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A fair deal for care in older age? Public attitudes towards the funding of long-term care

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English

The government has made nursing care in England and Wales free, while continuing to means-test personal care. This policy contrasts with the recommendation for free personal care made by the Royal Commission on Long-term Care in 1999. This article reports on a survey of attitudes towards financing care in old age from a representative sample of men and women in England aged 25 years and over. The majority of people feel that the state should finance care for older people. The article discusses the extent to which this is consistent with the government's position and the competing notions of equity that recent debate entails.

Français

Le gouvernement a déclaré la gratuité des soins infirmiers en Angleterre et au Pays de Galles, tout en continuant à soumettre les patients à un examen de ressources pour les soins personnels. Cette politique contraste avec la recommendation pour la gratuité des soins personnels faite par la Royal Commission sur les soins à longue durée en 1999. Cet article fait un rapport sur une enquête sur les différentes attitudes vis-à-vis du financement des soins pour les personnes âgées à partir d'un échantillon représentatif d'hommes et de femmes en Angleterre de 25 ans et plus. La majorité des personnes pensent que l'état devrait financer les soins pour les personnes âgées. L'article examine jusqu'à quel point ceci correspond à la position du gouvernement et aux notions rivales de l'équité à laquelle faisaient allusion des débats récents.

Español

El gobierno ha hecho que la atención médica sea gratuita en Inglaterra y Gales, mientras que continúa la forma de prueba al cuidado personal. Esta política contrasta con la recomendación para la atención médica personal gratuita que hizo la Comisión Real en el Cuidado a Largo Plazo en 1999. Este artículo informa sobre una encuesta de las actitudes hacia la financiación de la atención médica en la vejez tomada de un estudio de muestras representativo de hombres y mujeres en Inglaterra entre la edad de 25 años y mayores de 25 años. La mayoría de la gente siente que el gobierno debería financiar la atención médica de la gente mayor. El artículo discute hasta qué punto esto es consistente con la posición del gobierno y las opiniones conflictivas de equidad que recientes debates implican.

Key words: long-term care • older people • finance • survey findings

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Introduction

The long-standing debate about the merits of different financing mechanisms for health and social care for older people has recently taken a new twist. The Royal Commission on Long-Term Care recommended that the costs of Long-Term Care should be split between living costs, housing costs, and personal care costs.[1] Personal care should be available after assessment, according to need, and free – paid for from general taxation. This key recommendation was rejected by two of the Commissioners,[2] and then the government in Westminster and the Assembly in Wales (DoH, 2000a). The decision was made that individuals should where possible continue to bear financial responsibility for most of their personal care costs. A different decision was reached by the Scottish Executive, which accepted the Commission's main recommendation. Personal care has been free to all who need it in Scotland since July 2002 (Scottish Executive, 2002). Both the government in Westminster and the Scottish Executive accepted the Commission's recommendation for free nursing care regardless of care setting, and indeed most of the Commission's other recommendations.

In England and Wales, then, there is now a demarcation between nursing (health) and personal (social) care, with the former funded by the state and the latter subject to means-testing. Individuals who need care and are deemed able to afford to pay for it will continue to be responsible for the costs of their own personal care, and for their housing and living costs where care in a care home is required. Individuals will no longer be responsible for the cost of direct nursing care provided by a registered nurse. Nursing care, although free at the point of delivery within NHS hospitals and within domicilary settings, had been chargeable (fees subject to means-testing) within nursing homes and dual registration homes that provided both nursing and residential care – all homes are now 'care homes'.[3] Eligibility for free care, under the new legislative framework for England and Wales, is now based not on the patient's needs but on the job description of a particular health professional. Nurses have become directly responsible for rationing care (Heath, 2002).

Much of the commentary on the government's position has focused on the question of payment for personal care. An alliance of 15 organisations representing older people argued that the new system will continue to discriminate against older people and that the care system will remain unfair (Help the Aged, 2001),while the Liberal Democrat Party has voiced its support for making personal care free to all who need it (Liberal Democrat Party, 2000). Concerns have also been expressed that the new system of joint assessment of health and social care needs will prove unworkable in practice, because the boundary between nursing and personal care is difficult to draw and operationalise (Gough, 2001).

Third Way politics suggests a changed role and function for the welfare state (Blair, 1998; Giddens, 1998); this raises questions about who should perform these roles and functions. On the question of Long-Term Care funding the government, Royal Commission and a number of other groups have had their say on the matter. But what about the public? Is the government's position broadly in line with public attitudes to financing and paying for services, or did the Royal Commission more accurately reflect attitudes? There is relatively little evidence on public attitudes towards financing of services for older people. Public support for the NHS is solid, and some 80% of people think that the NHS is an essential service and must be maintained; 75% want to retain a universal health service and oppose a two-tier health service (Wanless, 2001).

However, views on the current mix of financing of health and social care services for older people are less well documented. The main recent evidence comes from a public opinion survey carried out in 1995 (Parker and Clarke, 1997). They found that public support was divided. 24% of respondents supported state support for all, regardless of income, while 24% supported a means-tested approach, with the state providing only for those who could not otherwise afford care. The most popular option, chosen by 48% of respondents, was for the state to provide a basic level of service for older people, with the option open to people who could afford to do so of 'topping-up' or supplementing this basic service.

This article discusses the extent to which the

government's position is consistent with public opinion on the financing and provision of health and social care services for older people. It focuses on two particular aspects of the government's current policy position, namely the extent to which people support the government's preferred mix of state financing and private self-funding, and their perceptions of the fairness or otherwise of this mix. The next section considers the policy context, and following sections present the methods and results of the survey, and discuss their policy implications.

The policy context

The financing of personal care

The chances of needing long-term institutional care are generally accepted as about one in twenty at age 65, and one in four at age 85 and over. Over 70% of people in care homes are publicly funded to some extent, and around 30% pay all of their own costs. This gives a figure (1995 estimate) of just over 126,000 self-payers in the UK. In domestic settings, around 1.2 million older people have some form of support at home. Over 600,000 people receive home help services provided by public agencies: this represents 20% of older people in the community with some level of dependency. There are some 670,000 people using privately paid-for support. There is some overlap between public and private home help services, with around 9% of people using both (Royal Commission on Long-Term Care, 1999a).

Although there is some uncertainty about the overall level of need for Long-Term Care and the costs involved, the Royal Commission's own figures suggest that the cost to the state would have increased from £7.1 billion to £8.2 billion each year had their recommendation for personal care been implemented; the costs met from private sources would have reduced from £4.0 billion to £2.9 billion (at 1995 prices). Free universal personal care would therefore cost the state £1.1 billion or 1% of GDP (rising to 1.4% of GDP in 2051).

The government argued that universal personal care did not represent the best use of available resources. Defending the position, the Prime Minister claimed that the government had to make a choice, because it would not be able to afford to provide free personal care as well as intermediate care (*Health Service Journal*, 2000). The government committed £1.4 billion of new investment to health and social care services by 2004 and a large proportion of this is going to intermediate care services (DoH, 2000a, 2000b). It therefore seems reasonable to ask whether the public think this is indeed the best use of available resources.

Equity

The focus on the distinction between free nursing care and free personal care has had important consequences for the Long-Term Care debate. To many commentators it has appeared that the problem is essentially technical in nature, concerning whether or not a workable definition of nursing care can be identified. This has distracted attention from an examination of principles, such as equity, underpinning the debate.

Equity seems a reasonable focus for a study in Long-Term Care because the Royal Commission and the government both claim to be applying equity principles. Indeed, it is a stated government objective for Long-Term Care. In a speech in the House of Commons, Alan Milburn (1999) stated that:

> We shall base any future reforms ... on three key principles: choice, fairness and quality ... just as elsewhere in our welfare reform programme, our policy will be that people should provide for themselves whenever they are able to do so.

It is usual to start discussions of equity by distinguishing between horizontal and vertical equity. Horizontal equity means that equals are treated equally. Thus, when two people need hip replacements, they should wait the same length of time before surgery and receive the same volume and quality of care. Vertical equity, in contrast, is concerned with the unequal treatment of unequals. This dimension is less intuitively obvious, but actually underpins the financing of the welfare state in the UK. Rich people are better able to contribute towards the costs of health care than poor people. Because they are rich they are treated unequally, and required to pay more

through their taxes towards the costs of the NHS. It is possible to pursue one or more of these objectives at the same time – the NHS is equitable, in comparison with many other countries, in both provision and financing. The problem in Long-Term Care at present is that it is perceived to be unfair along both dimensions of finance and provision.

We recognise that discussions of equity are complicated. For example, there are irreducible differences between liberals, libertarians and others, who have different beliefs about the appropriate rules for the distribution of resources within societies (Nozick, 1974; Kymlicka, 1990). 'Classical' political philosophy, such as that set out by Rawls (1999), takes little account of families and other multi-member households. There are few clues about the proper distribution of resources between parents and children, or carers and those they care for. This is not the place to go into these differences, save to note that a separate analysis would be possible, assessing the 'fit' between the majority Commissioners' and government's positions and particular political philosophies. This would help to highlight the basis of the value judgements and choices made by each side. Instead, we note here the central importance attached to equity by political philosophers of all persuasions, and employ general arguments about equality and equity in Long-Term Care.

The Royal Commission report found that the financing of Long-Term Care in place in 1999 was both complex and unfair, particularly in terms of the balance between individuals' responsibility to pay for their own care and the state's responsibility to fund, which seemed arbitrary, depended on the location of care, and was therefore difficult for people to understand. They claimed that their recommendations, including their commendation to exempt personal care from means-testing, were based on judgements about the equity and efficiency of alternative policy options. The government and the two minority Commissioners, in contrast, concluded that free universal personal care would be less efficient and equitable than targeting resources at those people on the lowest incomes. If today's better-off older people continued to pay the same or even more for their own personal care, then there would be more public resources available for poorer older people.

It is useful to contrast the judgements of the majority Commissioners and government in three areas, namely housing and living costs, nursing care costs and personal care costs. We then go on to tease out the different notions of equity employed by the two sides.

Housing and living costs

Universal state funding of housing and living costs was dismissed by the Royal Commission, and the government agreed. The Commissioners argued that:

> People who receive care at home have to meet their living and housing costs themselves. The same should apply for people in residential settings.... These are legitimate items for which people may want to save in their old age. (Royal Commission on Long-Term Care, 1999a: 64)

Nursing care costs

The Commissioners and the government agreed that nursing care should be free at the point of delivery, irrespective of care setting and paid for from general taxation. This has the practical effect of removing any income barriers to nursing care, and extending the boundaries of the NHS out into all Long-Term Care settings, including care homes. (Note that this boundary had been drawn under the first two Conservative administrations of the 1980s, so the Labour government was partially reversing this earlier policy.)

Personal care costs

The method of financing personal care was the major source of disagreement between the Commissioners, and between the majority Commissioners and government. The majority Commissioners argued that the principle of free universal access to care should be extended to all personal care. This has the effect of making the provision of care more equitable. The majority Commissioners argued that because the

NHS is free, nursing and personal care should therefore be free in care homes and domestic settings. They claimed that if both nursing and other personal care were financed by the state, then the principle of equal care for equal needs would be properly recognised for the first time. They argued that the state, through the NHS, pays for all the care needs of people suffering with cancer and heart disease, but people who suffer from Alzheimer's disease may get little or no help with the cost of comparable care needs. Both of these conditions are debilitating, and both require a mixture of health and social care.

However, making care free to all involves trade-offs. In particular, free state-financed care means that those who can afford to pay for their own care enjoy free access. Better-off people who currently pay for nursing care in care homes will in future receive it free, and so contribute less directly towards their care than they do now. This is essentially the argument that the government has used against the provision of universal free personal care.

Government policy: equity and politics

So, what is being equalised, and on the basis of what arguments? In practice, the nature of the claims made about equity have not been made explicit, at least in political debate about the Royal Commission report. The Royal Commission report is not as clear as it might be about its equity arguments – they are spread through the text and not brought together in any one place. The government, for its part, has stated that it is committed to greater fairness in Long-Term Care, but it is striking that there is no single, clear statement that sets out how the government thinks a fairer system can be achieved. Indeed, the government worried that:

> Making personal care free for everyone carries a very substantial cost, both now and in the future. It would consume most of the additional resources we plan to make available for older people through the NHS Plan. Yet it would not necessarily improve services as the Note of Dissent to the Royal Commission's report makes clear. It does not help the least well off. We have not followed this recommendation because we believe our alternative proposals to improve standards of care and fair access to services will generate more important benefits of health and independence for all older people, now and in the future. (DoH, 2000a: 11)

Three points can be made about this position. First, it seems to place stress on fair access, but in practice the government is concerned with equality of *charging*:

> Not only do charging policies vary hugely, but in some councils it is the poorest members of society who are most in need of care who pay the highest charges. The government has therefore taken a new power in the Care Standards Act to allow binding statutory guidance to be issued.... (DoH, 2000a: 14)

Subsequent guidance (Department of Health, 2001) shows that the government is seeking to reduce variations in charging, in a way that will leave charging in place but make payments slightly more equitable for lower income groups. The government cannot claim that it is concerned with fair access to services – this is precisely what it has set itself against by rejecting free personal care.

Second, the government offers no explicit equity – that is, no distributional – principle. A concrete example helps to make this point. In spite of stating that the majority Commissioners' recommendations will not help the least well off, the government's own proposals do not help the least well off either. People on low incomes who live in care homes already have free nursing care, but still contribute much of their income towards housing, living and personal care. The poorest people have, from April 2002, a personal allowance of just £16.80 per week as 'pocket money' (Help the Aged, 2002).[4] More generally, the government has not said what it thinks would be a fair split between state and individual financing – even though it has said that this is needed – and as a result we do not know what level of Long-Term Care payment it considers fair for individuals.

Third, the government is seeking to determine the trade-offs that are considered in the public debate. Ministers have argued, for example, that intermediate care will improve access and quality of services for older people. The problem with this position is that the government is confounding services that are provided to different groups of people. If the government's plans for intermediate care are realised (a big 'if' at present), then unnecessary hospital and care home admissions might be avoided. People in receipt of Long-Term Care are, in practice, a different group – they may go into hospital at some point, but are really receiving a different bundle of services. So, action on intermediate care will not help most people in Long-Term Care. The government is therefore offering a political choice rather than one based on any clear criterion for deciding how to support a single, defined group of people.

Thus the policy choice offered by the government is framed as one between universal state-financed care services for all older people and a system involving a mix of public finance and private self-funding, with state resources targeted at the least well off. In designing our study, we made three observations about the debate to date:

1. These are not the only financing options, as we set out below, and it is possible to identify alternatives.
2. The government and Royal Commissioners were both making assumptions about wider public attitudes on equity of services for older people, which may or may not be well founded.
3. It is not possible to test the government's assertions about the relative merits of spending public money on Long-Term Care and intermediate care empirically, since intermediate care is still far from being fully implemented.

We therefore focused our study on Long-Term Care, seeking to understand public attitudes on equity and financing.

Methods

The aims of the survey were to increase our understanding of:

- the public's views about the *role of the state* and the preferred *model* of financing health and social care services;
- the extent to which the public distinguish between *care settings* when it comes to applying the principle of equal treatment for equal need regardless of income;
- the extent to which the public are *prepared to contribute* towards the costs of personal care.

Survey population

A proportionate stratified sampling methodology was used for the survey. The population was stratified on the basis of age, gender, ethnicity, geography and household income in order to ensure that these groups are represented in the survey sample in the proportions they appear in the population of England; sampling from the strata was random. One thousand people were interviewed by telephone, all interviewees were aged over 25 years and living in England.

- 60% of the sample were female compared to 51% of the population in England (ONS, 2000a);
- 9% of the sample were from minority ethnic groups compared with 7% nationally (ONS, 2000b);
- 50% of the sample were aged between 25 and 44 years compared to 30% nationally, 32% were aged 45–64 compared to 23%, and 18% were aged 65 or above compared to 16% nationally (ONS, 2000a);
- 31% of the sample had a weekly household income of £199 per week or less, 31% had an income of £200 to £399, 14% had an income of £400 to £599, and 12% had an income of £600 or above. This compares to average gross weekly earnings of full-time employees of £224 in the lower quartile, £462 among the upper quartile and £635 among the highest decile (ONS, 2000c);
- 29% of the sample lived in the north of England (North East, North West, Yorkshire and the Humber), 30% lived in the Midlands (East and West) and East Anglia, and 41% lived in the south of England (South East, South West and London). This compares well with national estimates of the resident population – 30% live in the north of England (as above), 30%

live in the Midlands and East Anglia (as above) and 41% of English residents live in the south of England (as above) (ONS, 2000d).

The questionnaire

Respondents were asked first about the best model of financing care. They were given a range of options from which to choose, from the state paying for care regardless of people's income to everyone making their own arrangements.

A set of questions asked respondents about their preferred method of financing care services; cost components of care services were framed within differing combinations of care settings. Three care settings were offered – hospital, care homes and people's own homes. Care services were divided into three cost components – hotel costs, personal care costs and nursing care costs. The survey did not assume respondents were familiar with definitions of nursing care and personal care, therefore the survey questions were task-oriented in order to help respondents make an informed judgement, for example respondents were asked whether:

- people who are in nursing homes (now care homes) should pay from their own incomes for their food and for their accommodation if they can afford to do so (these are ordinarily described as 'hotel costs');
- people who are in hospital who need help with changing their dressings and taking their medicine should not have to pay for this care from their own incomes even if they can afford to do so (these are all tasks that are ordinarily described as 'nursing care' and involve the knowledge or skills of a qualified nurse);
- people who are in their own home who need help with washing, eating and drinking or going to the toilet should pay for this care if they can afford to do so (these are all tasks that are ordinarily described as 'personal care').

The government had justified its policy to continue means-testing access to personal care by arguing that this allowed more resources to be better targeted at those in greatest need and so this trade-off was put to respondents.

Given the government's decision to continue means-testing access to personal care, the remaining questions focused on their willingness to pay for care. Respondents were presented with a range of possible charges based on estimates of actual costs. They were asked how much someone in financial circumstances similar to themselves could reasonably be expected to contribute towards the cost of personal care.

Unit cost data were presented in *Research volume 1* of the Royal Commission report (Royal Commission on Long-Term Care, 1999b). These data were the most reliable we were able to identify. The unit cost of personal care in domestic settings was given to be £8.50 per hour (1995/96 prices). The level of support needed by older people on the margins of institutional care will differ depending, for example, on whether they are disabled by a physical or a mental health condition, whether they live alone, with a spouse or with another relative/friend, and the kind of housing they occupy. Covering all major combinations of circumstance would have made the questionnaire too complicated. Instead, the survey asked about willingness to pay for three hours of personal care per week at home (ordinary housing with no carer) at a cost of £25 for three hours. This is based on vignette 5 given in *Research volume 2* of the Royal Commission report (see Box 1). Out of the six vignettes given, three hours of personal care per week is the least intensive amount. Therefore, willingness to pay was tested at the lower end of the contin-

Box 1: Vignette 5

Man aged 85+, living alone. He is prone to falls and is a recent widower, not used to performing any domestic tasks. Cooking, cleaning and doing the laundry are problematic for him. He is lonely. He has short-interval needs. He does not receive Attendance Allowance.

This person was estimated to require three hours of personal care per week, 52 weeks per year.

Source: Royal Commission on Long-Term Care (1999c)

uum of personal care need. Respondents were presented with three options:

- estimated full cost (£25);
- contribution of less than 50% of full cost (£10);
- no payment.

The total unit cost (based on the average cost) of care within care homes ranged from £275 per week (residential homes) to £337 per week (nursing homes) (1995/96 prices, Royal Commission on Long-Term Care, 1999b). The unit cost of *personal care* (as distinct from housing costs, living costs and nursing care costs) within care homes was not known at the time of this study;[5] for this survey, personal care was given a notional cost of £75 per week – at about a quarter of the total unit cost of care in a care home given by the Royal Commission. Survey respondents were presented with four options for contributing to the cost of personal care (all refer to weekly costs):

- estimated full cost (£75);
- contribution of less than 50% of full cost (£35);
- contribution of less than 75% of full cost (£10);
- no payment.

Analysis

The results section reports the findings for the overall sample. It also reports the results of a sub-group analysis in which sub-groups were compared against the findings for the overall sample – significant differences are indicated in both the text and tables.[6]

Additional statistical analysis was also undertaken within sub-groups, and although significant differences are noted in the text, they are not indicated on the tables.

Results

Who should pay for health and social care services?

Table 1 shows an overwhelming view among respondents (99%) that the state should retain at least some responsibility for financing health and social care services, either for all people or at least for those who cannot afford to pay for themselves. A significant majority (61%) were in favour of collective public financing of comprehensive health and social care services. 26% supported a top-up model of finance and 12% supported a means-tested system of finance.

Differences between sub-groups

There was very little significant variation in support for collective public financing between sub-groups when compared with the overall sample; only in the north of England was support significantly greater. Support for means-testing increased with age, although statistical comparisons between the age groups found that the only significant difference was between those aged 65 and over when compared to those aged 25–44 years. Comparisons between income groups found that support for means-testing was significantly higher among those earning £199 or less per week compared to all other income groups; support was also significantly higher among those earning £200 to £399 compared to those earning £400 to £599 per week. Support for a top-up model decreased with age, although these differences were not significant, and tended to increase with income. Support was significantly higher among those earning £400 to £599 per week compared with the overall sample. Support for a top-up model was also significantly greater in the north of England compared with the overall sample. These differences are arguably secondary in policy terms given the overall results.

Attitudes across care settings

Table 2 shows significant variation in overall attitudes toward paying for different components of care (hotel, personal care and nursing care) within different care settings (hospital, care homes and people's own homes). However, it also shows that a majority of the public support state financing in all cases.

Support for state-financed hotel costs ranged from 53% (care homes) to 73% (hospitals); support for state-financed nursing care ranged from 63% (hospitals) to 76% (care homes), and sup-

Table 1: The public's preferred model of financing care (% support)

	Collective public financing	Private financing	Means-testing	'Top-up' model
Overall	**61**	1	12	26
Sex				
male	62	1	9*	28
female	61	1	13	25
Ethnicity				
white	62	1	11	26
other	56	2	15	27
Age				
25-44	60	1	10	29
45-64	63	1	12	24
≥65	61	2	16	22
Income level				
≤£199	61	1	17*	21
£200 to £399	61	2	11	26
£400 to £599	57	1	5*	37**
≥£600	61	00	9	30
Residence				
north of England	68*	1	11	20*
Midlands/East Anglia	60	1	10	29
south of England	57	1	13	28

Notes:
N=1,002
Figure in bold in the overall results indicates a significant difference compared to next most popular option, $p<0.05$.
*Indicates a significant difference compared with the sample as whole (overall), $p<0.05$.
** Indicates a significant difference compared with the sample as whole (overall), $p<0.01$.

port for state-financed personal care ranged from 58% (domestic settings) to 82% (hospitals) – all differences are significant. Surprising, perhaps, is the significantly higher support for state-financed nursing care in care homes compared with hospital settings, although this appears a slight anomaly as support for state-financed hotel costs and personal care costs in hospitals was significantly higher than in all other settings. Respondents may have possibly misunderstood the question or, more likely, some may have been led by the association in the question, the question referred to *nursing* care in *nursing* homes (all homes are now 'care homes'[7]).

Differences between sub-groups

Table 2 shows no significant variation in support for state-financed nursing care costs between sub-groups when compared with the overall sample. Comparisons between age groups found that support for state-financed nursing care, across all settings, was significantly higher among the younger age groups (25–44 and 45–64) compared to those aged 65 and over. Comparisons between income groups found that support for state-financed nursing care was significantly different only within hospital settings, and support was greater among higher income households (£200 to £399, £400 to £599 and ≥£600) compared to those on the lower income (≤£199). Support was significantly higher for state-financed nursing care costs in care homes and domestic settings among white people compared to other ethnic groups.

In terms of support for state-financed personal care, Table 2 shows little significant variation in support between sub-groups compared with the overall sample. There were, however, some differences between ethnic groups and geographical areas – support was significantly lower among ethnic groups and significantly higher in the Midlands. Statistical comparisons between sub-groups found that support for state-financed

Table 2: Public support for state financing across care settings (% support)

	Nursing care costs			Personal care costs			Hotel costs		
	Hospital	Care home	At home	Hospital	Care home	At home	Hospital	Care home	At home
Overall	63	**76**	65	**82**	60	58	**73**	53	–
Sex									
male	65	76	67	80	60	60	75	55	–
female	62	76	63	84	60	57	72	52	–
Ethnicity									
white	64	77	66	84	60	59	74	53	–
other	56	66	65	68**	55	47	65	49	–
Age									
25-44	66	75	66	83	62	60	76	54	–
45-64	64	82	67	85	61	58	74	85	–
≥65	54	67	57	77	53	54	63**	57	–
Income level									
≤£199	54	70	60	76	54	52	62**	49	–
£200 to £399	65	80	65	87	61	61	81**	55	–
£400 to 599	68	83	70	88	66	58	74	57	–
≥£600	74	74	69	80	66	64	75	57	–
Residence									
north of England	63	77	67	84	57	57	77	51	–
Midlands/East Anglia	63	75	67	85	67*	64	71	57	–
south of England	63	75	61	79	57	54	72	51	–

Notes:
N=1,002
Figures in bold in the overall results indicate a significant difference across care settings, $p<0.05$.
* Indicates a significant difference compared with the sample as whole (overall), $p<0.05$.
** Indicates a significant difference compared with the sample as whole (overall), $p<0.01$.

personal care provided within care homes was significantly more popular among the youngest age group (25–44) when compared with the older age group (≥65). Support for state-financed personal care in domestic settings was significantly higher among the highest income group (≥£600) when compared with the lowest (≤£199) and among white people compared to other ethnic groups.

Table 2 shows little significant variation in support for state-financed hotel costs between sub-groups compared with the overall sample. The only significant differences were within hospital settings; here support for state-financed hotel costs was significantly greater among lower income groups (≤£199, £200 to £399) and among the older age group (≥65) compared with the overall sample. Statistical analysis between sub-groups themselves revealed no further significant differences.

Attitudes to targeting via an income test

A total of 60% of respondents had supported state-financed personal care in *care homes*, and the same proportion continued to support this even when presented with the government's justification for targeting resources using the means-test. Making the government's position explicit reduced support for free personal care in *domestic settings* but only by 5%.

Differences between sub-groups

Statistical analysis between sub-groups revealed significant differences between age groups: support for the government's position was significantly stronger in the older age group (≥65) compared to the youngest age group (25–44). And between income groups, support for the government's position was significantly stronger among those on lower incomes (≤£199)

compared to those on higher incomes (£200 to £399, £400 to £599 and ≥£600). There was no significant difference between ethnic groups.

Willingness to contribute towards the costs of personal care

Table 3 shows that 56% of respondents were opposed to contributing towards the cost of personal care in care homes. This is broadly consistent with the result shown in Table 2, where 60% favoured state-financed personal care in care homes. Around one in ten thought it reasonable to meet the costs of personal care in full, and just over a third were prepared to make a contribution.

In terms of contributing to personal care costs in domestic settings, Table 4 shows that about half (51%) of respondents were opposed to any contribution. A fifth were willing to pay the cost in full. Significantly more people were opposed to paying for personal care in care homes compared with domestic settings.

Differences between sub-groups

Table 3 shows a few notable differences in attitudes toward contributing toward personal care costs in care homes between the sub-groups when compared with the overall sample. Support for a reduced contribution was significantly higher in the middle-aged group (45–65) compared with the overall sample. Opposition to contributions was significantly stronger among the younger age group (25–44) compared with the sample overall. Generally, and perhaps not surprisingly among those willing to contribute towards the costs of personal care, the higher the weekly household income the more money respondents were willing to contribute, although statistical comparison between income groups revealed that this was only significantly differ-

Table 3: Willingness to contribute toward the cost of personal care in care homes (% support)

	Full cost	50% of full cost	75% of full cost	Nothing
Overall	9	17	19	**56**
Sex				
male	12	16	17	56
female	7	17	20	56
Ethnicity				
white	9	16	19	57
other	11	23	20	45*
Age				
25-44	8	20	22	50*
45-64	10	11**	13**	66**
≥65	10	18	19	53
Income level				
≤£199	8	15	21	56
£200 to £399	9	18	20	54
£400 to 599	10	17	19	53
≥£600	15	21	7**	56
Residence				
north of England	10	16	22	53
Midlands/East Anglia	6	18	19	57
south of England	10	17	16	57

Notes:
N=1,002
Figure in bold in the overall results indicates a significant difference compared to next most popular option, $p<0.05$.
*Indicates a significant difference compared with the sample as whole (overall), $p<0.05$.
** Indicates a significant difference compared with the sample as whole (overall), $p<0.01$.

ent between the highest income group (≥£600) who were prepared to pay the cost in full compared to those in the lowest income group (≤£199).

Table 4 shows few significant differences in attitudes towards contributing to personal care costs in domestic settings between the subgroups and the overall sample. However, among those willing to contribute towards the costs of personal care at home, the higher the weekly household income, the more respondents were willing to contribute towards the cost of care – significantly so in the higher income group (≥£600) when compared with the overall sample.

Table 4: Willingness to contribute toward the cost of personal care at home (% support)

	Full cost	50% of full cost	Nothing
Overall	21	28	**51**
Sex			
male	22	23*	54
female	20	31	48
Ethnicity			
white	21	28	51
other	26	31	43
Age			
25-44	22	32	46
45-64	20	23	57
≥65	20	27	53
Income level			
≤£199	18	31	51
£200 to £399	18	33	49
£400 to 599	26	28	47
≥£600	32*	16**	52
Residence			
north of England	21	27	52
Midlands/East Anglia	19	28	53
south of England	22	29	49

Notes:
N=1,002
Figure in bold in the overall results indicates a significant difference compared to next most popular option, $p<0.05$.
*Indicates a significant difference compared with the sample as whole (overall), $p<0.05$.
** Indicates a significant difference compared with the sample as whole (overall), $p<0.01$.

Discussion

The interview survey asked respondents about the role of the state and their preferred model of financing of Long-Term Care, their attitudes towards payment of care costs by care setting, and their own willingness to contribute towards care costs. The most striking single result was that people strongly supported a role for the state. On the face of it, this might be taken as evidence in favour of the majority Royal Commissioners' proposals for free personal care. To some extent it is, but the results suggest that the situation is more complicated. As we move through the discussion, we will note the light that the results shed on arguments about the equity implications of the government's and majority Royal Commissioners' policies and proposals.

On the preferred model of financing Long-Term Care, our results are broadly similar to the findings of Parker and Clarke (1997) and those reported in the more general British Social Attitudes Survey (National Centre for Social Research, 1999). Both surveys indicate support for universal provision – about 75% of respondents in the Parker and Clarke survey supported universal provision compared with 85% in our survey. However, the crucial difference between our survey and the Parker and Clarke survey was on the level of service provision within a universal system. In our survey a majority of 63% supported comprehensive services for all and in the Parker and Clarke survey a majority of 48% supported a top-up model ('basic' universal services for all older people with the option to top-up). The distinction between these models appears intuitively attractive but they are difficult to separate in practice. 'Topping-up' can be in terms of quality or quantity – but this is usually easier to define for the hotel element of care, for example better quality (a private room in a hospital), or quantity (three days' 'additional' care in hospital after giving birth, offered by a private London hospital).

Interpreted in equity terms, this part of the survey suggests that the government's alternative objective – equity of charging – is not supported. It also suggests a possible distributional principle, which, as we noted earlier, the government has so far failed to clarify – allocation of resources according to need. These results are closer to the majority Royal Commissioners' preferred main equity objective – maximising

equity of provision according to need within the Long-Term Care system.

The government, in contrast, has opted to focus on public expenditure and its redistribution (DoH, 2000a), arguing that free personal care is not the best use of available resources. As noted earlier in the article, this argument is not currently testable empirically. The government holds to this position in spite of some evidence to suggest that both today's and tomorrow's pensioners on low to middle incomes, living at home, may not be able to afford to pay for the care they need (Evandrou and Falkingham, 1998; Deeming and Keen, 2002). So, if anything, the policy sets itself against available evidence.

Turning to attitudes by care setting, respondents were consistent in their support for free personal care. We tested the strength of support for free personal care by framing questions in three ways. Questions about paying for personal care 'in principle' produced a response of around 60% in favour of free personal care in both care homes and domestic settings. Questions which pointed out the government's preference for means-testing of personal care did not alter the level of support: 60% of respondents continued to support free personal care in care homes and some 53% for domestic settings. A third sequence of questions about people's willingness to pay for their own care again produced similar figures. The results clearly point, then, to a 60–40 split in favour of free personal care in nursing homes and broadly the same split over free personal care in domestic settings.

We found stronger support for state provision of universal personal care among younger respondents (25–44 years) – exactly those people government wishes to encourage to invest for their future old age, through pensions and other financial vehicles. It is widely believed that the expectations of this group differ from those of older generations, who are more likely to be wedded to the principles of the welfare state, but our research found no evidence to support this. If anything, younger people seem to expect more from the state in this sample. There was also stronger support for universal free personal care from those with higher household incomes. Arguably this might be expected as the middle classes, and their heirs, are precisely those with the most to gain from free personal care. Support for state-financed care costs was generally stronger among white people compared to other ethnic groups, and significantly so in some instances. Although this is not easily explained, one possibility might be that some of the respondents in the minority ethnic groups, who have not grown up in Britain, may be used to a system of health and social care that is different, either in terms of provision or finance, to that in the UK. These differences between subgroups are, arguably, secondary in policy terms given that most supported state-financed care.

Majority public opinion is closer to the majority Royal Commissioners' position than the government's – personal care should be free to all on a non-means-tested basis. Respondents went further: a majority also wanted the state to fund hotel costs for Long-Term Care in care homes. State funding of hotel costs was dismissed by the Royal Commission, and the government agreed. Public opinion tends to support a focus on equity of provision, and acceptance of redistribution of financing via general taxation. Ensuring consistency in the application of funding and access to both health and social care services was a main recommendation of the majority Royal Commissioners, and the public appears to agree. The minority Commissioners argued that just because healthcare is free it does not follow that personal care should be free too. While this is undoubtedly true, most people do not accept the rationale for making some elements of care free and others means-tested. There are a number of reasons why this might be so. It may be that the public favour less redistribution, or, like the majority Commissioners, they would prefer not to use health and social care services as a direct mechanism for fiscal redistribution. Or, a majority of the public may not be convinced that the government will redirect resources saved through a means-tested system in a way that they view as fair or reasonable.

This said, the 60–40 split indicates that there is a substantial minority of people who favour at least some contribution by individuals. This group would prefer to maximise progressive financing *within* the population of people who need Long-Term Care – as distinct from believing that redistribution might be from taxpayers in general to people in receipt of Long-Term

Care. Forty per cent is a large enough number to allow for the interpretation that public opinion is split on the issue of payment for Long-Term Care, and in terms of practical politics may allow the government to continue to support means-testing. Wendt (2001), one of the majority Commissioners, has reflected that it might have been better had the Commission not drawn a distinction between nursing and personal care at all – since this might have made it more difficult politically for the government, as it would have had to introduce the distinction itself.

The final set of questions tested the willingness of respondents to contribute to the costs of personal care. A majority of people were *unwilling* to pay personal care costs in full. Most people, including those in high-income groups, thought it was unreasonable to expect them to pay the full costs of personal care. Again, this tends to support the view that the Royal Commissioners' proposals were closer to public opinion than the government's. That is, there is limited support for redistribution *within* the group of people who need Long-Term Care, and people expect at least some contribution from the state.

At present the government's position is a fudge. It might argue that it is assailed by a range of forces, including issues such as inheritance which we have not investigated here, but in truth the government is pursuing a strategy of minimum change in Long-Term Care. It has pursued a number of discrete policy objectives within the overall debate, but there is no early prospect of major reform. Long-Term Care thus remains a textbook case of disjointed and incremental change being preferred to fundamental reform. Indeed, it appears to be yet one more example of the long-running policy conflict over the nature and location of the health–social care boundary discussed by Lewis (2001). If it wants to maintain its current stance, the government will have to convince the public of the case for people paying for their own Long-Term Care, particularly as there may be little incentive for most people to save or invest if they are unlikely to avoid a means-tested old age (Rake et al, 2000). Attempting to re-frame the debate as one between financing Long-Term Care and intermediate care is, surely, an irrelevance. The government will also need to ensure that the new contract between the state and the individual is clear – including the true costs of care – if people are to make informed choices about saving for old age. One reason why the government has pursued this strategy is because it believes there has not been a clear consensus within the population at large. These survey results suggest some evidence for this view, but the results also reveal support for state financing of personal care as well as nursing care. It remains to be seen whether this is translated into political pressure at some point in the future.

Notes

[1] The Royal Commission (1999a: 67) defines personal care as care that directly involves touching a person's body (and therefore incorporates issues of intimacy, personal dignity and confidentiality), and is distinct both from treatment/therapy (a procedure deliberately intended to cure or ameliorate a pathological condition) and from indirect care such as home help or the provision of meals. This type of care is the main source of contention in the debate about the distinction between health care and social care. According to the Royal Commission (1999a: 68), personal care would cover, for example, all direct care related to:

- personal toilet (washing, bathing, skin care, personal presentation, dressing and undressing and skin care);
- eating and drinking (as opposed to obtaining and preparing food and drink).

[2] There was not agreement among Commissioners themselves on this. A majority supported this recommendation and it was the key recommendation of the report; however, two of the Commissioners (Joel Joffe and David Lipsey) did not and this was noted in the report (Royal Commission on Long-Term Care, 1999a: 113–43, 'Note of Dissent' – this note is sometimes referred to as the 'minority report').

[3] Since April 2002, the distinction between nursing and residential homes has disappeared and all homes are now 'care homes'; there are those

that are registered to provide nursing and those that are not (DoH, 2000c).

[4] This is a minimum and local authorities have the discretion to increase the personal allowance in order that money can be made available to the partner still living at home (Help the Aged, 2002).

[5] Since this work was completed, Laing has calculated that care assistant staff costs per resident are £92 per week (older people in residential homes) and £108 per week (older people in nursing homes) (Laing, 2002).

[6] In order to calculate whether a difference between two percentages is significant at the 95% confidence level the following formula was used:

$$\pm 1.96 = \frac{P1\ (100 - P1)}{N1} + \frac{P2\ (100 - P2)}{N2}$$

(P = percentage finding, N = effective sample size)

[7] See Note 3 above.

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