Public Health Association
AUSTRALIA

PHAA Submission on The Extent and Nature of Poverty in Australia

Contact for recipient:
Senate Standing Committee on Community Affairs – References Committee
E: community.affairs.sen@aph.gov.au
T: (02) 6277 3515

Contact for PHAA:
Terry Slevin – Chief Executive Officer
A: 20 Napier Close, Deakin ACT 2600
E: phaa@phaa.net.au **T:** (02) 6285 2373

March 2023

Contents

Preamble

The Public Health Association of Australia

The Public Health Association of Australia (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public's health in Australia.

The PHAA works to ensure that the public's health is improved through sustained and determined efforts of the Board, the National Office, the State and Territory Branches, the Special Interest Groups and members.

The efforts of the PHAA are enhanced by our vision for a healthy Australia and by engaging with like-minded stakeholders in order to build coalitions of interest that influence public opinion, the media, political parties and governments.

Health is a human right, a vital resource for everyday life, and key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people's health. The health status of all people is impacted by the social, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

All members of the Association are committed to better health outcomes based on these principles.

Vision for a healthy population

A healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health for all.

The reduction of social and health inequities should be an over-arching goal of national policy and recognised as a key measure of our progress as a society. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.

Introduction

PHAA welcomes the opportunity to provide input to the Committee's inquiry into the extent and nature of poverty in Australia.

PHAA's vision is for:

> "*a healthy people … living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health for all. The reduction of social and health inequities should be an over-arching goal of national policy and recognised as a key measure of our progress as a society. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally*."

Achieving this vision must be based on a minimum standard of living which is above any definition of poverty. As current data about the extent of poverty in Australia starkly reveal, that is not the condition Australia is currently experiencing.

Poverty is not an unavoidable social necessity, it is a policy choice. It is entirely possible for a modern democratic society such as Australia, blessed with sound governance, ample resources, high levels of education, and adequate levels of social cohesion and trust, to make the policy choices necessary for a poverty-free society. But through our political decisions over many decades, we have simply failed to do so.

The key drivers of poverty are easily identified; employment policies which seek to contain lower wages from growth, social welfare policies which severely limit basic social security to below the poverty line, housing policies which constrain investment (including public investment) in new affordable housing, and policies relating to rent which allow lower-end private rental prices to become unaffordable, are all examples of economic settings which drive increased poverty.

To these may be added permissive policies towards exploitative and addictive products and services including nicotine addiction, alcohol abuse, gambling addiction, and the heavy promotion of unhealthy foods which lead to chronic diseases. The impacts of addictions become powerfully economic, further trapping people in conditions of poverty.

Poverty is not merely about a lack of *resources*, but a lack of *choice*. When people are deprived of access to opportunities for obtaining reasonable wages, affordable housing, and a competitive rental market, they remain in conditions of poverty without any capability to do anything about their situation. When food insecurity increases the rate of illness and disease in people, their capacity to work, complete study, and meet other goals is reduced. When people are deprived of choices to live healthy lives through the massive marketing and provision of addictive products and services, they become further trapped.

Poverty in wealthy, developed economic societies such as Australia has been a policy choice. But this can be corrected.

Addressing poverty does not entail the removal of all degrees of inequality, only its moderation. Research shows that the community does not demand that economic and social policies create strict equality for all, but only that they limit the extent of inequality to a tolerable degree, and ensure that the degree of inequality which is present is linked to some notion of fairness. Again, key policy settings in Australia are not meeting such expectations.

The current inquiry can be a vehicle for new advancing better policy directions to reduce inequality and address poverty in Australia in the spheres of social welfare support, housing policy, control of gambling, and many other policy spaces.

Your inquiry has a very broad remit. We suggest that you focus on making recommendations in the following areas:

- The need to increase the basic rate of social security payments
- The need to find ways to increase housing availability and affordability
- The need to ensure greater levels of food security for those below the poverty line
- The need to enhance the availability and accessibility of primary health care
- The need to include dental care within the Medicare system
- The need to bring under control gaming machine proliferation and online gambling.

Response to the Inquiry Terms of Reference

ToR (a): The rates and drivers of poverty in Australia

Extent of poverty

It is estimated that one in eight people live in poverty in Australia, including one in six children.[1]

But crucially, we also know that the extent of poverty is responsive to policy choices by governments. The report *Poverty in Australia 2022: A Snapshot*, found that while the poverty rate rose to 14.6% in March 2020 at the beginning of the pandemic, it fell to a 17 year low of 12% by the June quarter due to the introduction of higher income support payments such as the JobSeeker coronavirus supplement and the JobKeeper payment.[2] In real terms, the boosted payments lifted 646,000 people out of poverty.

Health status as a determinant of poverty

Poor health is a determinant of poverty. Due to poorer health, those in lower socioeconomic groups are more likely to have to experienced 'catastrophic' expenditure on healthcare, which refers to spending 10 % or more of their income on healthcare.[3] People on lower incomes often feel forced to treat spending on healthy foods and healthcare as discretionary, rather than necessary.

A survey by the Australian Council of Social Services (ACOSS) of 449 people living on JobSeeker, Youth Allowance and Parenting Payments found that when people are struggling to make ends meet, they will spend less money on healthy foods, healthcare, and medications in favour of cheaper, less nutritious foods, fuel and rent.[4]

Barriers to access as a determinant of poverty

Unfair barriers to accessing health care reflect weaknesses in healthy system design, structural forces which maintain inequalities in income and wealth, and various forms of discrimination and marginalisation.[5] Unfair health chances reflect inequalities in exposures due to economic or political inequalities, and heightened vulnerabilities as a consequence of discrimination or marginalisation.[6]

Gambling as a determinant of poverty

Australia has the highest levels of gambling losses per capita in the world, with losses worth $24.9 billion in 2018-19, and increasing at a rate of around 5% per annum.[7] Moreover gamblers' financial losses alone are not the only cost of gambling. The AIHW has estimated "the social costs of gambling – including adverse financial impacts, emotional and psychological costs, relationship and family impacts, and productivity loss and work impacts – at around $7 billion in Victoria".[8]

Gambling causes harm to the physical, social, and mental health of communities, families, and individuals. Moderate to severe problem gambling results in suicide, relationship breakdown, financial difficulty, mental health problems such as anxiety and depression, and crime.[9] Gambling particularly affects vulnerable groups in the community such as people from low socioeconomic backgrounds.[10]

ToR (b): The relationship between economic conditions and poverty

One of the major drivers of economic security for people is the condition of health and wellbeing in which they live.

Over many years PHAA has consistently made the case for preventive health investment through our Budget submissions. All too slowly governments have come to accept the economic point that sound public health policy is sound economic policy,

The economic case is simple and powerful: prevention (or minimisation) of disease in the community saves governments – and the private economy – very significant costs in terms of financial and labour resources. The benefits of having stopped something from happening are often difficult to perceive. But the COVID-19 pandemic has provided a tragically clear demonstration. We must learn from this experience.

According to the Productivity Commission, on average Australians live for around 13.2% of their lives in ill health – one of the highest proportions of any OECD nation, exceeded only by people in Turkey and the United States[11]. This is a major economic and social challenge. National economic and fiscal policy must be framed to address it.

Years spent in ill health present two major forms of economic loss: the opportunity cost of lost productivity during working years, and the direct cost (often increasingly expensive) of treatment and care. The reality is that we will inevitably expend resources on 'health'; but we have choices about whether we spend efficiently on preventing disease and maintaining wellbeing, or more expensively and less efficiently on treating illness.

The degree of wellbeing and health – or alternatively, the extent of disease – across the population is a major driver of that population's economic vitality, to say nothing of the social importance of wellbeing. Population health is also a major driver of the inflow and outflow of government revenue and expenditure.

For example, the OECD's *Heavy Burden of Obesity: The Economics of Prevention* report (2019)[12], examining 52 developed member nations, calculated the economic impact of overweight and obesity, which is one of modern society's most common forms of ill-health, and a driver of several major disease conditions. The report put the estimated economic cost to Australia at an astonishing 3.1% of GDP, including lowered labour market outputs equivalent to the productive output of 371,000 full-time workers, as well as an average reduction in lifespan of 2.7 years per person.

To give another example, the November 2020 *Report of the Productivity Commission inquiry into Mental Health*[13] gave an estimate of the economic cost (measured as at 2018-19) of mental illness in Australia (comprising direct expenditure on mental healthcare and support services, lower economic participation, and cost of replacing the support provided by carers) at up to $70 billion per annum.

These costs clearly form one of the largest economic burdens facing Australia's governments. They are drivers of continual pressure on national and state/territory governments to make our health systems (or more accurately, our *illness treatment* systems) more financially "sustainable". However, the concept of sustainability does not simplistically imply a need for government expenditure constraint, but rather it makes a case for a holistic approach to ensuring that higher socio-economic policy goals can be delivered in a manner which can be reliably maintained over many years. In fact, too much *constraint* on investing in disease prevention and wellbeing is in fact financially counter-productive in the long term, if it increases the extent of chronic disease and other illness and injury in the population.

In addition to the growing *scale* of problems of disease, their *spread* is becoming more socially uneven. Australia faces a steadily growing problem of economic inequality and inequity, including specifically inequity of health status and outcomes.[14, 15, 16] While this is true of the population as a whole, the greatest challenges to wellbeing in Australia are the conditions faced by Aboriginal and Torres Strait Islander Australians, Australians of lower socio-economic status and resources, and rural and regional Australians. This inequality has a compounding nature, because socio-economic disadvantage persistently causes inability to take health enhancing action, and inability to access services to deal with illness.

As of 2021 the Commonwealth Government's bipartisan National Preventive Health Strategy officially acknowledges the vital importance of preventive health, and commits to achieving a national health spending effort of 5% of all health spending being directed to preventive policies.[17]

We also note that the Australian Government has announced the development of a 'wellbeing framework' for future Commonwealth Budgets. This would be a positive step towards shifting priorities towards measures that would reduce poverty.

ToR (c): The impact of poverty on individuals in relation to employment, housing security, health and education outcomes

Housing Security

The *2022 Rental Affordability Snapshot* published by Anglicare found that out of a snapshot of 45,992 rental listings around Australia, just eight individuals – statistically 0.0% – were affordable for a single person living on JobSeeker.[18] The report also found that 0.0% of rentals were affordable for someone living on the Youth Allowance. The situation was only marginally better for working people on low incomes, with 1.6% of rentals affordable for a single person working full-time on minimum wage.[19]

Housing affordability is closely linked to food security with 45% of renters and 69% of those living in social housing, mobile housing or between housing experiencing food insecurity.[20]

Important indirect consequences of a lack of housing security, such as high cost and supply constraints that force people to restrict spending on things like food, medical treatment or medications, and insufficient supply of housing for people living with disabilities or chronic health issues, may amplify health issues and negative effects that a lack of housing or poor housing has on mental health, wellbeing and self-esteem.[21]

Food Security

Food security is fundamental to health equity. Food insecurity is defined as inconsistent access to adequate nutritious food due to a lack of money (either due to low income and/or combined with the high cost of living) or other resources (including but not limited to transport, affordable housing with food preparation and storage facilities in working order).[22,23,24] Food insecurity and hunger are persistent social and public health issues. Food insecurity has been estimated to affect over 4 million Australians a year, though this may be an underestimate.[25]

Recent natural disasters and the COVID-19 pandemic have highlighted the fragility of food supply chains, affecting food price and availability. This, along with the impact of a sudden loss of income, lockdowns, border closures and travel restrictions, has increased the risk of food insecurity among previously food secure households, but has particularly impacted those with more chronic food insecurity.[26,27,28,29]

Availability, access, use, stability, are the four pillars of food security. Agency and sustainability are two further pillars that are increasingly being recognised in addition.[30,31]

The social and public health burden of food insecurity includes increased risk of: all-cause and cardiovascular mortality, [32] diet-related chronic disease,[33] obesity, [34] malnutrition, mental health service utilisation, [35] healthcare costs, [36,37] impaired child development, [38,39,40] and lost economic productivity. [41]

Globally, current levels of food insecurity are the result of inequalities in food distribution and access, as well as war, political unrest, pandemics, natural disasters, and climate migration. Consistent with the social gradient of health, [42] food insecurity is more prevalent among groups and populations that experience social disadvantage.[43,44]

Populations who experience socioeconomic disadvantage e.g., Aboriginal and Torres Strait Islander peoples', people experiencing homelessness, people living in rural and remote areas, the elderly and those already experiencing high rates of food insecurity are likely to be most vulnerable to the effects of climate disruption, [45,46,47] and may be forced to spend an even greater proportion of income on food. [48] For a family on a low income, purchasing a healthy diet is estimated to cost 20-31% of the disposable household income, compared with 18% for those on a median disposable income. [49]

Population sub-groups experience higher rates of food insecurity: 92-100% among homeless;[50,51] 70% refugee and asylum seeker households;[52,53,54] 13% older households;[55,56] 20-25% low to middle income;[57,58,59] 25-50% university students[60,61,62] and people living on social protection payments[63] and those living with disabilities.[64]

More information can be found in PHAA's recent submission to the House of Representatives Standing Committee on Agriculture on Strengthening and Safeguarding Food Security in Australia.[65]

ToR (d): The impacts of poverty amongst different demographics and communities

Women

Gender plays a major role in poverty. Gender is a significant determinant of many social conditions, including morbidity and mortality; life expectancy; quality of life; access to health care; health promotion; healthy lifestyles; and physical, mental, emotional wellbeing. [66,67] Sustainable Development Goals (SDGs) #3 (good health and well-being), SDG #5 (gender equality) and SDG #10 (reduced inequality) directly relate to gender and health, and other SDGs to some extent intersect with gender (for example, SDG #1 (No Poverty) and SDG #4 (Quality Education)). Gender intersects with other social determinants of health that result from the distribution of power and resources along the social gradient, including but not limited to pay equity, workforce participation, culture and ethnicity, religion, housing, education, rural or urban residence, and superannuation.[68,69]

Women live longer than men, however they are more likely to be financially insecure, live alone, be in residential care, be affected by dementia, and live fewer active years despite older age.[70] The gender-based differential in wealth accumulation, [71] in tandem with increasing housing costs, has resulted in a crisis of a housing affordability and security, with an increased risk of homelessness.[72] Additional and unacceptable housing risks are faced by women in family violence situations.[72,73] The risk of poor mental health compared to men escalates in the context of relative poverty for older Australian women.[74]

People with disability

People with disability are often excluded from employment, and from education, through direct and indirect discrimination,[75] and are otherwise disadvantaged with respect to almost all social determinants but particularly education, income, and employment.[76]

The 2018 ABS Survey of Disability, Aging and Carers highlights stark inequities. In 2018:

- 53% of people with disability aged 15-64 years were engaged in the labour force compared to 84% of people without disability.
- The unemployment rate for people with disability was more than double the rate for people without disability.
- Median gross personal incomes of people with disability were half that of people without disability, and half of people with disability lived in a household in the lowest two quintiles of household income.[77]

People with disability are at higher risk of homelessness than the general population due to low incomes, low rates of employment, and restricted capacity in the private rental market, and are overrepresented among people experiencing homelessness in Australia.[78]

People with disability have poorer housing outcomes compared with the Australian population as a whole, and households with people with a disability frequently have difficulty securing appropriately located accommodation, often living on the urban fringe in less expensive regional housing that is some distance from services.[79] Of clients accessing specialist homelessness services, 15% (27,700) reported that their main source of income was the disability support pension and 36% of specialist homelessness service clients who identified a need for disability services did not have their needs met.[79]

Aboriginal and Torres Strait Islander people with disability experience even higher disadvantage with respect to social determinants of health in comparison to Aboriginal and Torres Strait Islander people without disability, non-Indigenous Australians with disability, and the general population.

More than a third (34.4%) of Aboriginal and Torres Strait Islander people with a disability lived in a household in the lowest quintile of household income.[80]

For further information see PHAA's policy position statement on *Disability and Health* (2022).[81]

First Nations Peoples

Aboriginal and Torres Strait Islander households have, on average, a weekly gross income which is $362 less than that of non-Indigenous households.[82] In 2018-19, 39% of Aboriginal and Torres Strait Islander people reported days without money for basic living expenses in the previous 12 months.[82] In the same time period, the employment rate for Aboriginal and Torres Strait Islander people aged 25-64 years was 49-52%.[83,84] This was lower than for non-Indigenous people at 75%.[84]

Food insecurity is a significant issue for Aboriginal and Torres Strait Islander peoples in remote, regional, and urban parts of Australia.[85] This has a long history commencing with the colonisation of Australia and continuing through policy and social and economic influences. These influences are exacerbated by lower income and employment rates, inadequate housing, and the challenges of food affordability and availability. The culmination of this means that, presently as many as one-quarter (24%) of Aboriginal and Torres Strait Islander people report having run out of food in the previous 12 months and could not afford to buy more, many going without.[85] A high incidence of malnutrition persists alongside the disproportionate burden of chronic disease.

The interplay of disadvantage around food availability, access and use for Aboriginal and Torres Strait Islander peoples residing in urban, rural, and remote areas is complex and not yet well understood. These factors are all interrelated and have a combined effect of creating significant structural barriers to regular healthy eating. Income and the cost of food are key factors influencing food choice.[86] In some Aboriginal and Torres Strait Islander communities it has been estimated that 50% of disposable household income is used to purchase food, with 62% of the food budget being spent on discretionary items.[49]

LBGTQIA+ people

There is clear evidence of poorer health and wellbeing outcomes (both physically and mentally) for LGBTQIA+ people, particularly when compared with the general population or other comparable groups.[87] This can result in increased drivers of poverty, including higher rates of homelessness.[87]

In relation to people with intersex variations there is evidence of high rates of trauma, poverty and early school leaving.[88,89,90]

ToR (e): The relationship between income support payments and poverty

Income support payments are meant to alleviate poverty, thereby preventing poor health.[91] The Coronavirus Supplement in 2020 was an excellent example of income support protecting mental health during a period of financial stress for many people.[92]

Income is a powerful social determinant of health. Income support payments provide a safety net for people who would not otherwise have an income, or for whom their income would be far too insufficient to meet basic needs such as food, housing, utilities, and healthcare. Social security payments in Australia should therefore be positive for health by reducing food insecurity, homelessness, and the adverse mental and physical health impacts of poverty and financial stress. In addition, effective income support programs with adequate payments reduce the cost of poverty and inequality to the health sector, as well as the community and education sectors.

Increasing the lowest income support payments would allow single parent families and jobseekers to live with dignity, provide funds for access to health and dental care, enable payment of rising utility bills, and funds for rising food and housing costs. It would also provide enough income for jobseekers to take up employment, training, and educational opportunities. Trying to make budget cuts via social security is counter-productive and undermines Australia's essential safety net.

ToR (f): Mechanisms to address and reduce poverty

A range of policy and investment decisions are needed to address and reduce poverty. First and foremost, the degree of basic financial social security must be increased.

Increase social welfare support to an adequate level

A poverty-free economic system must have an adequate social security net ensuring that every person has the resources to meet basic needs such as food, housing and utilities. The Australian welfare system must ensure that all people have minimum income resources to prevent poverty and prevent the increase in ill health that flows from poverty.

PHAA has long been a supporter of the Raise the Rate campaign, led by ACOSS. The present low rate of income support is clearly below the poverty line. PHAA strongly supports the urgent need to raise the rate of Jobseeker and other income support payments to at least $76 a day.

Increase the availability and affordability of primary care services

Access to primary health care is fundamental to good health, and is particularly essential for people in or near conditions of poverty.

National primary health care policy should support the provision of comprehensive primary health care services, including oral health, that are equitable, fair, and not provided based on people's ability to pay.

PHAA has consistently sought the development of a national primary health care policy as an essential driver to recognise and integrate community primary health care sectors. To date, Australia's efforts to develop a national policy have not clearly articulated the definition and understanding of comprehensive primary healthcare and have not had adequate bipartisan support. After a decade of delay, the 2022 release of the Australia's Primary Health Care 10 Year Plan 2022–2032 is encouraging, but the delivery of this strategy has yet to be secured.

Redress the absence of dental care from the Medicare system

Population and targeted prevention strategies are essential to reduce the burden of oral diseases and oral health inequities in Australia. One of the major elements of our health is dental health, but this remains excluded from the Medicare system.

All Australians should have access to high-quality, person-centred and values based, culturally appropriate, safe, affordable, timely and cost-effective oral health care. PHAA has long called for universal equitable access to oral health care through its inclusion within Medicare. The social and economic argument for the maintenance of a strong social security platform for health does not make any exception for dental aspects of our health. There is no reason why the role of health security in sustaining a healthy population and workforce, and preventing poverty, somehow fails to include dental care.

Redress the draining of resources from people through addictive gambling

Major efforts must be taken to redress the extraction of resources from people that occurs through addictive gambling practices, most prominently gaming machines and online gambling. We note that this is the subject of a current inquiry by the House of Representatives Standing Committee on Social and Legal Affairs. We recommend, however, that this inquiry also notes the powerful role of gambling in depriving people of resources and maintaining conditions of poverty for many, as well as the adverse influence of gambling lobby groups on policy.

Conclusion

The PHAA appreciates the opportunity to make this submission. We urge you to make strong recommendations relating to:

- The need to increase the basic rate of social security payments
- The need to find ways to increase housing availability and affordability
- The need to ensure greater levels of food security for those below the poverty line
- The need to enhance the availability and accessibility of primary health care
- The need to include dental care within the Medicare system
- The need to bring under control gaming machine proliferation and online gambling

Please do not hesitate to contact me should you require additional information or have any queries in relation to this submission.

Terry Slevin
Chief Executive Officer
Public Health Association of Australia

March 2023

References

[1] Poverty in Australia 2023: Who is affected, 2023, https://povertyandinequality.acoss.org.au/poverty-in-australia-2023-who-is-affected/

[2] Poverty In Australia 2022: A Snapshot, https://povertyandinequality.acoss.org.au/a-snapshot-of-poverty-in-australia-2022/

[3] Callander E J, Fox H and Lindsay D, 2019, "Out-of-pocket healthcare expenditure in Australia: trends, inequalities and the impact on household living standards in a high-income country with a universal health care system" *Health Economics Review* 9 (10) https://doi.org/10.1186/s13561-019-0227-9

[4] ACOSS (Australian Council of Social Service), 2022, *How JobSeeker and other income support payments are falling behind the cost of living*, ACOSS, accessed 17 October 2022, https://www.acoss.org.au/wp-content/uploads/2022/09/ACOSS-cost-of-living-report_web_v02.pdf

[5] Ottersen OP, Dasgupta J, Blouin C, et al. The political origins of health inequity: prospects for change. The Lancet 2014;383:630-67

[6] Commission for Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization; 2008

[7] Office QGSs. Australian gambling statistics 1992-93 to 2017-18. Queensland Treasury; 2019.

[8] AIHW 2021, https://www.aihw.gov.au/reports/australias-welfare/gambling

[9] Productivity Commission. Gambling, Report No. 50. Volumes 1 & 2. Canberra: Productivity Commission; 2010.

[10] Billi R, Stone CA, Marden P, Yeung K. The Victorian Gambling Study: A longitudinal study of gambling and health in Victoria 2008-2012. Victoria, Australia: Victorian Responsible Gambling Foundation; 2014.

[11] Productivity Commission, Shifting the Dial: 5 year productivity review, 2017, supporting paper 4, Why a better health system matters, 11, at https://www.pc.gov.au/inquiries/completed/productivity-review/report

[12] https://www.oecd.org/health/health-systems/Heavy-burden-of-obesity-Policy-Brief-2019.pdf

[13] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra, chapter 3, page 149; https://www.pc.gov.au/inquiries/completed/mental-health/report

[14] Pulok MH, van Gool K, Hall J. Inequity in healthcare use among the indigenous population living in nonremote areas of Australia. Public Health 2020;186:35-43

[15] Yashadhana A, Pollard-Wharton N, Zwi AB, Biles B. Indigenous Australians at increased risk of COVID19 due to existing health and socioeconomic inequities. The Lancet Regional Health – Western Pacific 2020;1

[16] Flavel J, Baum F. The influence of socio-economic conditions on the epidemiology of COVID-19 in Australia. Medical Journal of Australia 2022;216:344-5.

[17] National Preventive Health Strategy 2021, https://www.health.gov.au/sites/default/files/documents/2021/12/national-preventive-health-strategy-2021-2030-national-preventive-health-strategy-2021-2030-summary.pdf

[18] 2022: Rental Affordability Snapshot, Anglicare Australia, https://www.anglicare.asn.au/publications/rental-affordability-snapshot-2022/

[19] Bourke E and Foo M, 2022, *Rental Affordability Snapshot: National Report, April 2022*, Anglicare Australia, https://www.anglicare.asn.au/wp-content/uploads/2022/04/Rental-Affordability-Snapshot-National-report.pdf

[20] Miller K and Li E, 2022, *Foodbank Hunger Report 2022*, Foodbank, https://reports.foodbank.org.au/wp-content/uploads/2022/10/Foodbank-Hunger-Report-2022-1.pdf

[21] Keough B, Skinner V, Williams C, Tually S, Rowley C and Jones R, 2020, "Housing and health: a multidirectional relationship", Don Dunstan Foundation, https://www.dunstan.org.au/wp-content/uploads/2020/07/Health-Housing-Homelessness-PAPER-1.pdf

[22] Anderson SA. Core Indicators of Nutritional State for Difficult-to-Sample Populations. The Journal of Nutrition. 1990;120(suppl_11):1555-600.

[23] American Dietetic Association. Position of the American Dietetic Association: Food insecurity in the United States. J Am Diet Assoc. 2010;110(9):1368-77

[24] Bowden M. Understanding food insecurity in Australia. In: Australia CFC, editor. Victoria: Australian Institute of Family Studies; 2020.

[25] McKechnie R, Turrell G, Giskes K, Gallegos D. Single-item measure of food insecurity used in the National Health Survey may underestimate prevalence in Australia. Aust N Z J Public Health. 2018;42(4):389-95.

[26] Fredericks B, Bradfield A. Indigenous Australians and COVID-19: Highlighting ongoing food security issues. International Journal of Home Economics. 2021;14(1): 53–65.

[27] Kent K, Murray S, Penrose B, Auckland S, Godrich S, Lester E, et al. Food insecure households faced greater challenges putting healthy food on the table during the COVID-19 pandemic in Australia. Appetite. 2022;169:105815.

[28] Kent K, Murray S, Penrose B, Auckland S, Visentin D, Godrich S, et al. Prevalence and Socio-Demographic Predictors of Food Insecurity in Australia during the COVID-19 Pandemic. Nutrients. 2020;12(9):2682.

[29] Smith K, Lawrence G. From disaster management to adaptive governance? Governance challenges to achieving resilient food systems in Australia. Journal of Environmental Policy & Planning. 2018;20(3):387-401.

[30] United Nations. Universal Declaration of Human Rights http://www.un.org/en/universal-declaration-humanrights/: UN.

[31] Kent G. Freedom from Want: The Human Right to Adequate Food. Washington: Georgetown University Press; 2005.

[32] Banerjee S, Radak T, Khubchandani J, Dunn P. Food Insecurity and Mortality in American Adults: Results From the NHANES-Linked Mortality Study. Health Promotion Practice. 2020;22(2):204-14.

[33] Gundersen C, Tarasuk V, Cheng J, de Oliveira C, Kurdyak P. Food insecurity status and mortality among adults in Ontario, Canada. PLoS One. 2018;13(8):e0202642.

[34] Dinour LM, Bergen D, Yeh MC. The food insecurity-obesity paradox: a review of the literature and the role food stamps may play. J Am Diet Assoc. 2007;107(11):1952-61.

[35] Tarasuk V, Cheng J, Gundersen C, de Oliveira C, Kurdyak P. The Relation between Food Insecurity and Mental Health Care Service Utilization in Ontario. Can J Psychiatry. 2018;63(8):557-69.

[36] Berkowitz SA, Basu S, Meigs JB, Seligman HK. Food Insecurity and Health Care Expenditures in the United States, 2011-2013. Health Serv Res. 2018;53(3):1600-20.

[37] Tarasuk V, Cheng J, De Oliveira C, Dachner N, Gundersen C, Kurdyak P. Association between household food insecurity and annual health care costs. CMAJ. 2015;187(14):E429-36.

[38] Shankar P, Chung R, Frank D. Association of food insecurity with children's behavioral, emotional and academic outcomes: A systematic review. Journal of Developmental and Behavioral Pediatrics. 2017;38(2):135-50.

[39] Huang J, Vaughn MG. Household Food Insecurity and Children's Behaviour Problems: New Evidence from a Trajectories-Based Study. Br J Soc Work. 2016;46(4):993-1008.

[40] Ramsey R, Giskes K, Turrell G, Gallegos D. Food insecurity among Australian children: Potential determinants, health and developmental consequences. Journal of Child Health Care. 2011;15(4):401-16.

[41] Shepherd DS, Setren E, Cooper D. Hunger in America: Suffering we all pay for https://cdn.americanprogress.org/wp-content/uploads/issues/2011/10/pdf/hunger_paper.pdf: Center for American Progress; 2011

[42] Bloom DE, Canning D. Commentary: The Preston Curve 30 years on: still sparking fires. Int J Epidemiol. 2007;36(3):498-9; discussion 502-3.

[43] Keating A. Food security in Australia: The logistics of vulnerability. In: Farmar-Bowers Q, Higgins V, Millar J, editors. Food security in Australia: Challenges and prospects for the future: Springer; 2013.

[44] Tapsell L, Probst YC, M L, Friel S, Flood VM, McMahon A, et al. Food and nutrition security in Australia-New Zealand region: Impact of climate change. In: Simopoulos AP, editor. Healthy agriculture, healthy nutrition, healthy people. Washington DC: Karger; 2011.

[45] Porter JR, Xie L, Challinor AJ, Cochrane K, Howden SM, Iqbal MM, et al. Food security and food production systems. In: Field CB, Barros VR, Dokken DJ, Mach KJ, Mastrandrea MD, Bilir TE, et al., editors. Climate Change 2014: Impacts, adaptation and vulnerability Part A: Global and Sectoral Aspects Contribution of Working Group II to the Fifth Assessment Report of the Intergovernmental Panel on Climate Change. Cambridge, United Kingdom and New York, NY USA: Cambridge University Press; 2014. p. 485-533.

[46] Melbourne Sustainable Society Institute. Appetite for Change: Global warming impacts on food and farming regions in Australia. Melbourne: WWF Australia; 2015

[47] Friel S, Marmot M, McMichael A, Kjellstrom T, Vågerö D. Global health equity and climate stabilisation: a common agenda. Lancet. 2008;372(9650):1677-83.

[48] Food and Agriculture Organization. The state of food insecurity in the world: How does international price volatility affect domestic economies and food security? Rome: FAO; 2011

[49] Lee A, Lewis M. Testing the Price of Healthy and Current Diets in Remote Aboriginal Communities to Improve Food Security: Development of the Aboriginal and Torres Strait Islander Healthy Diets ASAP (Australian Standardised Affordability and Pricing) Methods. Int J Environ Res Public Health. 2018;15(12).

[50] Booth S. Eating rough: food sources and acquisition practices of homeless young people in Adelaide, South Australia. Public Health Nutrition. 2007;9(2):212-8.

[51] Crawford B, Yamazaki R, Franke E, Amanatidis S, Ravulo J, Torvaldsen S. Is something better than nothing? Food insecurity and eating patterns of young people experiencing homelessness. Aust N Z J Public Health. 2015;39(4):350-4.

[52] Gallegos D, Ellies P, Wright J. Still there's no food! Food insecurity in a refugee population in Perth, Western Australia. Nutrition & Dietetics. 2008;65(1):78-83.

[53] Mansour R, John JR, Liamputtong P, Arora A. Prevalence and risk factors of food insecurity among Libyan migrant families in Australia. BMC Public Health. 2021;21(1):2156.

[54] McKay FH, Dunn M. Food security among asylum seekers in Melbourne. Aust N Z J Public Health. 2015;39(4):344- 9.

[55] Russell J, Flood VM, Yeatman HR, Mitchell PB. Prevalence and risk factors of food insecurity among a cohort of older Australians. The Journal of Nutrition, Health and Aging. 2014;18(1):3-8.

[56] Temple JB, Russell J. Food Insecurity among Older Aboriginal and Torres Strait Islanders. Int J Environ Res Public Health. 2018;15(8).

[57] Kleve S, Davidson ZE, Gearon E, Booth S, Palermo C. Are low-to-middle-income households experiencing food insecurity in Victoria, Australia? An examination of the Victorian Population Health Survey, 2006-2009. Aust J Prim Health. 2017;23(3):249-56.

[58] Ramsey R, Giskes K, Turrell G, Gallegos D. Food insecurity among Australian children: Potential determinants, health and developmental consequences. Journal of Child Health Care. 2011;15(4):401-16.

[59] Nolan M, Rikard-Bell G, Mohsin M, Williams M. Food insecurity in three socially disadvantaged localities in Sydney, Australia. Health Promotion Journal of Australia. 2006;17(3):247-53.

[60] Gallegos D, Ramsey R, Ong KW. Food insecurity: is it an issue among tertiary students? Higher Education. 2014;67(5):497-510.

[61] Murray S, Peterson C, Primo C, Elliott C, Otlowski M, Auckland S, et al. Prevalence of food insecurity and satisfaction with on-campus food choices among Australian university students. International Journal of Sustainability in Higher Education. 2021;22(4):731-46.

[62] Whatnall MC, Hutchesson MJ, Patterson AJ. Predictors of Food Insecurity among Australian University Students: A Cross-Sectional Study. International Journal of Environmental Research and Public Health. 2020;17(1):60.

[63] Temple JB, Booth S, Pollard CM. Social Assistance Payments and Food Insecurity in Australia: Evidence from the Household Expenditure Survey. International Journal of Environmental Research and Public Health. 2019;16(3):455.

[64] Brucker DL. The association of food insecurity with health outcomes for adults with disabilities. Disability and Health Journal. 2017;10(2):286-93.

[65] https://www.phaa.net.au/documents/item/5773

[66] Griffin B, Sherman KA, Jones M, Bayl-Smith P. The clustering of health behaviours in older Australians and its association with physical and psychological status, and sociodemographic indicators. Ann Behav Med. 2014;48(2):205-14.

[67] Australian Institute of Health and Welfare. Risk factors contributing to chronic disease.Cat. no. PHE 157. . Canberra: Australian Institute of Health and Welfare; 2012.

[68] Jones T, del Pozo de Bolger A, Dune T, Lykins A, Hawkes G. Female-to-Male (FtM) transgender people's experiences in Australia: A national study. Dordrecht/Cham.: Springer; 2015.

[69] Richters J, Altman D, Badcock PB, Smith AM, de Visser RO, Grulich AE, et al. Sexual identity, sexual attraction and sexual experience: the Second Australian Study of Health and Relationships. Sex Health. 2014;11(5):451-60

[70] AIHW. Older Australia at a glance. Canberra: Australian Institute of Health and Welfare;2018.

[71] WHV. Spotlight on older women's health and well-being. Women's Health Victoria. https://whv.org.au/resources/whv-publications/spotlight-older-womens-health-and-wellbeing. Published 2017. Accessed 2021.

[72] AHRC, Patterson K, Proft K, Maxwell J. Older Women's Risk of Homelessness: Background Paper. Sydney: Australian Human Rights Commission;2019.

[73] South SH. Australian Association of Gerontology Position Paper: Older women who are experiencing, or at risk of, homelessness. Australasian journal on ageing. 2019;38(1):66-68.

[74] Ervin JL, Milner A, Kavanagh AM, King TL. The double burden of poverty and marital loss on the mental health of older Australian women; a longitudinal regression analysis using 17 annual waves of the HILDA cohort. Social Psychiatry and Psychiatric Epidemiology. 2021.

[75] Murray S, Peterson C, Primo C, Elliott C, Otlowski M, Auckland S, et al. Prevalence of food insecurity and satisfaction with on-campus food choices among Australian university students. International Journal of Sustainability in Higher Education. 2021;22(4):731-46.

[76] Whatnall MC, Hutchesson MJ, Patterson AJ. Predictors of Food Insecurity among Australian University Students: A Cross-Sectional Study. International Journal of Environmental Research and Public Health. 2020;17(1):60

[77] Temple JB, Booth S, Pollard CM. Social Assistance Payments and Food Insecurity in Australia: Evidence from the Household Expenditure Survey. International Journal of Environmental Research and Public Health. 2019;16(3):455.

[78] Beer A, Baker E, Lester L, Daniel L. The Relative Risk of Homelessness among Persons with a Disability: New Methods and Policy Insights. International Journal of Environmental Research and Public Health. 2019;16(22):4304.

[79] Australian Institute of Health and Welfare. Specialist homelessness services annual report 2020–21: AIHW, Australian Government; 2021 [Available from: https://www.aihw.gov.au/getmedia/95657e24-6730-4249-93cf-64d1d284baad/Specialist-homelessness-services-annual-report-2020-21.pdf.aspx?inline=true

[80] Australian Bureau of Statistics. Aboriginal and Torres Strait Islander people with disability Canberra: ABS; 2021

[81] https://www.phaa.net.au/documents/item/5596

[82] AIHW. Indigenous income and finance. Release date 2021 Sep 16 [updated 2022 May 31]. Retrieved from: https://www.aihw.gov.au/reports/australias-welfare/indigenous-income-and-finance

[83] AIHW. Indigenous employment. Release date 2021 Sep 16 [updated 2022 May 31]. Retrieved from: https://www.aihw.gov.au/reports/australias-welfare/indigenous-employment

[84] Closing The Gap Report 2020. Employment. Retrieved from: https://ctgreport.niaa.gov.au/employment

[85] Rosier K. Food insecurity in Australia: What is it, who experiences it and how can child and family services support families experiencing it? Communities and Families Clearinghouse Australia practice sheet. https://aifs.gov.au/cfca/sites/default/files/publication-documents/ps9.pdf: AIFS; 2011.

[86] Larson N, Laska MN, Neumark-Sztainer D. Food Insecurity, Diet Quality, Home Food Availability, and Health Risk Behaviors Among Emerging Adults: Findings From the EAT 2010–2018 Study. Am J Public Health [Internet]. 2020 Sep [cited 2022 Nov 25];110(9):1422–8. Available from: DOI: 10.2105/AJPH.2020.305783

[87] ABS. General Social Survey http://www.abs.gov.au/ausstats/abs@.nsf/mf/4159.0#Anchor5 . Canberra: Australian Bureau of Statistics; 2014.

[88] Schützmann, Karsten, Lisa Brinkmann, Melanie Schacht, and Hertha Richter-Appelt. 2009. 'Psychological Distress, Self-Harming Behavior, and Suicidal Tendencies in Adults with Disorders of Sex Development'. Archives of Sexual Behavior 38 (1): 16–33. https://doi.org/10.1007/s10508-007-9241-9.

[89] Jones, Tiffany. 2016. 'The Needs of Students with Intersex Variations'. Sex Education 16 (6): 602–18. https://doi.org/10.1080/14681811.2016.1149808 .

[90] Carpenter, Morgan. 2018. 'What Do Intersex People Need from Doctors?' O&G Magazine 20 (4): 32–33

[91] Arno, P., House, J., Viola, D. et al. Social security and mortality: The role of income support policies and population health in the United States. J Public Health Pol 32, 234–250 (2011). https://doi.org/10.1057/jphp.2011.2

[92] Both, F, Butterworth, P., & Wilkins, R. Protecting mental health during periods of financial stress: Evidence from the Australian Coronavirus Supplement income support payment. Social Science and Medicine. (2022) https://www.sciencedirect.com/science/article/pii/S0277953622004646