PUTTING THE $7 CO-PAYMENT IN CONTEXT: AUSTRALIA'S INCREASINGLY FINANCIALISED SYSTEM OF HEALTHCARE

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In Australia's 2014 budget, the Liberal-National Party Coalition Government announced the introduction of a compulsory $7 'co-payment' fee for all General Practitioner (GP) visits, out-of-hospital pathology and medical imaging tests. The co-payment will apply for all patients, including concession card holders and children (capped to the first ten annual visits) and is part of a $10.5 billion reduction in government health expenditure. Accompanying policies include an increase in co-payments for pharmaceutical benefits scheme medicines, a freeze on all non-GP Medicare rebates (which will result in a rise, for example, in the costs of seeing a specialist), an overall lowering of the threshold of the Medicare Safety Net, and pulling back on a commitment to increase public hospital funding.

These policies, like others in the budget, form part of the Coalition government's vision of 'ending the age of entitlement'. Their announcement followed the release of a National Commission of Audit, which had recommended, amongst many changes to 'unsustainable' levels of government expenditure, a government-mandated minimum $5 GP co-payment for concession card holders and $15 for general patients.

From the moment the co-payment proposal (now policy) received prominent and public attention in late 2013, it was met with vocal and widespread opposition. The Australian Labor Party (ALP) and The Greens consistently responded with strident criticisms, characterising the policy as an attack on Australia's universal and free healthcare system. A variety of organisations both within and outside the health sector voiced formal opposition, including the Australian Medical Association, the

NSW Nurses and Midwives Association (NSWNMA), and the Australian Council of Trade Unions. Numerous mobilisations were held and activist groupings formed around the country to campaign against the co-payment.

Those opposing the proposition are well justified in characterising the compulsory co-payment as a significant blow to public healthcare provisioning. In 2013, over 80 per cent of GP services were bulk billed (Department of Health 2014); that is, the Federal Government directly covered the entire GP costs of the visit through the Medicare rebate.

This same statistic and much of the rhetoric voiced by those opposing the co-payment, however, can paint a distorted picture. Many have characterised such a co-payment as a radical break or a new threat to an otherwise relatively democratic and egalitarian healthcare system. Emphasising Australia's level of bulk billing, the ALP's Shadow Minister for Health, Catherine King, described the co-payment as 'an assault on the universality of Medicare' (2014). Such rhetoric was also reflected in statements from The Greens, with Senator (Dr) Richard Di Natale stating that a GP fee would undermine equal and universal access to health care (AAP 2014). At a Sydney demonstration against the fee and 'In Defence of Medicare' on January 4 2014, NSW Secretary of the Australian Services Union, Sally McManus stated that co-payments represent an attack on 'the most effective universal healthcare system in the world'.

Such statements, while usefully highlighting the regressive nature of the co-payment policy, give the impression of Australia's public healthcare system as universal and equal. As such, they are highly misleading. Medicare has never been a system of universal free health care and it has declined significantly in its scope, particularly since the 1990s. In this context, the co-payment policy – alongside the other budget cuts to Medicare – is consistent and coherent with the financialisation of healthcare engendered by successive Australian governments, both ALP and Coalition.

'Financialisation' refers to the ascendancy of financial motives into more and more facets of the economy (Epstein, 2005: 1), including household daily life. Structural shifts and government policies have systematically integrated households into financial activity, transferring onto households an increased financial responsibility for accessing basic items such as healthcare, as well as housing, retirement income and education.

Over the past two decades we have witnessed the partial privatisation and the substantial financialisation of healthcare provisioning, which have transferred onto individuals an increased responsibility for the risks and associated costs . Households have little option but to increasingly absorb these risks and cover these costs in order to maintain minimum health standards. This includes the risks and costs associated with seeing/not seeing a specialist, taking/not taking medication or going/not going to a hospital, which Medicare cannot be relied upon to adequately cover, as well as the risks and costs of having/not having private health insurance.

This shift towards a financialised approach to healthcare, and the consequences for households' cost and risk exposure in Australia, is a focus of this article. In outlining this shift and considering changes in healthcare, it is argued that the introduction of the $7 compulsory co-payment fee represents a continuation of, rather than a break with, the current 'financialised' trajectory of healthcare and the provisioning of other goods and services. The nature and scale of this financialised trajectory raises significant challenges for those opposing both the co-payment policy itself and the politics behind it, for it means confronting the increasingly hegemonic logic of a user–responsibility and user-pays mindset. However, it also raises possibilities for connecting the strong and vocal opposition to the co-payment with broader political issues, recognising the multi-faceted ways in which the risks and costs increasingly absorbed by households through processes of financialisation are experienced.

In developing this analysis of how the provision of health services fits in with an already financialised approach to goods and service provision in Australia, this article is structured as follows. The first section begins with an empirical and conceptual investigation of the financialisation of healthcare provisioning in Australia, and the consequences for Australian households. Drawing on data of household experiences, changes in government policy, the causes and consequences of financial stress and rates of take-up of private health insurance, this first section documents the increasingly risky, stressful and costly nature of healthcare provisioning, a trend that will be increased by a $7 co-payment on GP visits. The second section contextualises the changing nature of healthcare provisioning within the broader financialisation processes in which the issue needs to be considered. Drawing on the example of health and considering existing literature, this section emphasises the structural transfer of financial and non-financial risks onto households

that has characterised this financialised period. Finally, the article considers some of the implications of these trends for an alternative to the current financialisation agenda.

Financialisation and the Experience of Healthcare Provisioning in Australia

Over recent decades, many of the risks associated with healthcare provisioning have been transferred onto households. This means that households are increasingly required to navigate the risks and complexities associated with private provisioning, are compelled to consider hedging against the risks of not having coverage of key services such as ambulance cover, and are required to absorb the costs associated with such 'security'.

First, we should note the rapid increase in the number of people purchasing private health insurance. In 2011-12, 57.1 per cent of all Australians 18 years and over (9.7 million people) had private health insurance (ABS 2013).[1] This was a significant increase from the previous figure of 52.7 per cent in 2007-08 (ABS 2013), and represented a reversal of the overall declining trend of the 1970s, 80s and 90s. In these decades, following the introduction of Medibank then Medicare,[2] the percentage of adults investing in private health insurance had fallen from 80 per cent in 1970 to 30 per cent by the late-1990s (Flood *et al.* 2004:370).

Second, we can see that these changes in the purchase of private health insurance have been shaped by government policies, which since the late

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[1] Of all people with private health insurance, most (79.1%) had both hospital and ancillary cover, while 12.3% had hospital cover only and 7.2% had ancillary cover only (ABS 2013). This pattern was similar to 2007-08 (ABS 2013).

[2] Medibank was introduced in July 1975 as a universal, non-contributory health insurance to replace the previously voluntary and predominantly privately financed health insurance scheme (Private Health Insurance Administration Council) (PHIAC 2012). The subsequent Liberal-National Coalition Government restricted coverage and eligibility, before a re-elected Labor government reintroduced (with a different financing model) the 'Medibank model' as *Medicare* in February 1984 (Biggs 2003). For a more detailed institutional history of this process, see the Federal Parliamentary Library's e-brief: *http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/Publications_Archive/archive/medicare*.

1990s have driven, or at least consistently facilitated, the trend towards private insurance. In 1999 the Federal Coalition Government introduced private subsidies through the 30 per cent premium rebate of the Private Health Insurance Rebate scheme which, while means tested since 2012, continues today. This followed the 1997 introduction of a Medicare Levy Surcharge (MLS) of 1 per cent of taxable income for individuals earning greater than $50 000 p.a. ($100 000 p.a. for families) – which was not indexed until 2008, despite inflation. This policy had the explicit purpose of encouraging individuals to take out private health insurance (Australian Government Department of Health and Ageing, 2011:2). In July 2000, the Federal government then initiated '*Lifetime Health Cover'*, again explicitly to encourage people to take out hospital insurance earlier in life (Australian Government Private Health Insurance Ombudsman (PHIO), 2014:5). This latter policy means that those who don't purchase hospital cover by July 1st following their 31st birthday are required to pay an additional 2 per cent – and up to a maximum 70 per cent – loading on top of the normal premium for each year they are aged over 30 (PHIO 2014).[3]

Thirdly, and unsurprisingly, such increasing rates of private health insurance have been accompanied by a widespread perception of the inadequacy of the coverage and scope provided through Medicare. Data that gives an aggregate picture of the actual scope and adequacy of Medicare coverage is difficult to locate, particularly given constant innovation in technology and the corresponding ongoing requirement for increases in government expenditure.

What we do have data on, however, are the perceptions of the limitations of Medicare, as indicated in a 2009 survey undertaken by the ABS on patient experiences of health services. The survey (ABS 2009) found that people without private health insurance were:

- Twice as likely not to have seen a GP

[3] See PHIAC website for clarification: 'For example, a person taking up hospital cover for the first time at the age of 35 would have to pay a LHC premium loading of 10%. LHC premium loadings cease once the person has had hospital cover for a continuous period of ten years. LHC loadings were introduced on 1 July 2000, meaning that the 2010–11 year was the first reported period in which some people had their loading completely removed.' (PHIO 2014:13)

- Twice as likely to have found cost a barrier in accessing their medication, and
- Half as likely again to have delayed or not seen a specialist

In relation to hospital services, the ABS concluded that 'people who felt their health was excellent, very good or good were one and a half times more likely than people who felt their health was fair or poor to have been treated as a private patient' (ABS 2009). Furthermore, in a later 2011-12 survey, the ABS asked respondents their reasoning for having private health insurance. 'Security, protection and peace of mind' was the most common reason given; stated by 51.8 per cent of all people with private health insurance. The most common reason for not having private health insurance was 'cannot afford it/too expensive' (58.3 per cent) (ABS 2013). These statistics are likely to reflect the lower income levels of people without private health insurance, yet they are also indicative of the significant costs faced by those dependent on Medicare.

This evidence suggests that the growing proportion of Australians who are turning to private health insurance are doing so in order to guarantee adequate healthcare cover in circumstances where the public sector is perceived as inadequate. Behind such sentiment, and as recorded by the Australian Institute of Health and Welfare (AIHW), is the evidence of an increasingly stressed public sector. Between 1995-96 and 2011-12 there was an overall decrease in the number of public hospitals from 758 to 753. More strikingly, there was a significant decrease in the number of public hospital beds relative to the population, the ratio falling from from 3.3[4] beds per 1000 people in 1995-96 to 2.6 beds per 1000 people in 2011-12 (1997:8; 2013:8). An Evatt Foundation study posited:

> Australians are only too well aware that their healthcare system is increasingly unreliable, indeed dysfunctional. Public hospitals have major problems because of ever-increasing demand, under-funding and shortages of health professionals... Planned surgery is rationed. General practitioners must raise their fees to survive.

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[4] The AIHW only includes beds relative to population in statistics since 1996-97 (when the figure was 3.08 for every 1000 population, see AIHW 1998:15). This figure of 3.3 for 1995-96 was therefore calculated using the AIHW method based on the Australian population at the beginning of the period, which as of June 30 1995 was 18.1 million (see *http://www.abs.gov.au/AUSSTATS/abs@.nsf/2f762f95845417aeca25706c00834efa/e2f62e625b7855bfca2570ec0073cdf6!OpenDocument*).

> The fees for specialists make it increasingly difficult for many citizens to benefit from their care. Individual financial capacity is increasingly a major determinant of health outcomes (Dwyer 2006, italics added).

Seeing a GP or specialist, taking medication, or going to a hospital are basic health requirements, yet households rely more and more on private purchase to maintain access.

What are the implications of this trend towards private provisioning and away from a reliance on Medicare? It means that households have absorbed the responsibility, and the resultant risk exposure, for complex calculations and decisions. It means that access to healthcare has become financialised. For every calculation, households face a trade-off between the risk of not having access to quality healthcare, and the costs associated with private health insurance. Private health insurance then puts households in the position of calculating a whole array of new risks and uncertainties surrounding different decisions, whether weighing up the scope and coverage provided through different providers and policies, pricing and deciding which 'extras' such as specialist coverage or the degree of hospital coverage invest in, or calculating the appropriate amount to put towards an upfront payment. Because particular (in)securities are associated with different providers or schemes, the security of households also becomes dependent on the financial viability of the providers. This is particularly significant given that over 70 per cent of private health insurers are now run for profit (Fergusson 2013:59).

Such a transfer of risk and responsibility comes at a significant social cost as households are required to hedge against the risks of inadequate cover. This social cost is reflected in the growing component of household budgets dedicated to healthcare expenditure. As detailed in Table One on the following page, the ABS's Household Expenditure Surveys record that medical and healthcare expenses increased from 3.9 per cent of household budgets in 1984 to 5.3 per cent in 2009-10 (2011:30).

Table One: Medical care and health expenses as percentage of total expenditure

1984	1988-9	1993-4	1998-9	2002-3	2009-10	% Change
3.9	4.3	4.5	4.6	5.1	5.3	1.4

Source: ABS (2011:30).

Over the past five years, average weekly expenditure on health increased 44 per cent, in comparison with a 39 per cent change in the Consumer Price Index (2011:8). A study published in the *Medical Journal of Australia* estimates that households now directly cover through out-of-pocket expenditure 22 per cent of the healthcare costs in Australia (Yusuf and Leeder 2013:475). ABS data gives some further disaggregation, as follows:

> Major items contributing to overall household medical care and health expenditure were accident and health insurance (40 per cent) and health practitioners' fees (29 per cent), and medicines, pharmaceutical products and therapeutic appliances (27 per cent). The remainder was mainly taken up by hospital and nursing home charges (ABS 2012).

This is the broader context in which this new system of co-payments can be seen – as a continuation rather than a reversal of the shift onto households of the costs and financial risks associated with healthcare. Co-payments continue a trend whereby increasing private expenditure is perceived as necessary to meet an average household's healthcare needs. This is not to say that it is acceptable, still less inevitable. On the contrary, it should be a trigger for broader consideration of the social problems that result from the combined effects of financialisation and changes in healthcare policy and funding. The opposition to the co-payment policy could give momentum to a more comprehensive political response - articulating an agenda for a fully publically funded and administered, free and universal healthcare system.

These political economic processes, possibilities and prospects also require a more thorough analysis of how the decline in the public provisioning of healthcare fits within broader processes of financialisation and the central 'risk-shifting' dynamics of the financialisation process. Consideration and articulation of these broader 'risk-shifting' issues allows us to see how the campaign for a more equitable and universal healthcare system (and against the $7 copayment) can relate to a broader challenge to the ongoing shifting of financial and non-financial risks onto Australian households.

Financialisation and the Risk-Exposed Household

Underpinning, and often preceding, changes in healthcare provision, has been the process of 'financialisation': 'the increasing role of financial motives, financial markets, financial actors and financial institutions in the operation of the domestic and international economies' (Epstein 2005:1). A wealth of literature has explored the nature of this financialisation process, yet it has often described or emphasised very different dimensions, particularly when it comes to the questions of household finance. This is because, while it may be uncontroversial to claim that we live in a world that has seen the mass expansion of financial motives,[5] commentaries on financialisation tend to emphasise different aspects. Some characterise recent transformations either in terms of the structural 'neoliberal' changes affecting household income and expenditure, while others talk in terms of individuals engaging in more and more risky activities, thus neglecting the other corresponding (and critical) dimension. Both dimensions are fundamental in understanding the financialisation process and the changing nature of goods and services provision in Australia.

Many political economists have outlined the structural 'neoliberal' changes in the Australian economy, and the impact that such changes have had on Australian households (see, for example, Anderson 1999; Cahill *et al.* 2012; Cahill 2005; Stilwell and Jordan 2007). Policies of deregulation and privatisation have led to changing patterns of household provisioning, where governments have promoted a 'user-pays' mindset in

[5] One commentator has gone so far to assert that 'every man (women and child) is now a speculator' (Fraser 2006:1).

order to shift a series of expenses onto household budgets. Engagement with private markets and taking on associated costs has become increasingly necessary to maintain access to subsistence items such as healthcare, education and retirement income. Moreover, such structural changes have significantly extended the imposition of market imperatives on work, social and domestic life. We see, for example, that alongside important questions of affordability and expense, the provision of healthcare is increasingly shaped by private sector motives of profitability and efficiency, rather than the needs of healthcare recipients and the capacities of those working in the industry. Other scholars,such as post-Keynesian economist Steve Keen (2009) in an Australian context, put particular emphasis on the consequences of such processes in relation to increasing levels of household debt and the sustainability of debt repayments. Other studies have focused on the prevalence and significance of financial stress (see, for example, Rowley and Ong 2012; Marks 2005).

At an international level, Marxist economists such as Costas Lapavitsas (2011), Ben Fine (2010) and Paulo dos Santos (2009) have concretely linked neoliberalism with rising household debt levels through highlighting some of the financial aspects of such processes. In focusing on the increasing role of households as debtors and/or asset holders, Lapavitsas (2011) outlines the way that market-based provisioning has required households to 'invest' increasing proportions of their incomes in assets – including health insurance. This, in turn, has increased market exposure and levels of household debt. Similarly, dos Santos (2009:192) describes how financial changes have 'forced individuals into debt and necessitated the transfer of growing shares of their income'.

These cost- and debt-focussed accounts open up critical connections between neoliberalism and finance, and the way in which government policies have facilitated a trend whereby individuals cover more and more of the costs associated with goods and services such as healthcare, as described in the previous section of this article. Furthermore, such accounts have a popular and intuitive appeal in the context of the very high level of household debt as a proportion of disposable income in Australia – a proportion which rose from 40 per cent in the 1970s to over 150 per cent in 2011 (Freestone *et al.* 2011:64).

Certainly, individual and household costs – not least in relation to health – have increased over recent years, signifying the extent to which

households now absorb everyday costs that wereoften previously covered by governments or employers. However, these accounts that focus on increasing household costs, tend to neglect exploration of the underlying transfer onto households of financial and non-financial risks, and of the broader and more diverse costs associated with this transfer. The often hidden, yet underlying, dimension of household risk is fundamental for understanding the neoliberal turn and the corresponding increase in household 'investment' and debt levels. As we have seen in relation to healthcare, the impact of recent changes is not simply the increased cost of a particular consultation or treatment. The impact is also the risks that households face in terms of inadequate health coverage and the potential financial and non-financial consequences of not investing in private health insurance.

A variety of literature is dedicated to investigating the pervasive risks associated with everyday life. It has come from across the political spectrum, including the economic mainstream. Economists such as Robert Shiller (2003) and Joseph Stiglitz (2009) have recently applied longstanding neoclassical conceptions of the risk implicit in every decision (see, for example, Arrow 1951) to examine the typical modern risk-exposed household. Both theorists have, in their differing ways, acknowledged the difficulties that risk poses for households due to incomplete markets or behavioural irrationalities. Although these accounts identify the pervasiveness of risk in contemporary capitalism, they do not locate such ubiquitous risk within the significant structural and policy changes outlined in the 'neoliberalism' or 'financialised capitalism' literature. Rather, their lens for viewing increasing risk-exposure is in terms of the preferences and choices of individuals, abstracted from the changing patterns of expenditure of the state and employers that have underpinned household engagement with financial activities, such as private health insurance. The distinctive methodological individualism that is characteristic of applied neoclassical theory is evident.

Less abstracted is the work of scholars from other theoretical traditions. For example, a pioneering study by Ulrich Beck asserted that modern capitalism has shifted from an industrial to a risk society, whereby 'individuals reflect upon and flexibly restructure the rules and resources of the workplace and of their leisure time' (Beck 1992:3). That is, an 'individualised' society has developed that both affords individuals new opportunities for self-development, but also results in individuals

absorbing increasing levels of risk. While Beck made no substantial reference to financial risk, his thesis inspired a wave of post-structuralist engagement with the question. For example, Paul Langley explored the new relationship that individuals and households form with capital markets, whereby risk is constructed as an opportunity to be embraced, but with the potential of damaging outcomes:

> While many individuals and households undoubtedly gain from recently formed relationships with the capital markets, the material effects of these relationships are also highly divisive and, at points of crisis in particular, can be disastrous for those involved (Langley 2008:14).

Similarly, sociologist Leonard Seabrooke has outlined the way that individuals, through access to finance or credit, are embedded in cumulative financial processes, and the negative implications this may have, particularly for those in lower income groupings (Seabrooke 2006).

Notwithstanding its important insights, such literature still neglects to systematically connect the 'risk' society with the structural changes of an increasingly financialised economy and the type of neoliberal policy doctrines that this article has outlined in relation to health. Attention to these issues is required to adequately appreciate the full implications of the financialisation process(as explored by Martin 2002; Hacker 2006; Warren 2004; Bryan, Martin and Rafferty 2009; and Allon 2011). This perspective helps to show why, in order to maintain access to basic items such as housing, health, transportation, education, or pre- and post-retirement income (superannuation), households rely on private purchase and on private insurance, or, in the case of superannuation, partially on financial-market-derived revenues.

Significant components of consumption are now also buttressed by the hedging of risk. Through this process, households are increasingly cast as financially literate investors, capable of navigating complex financial markets and risk exposures in their daily functioning. And there are the additional 'non-financial' risks incurred through changing patterns of public provisioning. For example, if costs associated with private health care, comprehensive car insurance, home and contents insurance or dental check-ups are too high, households may take on the risks associated with not having protection provided through such coverage.

Reflecting this tendency, 18 per cent of adult Australians are reported to be 'severely excluded' from financial services (Connolly 2013).[6]

Jacob Hacker describes the transfer of what was previously socially dispersed risk onto individual household units. He illustrates how a policy framework driven by a crusade of 'personal responsibility' has meant that 'work, family and public and private benefits have all grown more risky at roughly the same time' (2006:5). Similarly, Elizabeth Warren outlines the increased requirement for families to engage in financial activities such as insurance markets (including health), unaffordable credit or complicated loans 'to keep safe… and let them earn a living' (2006:14). Relating financialisation specifically to the Australian household, Fiona Allon underscores the importance of 'taking into consideration the redistribution of risks and responsibilities onto the household and the implicit expectations that it will perform in particular ways' (2011:129). As even the International Monetary Fund acknowledges, the household has become the global financial systems 'shock absorber of last resort' (2005:89).

Looking at such financialised access and activity, we can see the interplay of 'neoliberal' changes and a 'risk society'. It is not only particular costs, but also the underlying exposure to risks – both financial and non-financial – that were once covered by governments or employers and have been transferred onto households. This dictated engagement with finance and risk does not preclude instances where households may decide, for example, to invest savings in a particular financial market or go into debt to access a new consumer durable. However, the 'choice' of households when 'investing' in a superannuation or health insurance scheme, or when taking on a mortgage or HECS[7] debt, is clearly constrained by the financialised context in which we now all operate.

The ascendancy of financial activity into increasing facets of daily life has not gone unnoticed by households, nor by financial institutions. It is certainly not solely in relation to health that households are feeling the pinch. A recent survey undertaken by REST Industry Super outlined that

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6 Connolly (2013) also provides analysis of the forms of insurance that people are not undertaking.

7 HECS refers to the Higher Education Contribution Scheme. Reforms to HECS in 2005/06 renamed the scheme HECS-HELP (Higher Education Loan Provision), which retains the same principles as HECS.

only 1 in every 7 (14 per cent) baby boomers felt confident enough about their financial situation to retire (2013:22). Insurance provider Genworth's latest report on homebuyer confidence in Australia detailed that 'a general rise in the cost of living' was the major factor underpinning mortgage stress levels in Australia (2012: 8). A similar report by the Fujitsu ratings agency in 2010 identified that cost of living was the major source of mortgage stress (Fujitsu, 2010: 29). An earlier report released by the Department of Families, Housing, Community Services and Indigenous Affairs had also emphasised the need to complement measures of income and subjective poverty with a measurement of financial stress, when determining 'how households were actually coping financially' (Marks 2005). Such a transfer of risks, costs, stress and debt raises critical concerns for the equity or wellbeing of Australian households, especially lower income households and households with little 'financial literacy'.

Australia's changing system of healthcare provisioning (including the $7 co-payment), together with the Australian household's experiences of such changes, needs to be seen within this broader context of financialisation, in an era where neoliberal ideologies and practices have been dominant. The broader context signals the significant challenge that articulating an alternative approach to healthcare will inevitably face. Yet it also raises possibilities. Locating the financialised approach to health within a generalised shifting onto households financial and non-financialised risks can open up new frontiers of resistance, which connect and articulate the various experiences of financialisation – whether it be the risks associated with healthcare, the stresses associated with housing or retirement income or the costs associated with education.

Conclusion

The preceding analysis identifies the $7 co-payment policy as a continuation of a financialised approach to healthcare provisioning. It uses the example of changes in healthcare to examine the more generalised transfer of financial and non-financial risks onto households. Households now have little option but to absorb and navigate an array of new risks, and cover associated costs and complexities, in order to maintain their provision of basic goods and services – including

healthcare and items such as housing, education and retirement income.

This particular understanding of the risk-shifting agenda has major implications for the way in which we conceive of, and articulate an alternative to, the financialisation of healthcare, and indeed the whole financialisation process. While it underscores the challenges faced by those opposing the financialised trajectory of healthcare provision, it also opens up new political possibilities. For example, the momentum surrounding the 'Save our Medicare' campaign could be connected with public concern about other areas of household insecurity, thus rearticulating a political agenda of comprehensive social security. Social concerns about reducing household exposure to interest rate volatility or protecting households from fluctuations in the market value of savings held in superannuation funds are widespread. The health risks that result from the shift to private provision and the unreliable public provision of basic health services are similar in character. Bringing these concerns together can help to articulate a challenge to the current financialised and neoliberal order.

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