/A$

« Avec

« $P =$

« $\left(A_1 \times \frac{R - 0,725 \times S}{2,67 \times S - 0,725 \times S} \times 0,9\right)$

« +

« $\left(A_2 \times \frac{R - 0,725 \times S}{2,67 \times S - 0,725 \times S} \times 0,9 \times \left(\frac{1 - 0,4}{2,67 \times S - 0,725 \times S} \times R + \frac{0,4 \times 2,67 \times S - 0,725 \times S}{2,67 \times S - 0,725 \times S}\right)\right)$

« +

« $\left(A_3 \times \frac{R - 0,725 \times S}{2,67 \times S - 0,725 \times S} \times 0,9 \times\right.$

« $\left.\left(\frac{1 - 0,2}{2,67 \times S - 0,725 \times S} \times R + \frac{0,2 \times 2,67 \times S - 0,725 \times S}{2,67 \times S - 0,725 \times S}\right)\right)$

« où :

« *a)* T est le taux de participation financière du bénéficiaire ;

« *b)* P est la participation financière calculée en fonction du plan d'aide accepté par le bénéficiaire ;

« *c)* A est le montant du plan d'aide accepté par le bénéficiaire ;

« *d)* A1, A2 et A3 sont les fractions du montant du plan d'aide accepté par le bénéficiaire :

« – A1 correspond à la fraction inférieure à 0,317 fois le montant mensuel de la majoration pour aide constante d'une tierce personne ;

« – A2 correspond à la fraction comprise entre 0,317 fois et 0,498 fois ce montant ;

« – A3 correspond à la fraction supérieure à 0,498 fois ce montant ;

« *e)* R est le revenu mensuel du bénéficiaire ;

« *f)* S est le montant de la majoration pour aide constante d'une tierce personne mentionnée à l'article L. 355-1 du code de la sécurité sociale ;

Many countries protect people against unlimited costs



GERMANY

While there is no ‘cap’ as such, in residential care a person’s **co-payment on care costs reduces year on year** until it reaches 35% (in year 4). They continue to pay 35%.



AUSTRALIA

An **absolute cap of ~$140,000** applies OR a maximum of **4 years payments** – whichever is hit sooner. Then the state takes over.



JAPAN

A **monthly cap on care co-payments** applies to all. The cap is also **relative** to financial means. Individuals continue to pay for as long as they need care.



WALES

A **weekly cap** on care co-payments applies in **homecare** only of **£100**. Individuals continue to pay for as long as they need care.

KEY POINTS

1. These models can be difficult to understand
2. What counts towards the cap is key and must be made clear
3. Some require people to continue to pay indefinitely which could help with affordability for the state

Finding 5

Most countries separate out accommodation costs



DENMARK

While individuals get fully-funded care, they **must pay for their accommodation/hotel costs**. But housing benefit can be used. Food charges are regulated and capped nationally.



FRANCE

Accommodation is counted separately. State aid is available, but only once **mandatory reciprocal duty for offspring** to provide support is assessed. Housing benefit can be used to help pay.



AUSTRALIA

For people falling under a financial threshold, the **state shares accommodation costs**. Individual contributions to 'hotelling' are means-tested and **capped on daily basis** with state paying remainder.



NEW ZEALAND/ BRITISH COLUMBIA

Like in UK, these countries **do not separate out accommodation** so it is difficult to see the breakdown. But it means cost-sharing measures (e.g. cap) are, where in place, applied to the whole bill.

KEY POINTS

1. Separating out accommodation costs can drive more transparency
2. Without extra support people can be left with high accommodation costs
3. Some countries regulate fees or set maximums or require fee breakdowns

Points for discussion



There is no single way to determine the balance



Social & cultural values around fairness need to underpin model



Political palatability and financial constraints/ affordability will also be key determinants

What if you were prime minister?

You have a limited amount of money.
What would be your priority?

1. Capping costs
2. Expanding the current means test
3. Ensuring everyone gets the same
4. Ensuring everyone gets something according to financial circumstances

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Links & further reading

On cost sharing:

1. Sharing the costs of social care: How other countries balance state and individual contributions
2. A new contract for social care: how to strike the right balance between state and individual responsibility?

International case studies:

1. What can England learn from the long-term care system in Japan?
2. What can England learn from the long-term care system in Germany?
3. Building resilience in adult social care: Learning the lessons from other countries' experiences of Covid-19
4. Adult social care in the four countries of the UK

Funding for social care:

1. What principles should underpin the funding system for social care?
2. How to fund social care?

On workforce:

1. New horizons: What can England learn from the professionalisation of care workers in other countries?
2. From ambition to reality: national policy options to improve care worker pay in England

On provision:

1. Fractured and forgotten? The social care provider market in England

Overall reform:

1. What health and care need: #2 – Adult social care
2. What does the Prime Minister mean by a National Care Service?

Thank you for your attention.



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