Thank you for seeking my comments on the proposed amendment, which increases the level at which the Medicare safety net payments are activated.

The lifting of the thresholds clearly will have some effect on people, and we know that older and poorer people are high users of medical services. http://www.hic.gov.au/abouthic/our_organisation/annual_report/03_04/statistics.htm provides indicative data (Table 21 in particular).

Around 90 percent of people never reach the net. (90% of people have 25 or fewer consultations; at $1000 they would have to have an average of $40 out of pocket per consultation. At $500 they would have to have $20 out of pocket on average.

A comment on the safety net more generally. I imagine that the government knows full well how the safety net has been used. Take IVF for example. The Medicare benefit is around $1000 and the procedure costs at least $3000. Before the safety net, two accounts would be rendered to the patient, one for submission to Medicare and the other to be paid out of pocket. Now they are rolled together because the remaining $2000 can be covered through the net. The same applies to virtually all medical and surgical procedures, down to and including the supply of wheel chairs!

My more general views about the safety net are included in the attachment.

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HEALTH WARNING: SAFETY NETS HARM YOUR HEALTH

Stephen Leeder

When a high-rise is in flames, the stairs are blocked, the ladders do not reach and no helicopter can operate because of up-draughts and smoke, a safety net may save lives. A safety net is a last and sometimes effective resort.

How is it that we now have a Medicare safety net? Is Medicare on fire? The Medicare safety net was introduced to assist citizens meet medical and health costs that accumulate because Medicare and the Pharmaceutical Benefits Scheme now cover less medical costs than they once did. The safety net was invented to catch those who were finding the going hard. But the safety net now has large holes, evoking wrenching apologies from politicians. Too many people, leaping from lower floors, have been using the net. The more affluent, who could afford parachutes or small rockets to cushion their fall, have been excessive, too. Despite the Federal Government's attempt to rein in its costs by raising the safety net thresholds to $500 for low-income earners and $1000 for other families, the budget papers reveal that the Medicare safety net will still cost taxpayers $1.1 billion over the next four years.

Medicare, when introduced, was emphatically not a safety net. This irritates many politicians whose purposes would be better satisfied if it was. It was introduced for social (equity) and economic (cost control) purposes. For both of these functions, Medicare, the smartest form of supply-side control of health care costs yet devised, *had* to be universal. If it was not, medical and hospital costs would increase literally out of control in the space beyond its coverage.

As Medicare has been down-sized in influence, this is what has happened. By subsidizing private health insurance as a means of 'taking pressure off the public hospital system,' akin to treating an abscess on the leg by applying a poultice to the arm, the current federal government ceded control over a portion of health care costs.

Unsurprisingly, these costs rose, and to help citizens meet them (and remember that these costs are *outside* Medicare), a safety net was introduced. There followed an ideological boon as well. By associating the term 'safety net' with 'Medicare', the hoary problem of Medicare's universality could at last be thumped. Come now the day when the whole of Medicare might be called a safety net, catering only for the needs of those who cannot afford to buy private care.

The problem is that, in foregoing control over health care costs by turning Medicare from universal cover to a restricted safety net, the federal government is positioning itself and its successors like pedestrians crossing a freeway. The government has lost control of health expenditure. In fact, the head of Ramsay Health Care, Australia's new largest

private hospital operator, has announced that consumers should expect private health insurance premiums to keep rising by twice the inflation rate every year.

The Medicare safety net is a response to a system failure – a failure to exert price control. We have allowed the one thing that Medicare has - the power of a monopoly purchaser of health care - to wither in all areas except pharmaceuticals, and even there it is only exercising a restrained use of monopoly power. Medicare has been outwitted, outplayed and outlasted by the suppliers and private health insurers.

Politicians have invoked the dual demographic features of an aging population – falling birth rates and rising numbers of older people – as an argument that sick individuals should make greater contributions to the health and welfare systems, as governments cannot see how greater productivity from fewer workers can carry the load through taxation revenue. An older population elevates the demand on both these systems – health and welfare - especially as medical technology evolves rapidly and expensively. More older people? Yes. A problem in itself? No. However, if linked to rising expectations and more expensive medical technology and a national incapacity to increase productivity (by failed investment in essential infrastructure)? Yes.

It is tempting, in panic at the sight of what is coming, to privatize the risk we face. However, simply passing the payment for the uncontrolled (i.e. beyond Medicare's control) medical and social care costs to individuals will not work.

The answer lies in regaining control over medical and health care costs. Only when that is achieved can larger social goals such as equitable provision of care succeed. Do safety nets have a future? When the funding (and cost controls) of health services are adequate, there will be no need for safety nets. The sooner the better.

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