

Health and Care Bill's naked onslaught on UK working class

Paul Bond

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The passing of an amendment to the Health and Care Bill on Monday marks a devastating attack on the working class across England. It ensures that poorer pensioners will bear a greater financial share of their social care costs than the better off.

The Bill sets a cap of £86,000 on the amount anyone will have to pay personally towards the cost of their social care. However, the amendment excludes from this figure any means-tested support that is received to help pay for these costs, meaning that poorer pensioners will pay personally the same as the richer.

The cap was originally proposed by Sir Andrew Dilnot's 2011 report on overhauling social care funding, commissioned by David Cameron's Conservative/Liberal Democrat coalition government. The report was welcomed by then Labour leader Ed Miliband as "an important step forward," and he offered Labour's support in finding "a way to make this work."

Cameron's government introduced the cap in the 2014 Care Act, but it was never implemented. The government is using the current amendment to effect its implementation, protect private assets and cut £900 million per annum from government expenditure by 2027.

The cap means that up to a quarter of those facing residential care in England could end up taking more from their assets than was envisaged in the 2014 Act. At least 125,000 people at any one time could face higher costs even than originally proposed by Dilnot.

Those with assets of less than £20,000 will not have to use these to pay towards care fees, although they might have to pay from their income. Those with more than £100,000 in assets will not be eligible for any council financial help.

Those with assets between £20,000 and £100,000 will

qualify for means-tested support to help pay for care. However, this contribution will not be included in the £86,000 personal liability cap.

Dilnot's proposal was that any means-tested support should be included in the total cap. Excluding it, wrote Dilnot, would be "unfair for those on low incomes," as the result would be that the poorer would only "contribute more slowly, rather than contributing less overall" than the richer.

That was exactly the class calculation Boris Johnson's government introduced in the amendment. Dilnot himself noted that anyone with assets of less than £186,000 will be penalised under the amended scheme.

Torsten Bell, head of low income research thinktank the Resolution Foundation, tweeted: "Here's a simple way to think about the problem the government has created: if you own a £1m house in the home counties, over 90% of your assets are protected. If you've got a terraced house in Hartlepool (worth £70k) you can lose almost everything."

Sally Warren, of healthcare charity the King's Fund, said the amendment "no longer protects those with lower assets from catastrophic costs."

When asked by the press, business minister Paul Scully refused to guarantee no one would need to sell their home to pay for care. He told Sky News: "I can't tell you what individuals are going to do... It will depend on different circumstances."

Dilnot's review marked the emergence of an official consensus that even the most essential publicly funded social provision had to be dismantled and privatised. It accepted that those living in care homes had to pay their annual living costs, including food and accommodation.

The Department of Health and Social Care guidance

on the Bill makes clear that “daily living costs” are excluded from the cap, so even the notion that £86,000 is the most an individual will have to pay personally is false. Set at a nationwide flat rate of £200 a week, these costs come on top of the cap.

Much of the press coverage has focused on a regional divide, as house prices vary wildly across the country. Analysis by the *Guardian* suggests that those requiring long-term elderly care in northern areas will spend at least 60 percent of their eligible property value, compared to around 20 percent in the wealthier south.

The amendment caused unease among Conservative MPs in the northern so-called “Red Wall” constituencies won from Labour in 2019’s landslide election, capitalising on Brexit. Sitting in socially deprived seats, they are aware of the simmering class hostility that can be unleashed by yet more austerity and cuts and wanted to distance themselves from the reality of their party’s policies and hide behind its promises to “level up” the north with the south of England.

Despite an 80-seat majority in the House of Commons, therefore, the vote only passed by 272-246, a majority of 26. Eighteen Tories voted against the government and there were 68 abstentions.

The rest of the Bill was equally vile. Since the planned changes were first floated in a White Paper in February, the press have been trying to spin them as a bold reversal of Lansley’s 2012 Act, which extended sweeping privatisation across the National Health Service (NHS). The Bill will replace Lansley’s Clinical Commissioning Groups—the vehicle for privatisation through their buying of services “on behalf of” patients and putting those services out to competitive tender—with Integrated Care Systems (ICSs).

The claim is that the ICSs are intended to “eliminate the need for competitive tendering where it adds limited or no value.” But this is far from hostility to private provision. The removal of fixed price tariffs, rather, offers the possibility of more private provision if companies come up with better prices.

Thinktanks have rejected claims that the Bill offered private firms a power grab, but it did not need to. It is a more thorough-going integration of private firms within the structures of the NHS. Each of the 42 regional ICSs in England will be made up of Integrated Care

Partnerships, Integrated Care Boards (ICBs), councils, charities and others. Alongside NHS clinicians and local public health officials, private health companies can have representatives on ICBs. Health Secretary Sajid Javid has said that such appointments will only be blocked if they “could reasonably be regarded as undermining the independence of the health service.”

The end to public tendering is likely to see existing outsourced work being rolled over, cementing the place of private companies. The NHS will only be required to tender services where this might lead to better outcomes. But competitive tendering and privatisation will continue, especially in the most lucrative sectors.

The British Medical Association (BMA) has expressed concern that the Bill “allows contracts to be awarded to private providers without proper scrutiny or transparency.” Given the naked cronyism of exorbitant private contracts handed out to government allies during the pandemic, this is well founded. Javid is keen to use the confused conditions of the pandemic as a smokescreen, arguing, “This is exactly the right time for these reforms.” The Bill also gives the health secretary a free hand to intervene in any local plans at any time.

Labour’s “opposition” to the Bill was for the record. Justin Madders summarised Labour’s ringing defence: “we on the opposition benches believe that the NHS should be the default provider. If it is not the only provider, it should be predominant provider... Where a service cannot be provided by a public body there is still the option to go beyond the NHS itself, but that should be a last resort and never a permanent solution.”

Unite the union’s national officer for health, Jacalyn Williams, described the Bill as “a licence for politicians to run down and sell off our NHS,” even as the health unions work might and main to prevent a struggle by their members to oppose the government and defend the NHS.



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