THE UNIVERSITY of ADELAIDE

RESTORING THE FAIR GO

Interim report to inform discussion about the policy alternatives for reducing Australian health inequities

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make history.

FOREWORD: PURPOSE OF THE INTERIM REPORT

Australia is becoming a less equitable society

Australia is becoming a less equal society than it has been in the past. From the end of the Second World War until the early 1980s measures of equality demonstrated a trend towards more equity, including health equity. However, since that time inequities have increased significantly. While overall life expectancy has continued to increase for all Australians, some groups are gaining years of life faster than others. This matters because fairer societies have been shown to perform well in many ways including levels of trust, social cohesion, education outcomes, crime rates, and mental health.[1]

These trends towards a less fair society are the reason this research focuses on how a fair go can be achieved in Australia. We know that population health is most strongly influenced by the broad determinants of health including housing, education, income, wealth and access to health services.

Determining policy actions for equity

Consequently, we have set out to research these broader determinants and examine the reasons why Australia has become less equitable. Perhaps most importantly we want to use this knowledge to determine what can be done to put Australia on the path to being more equitable. To do this well we know we have to tap into the knowledge from a range of actors, and use this knowledge to craft a series of short, medium and long term actions that policy makers can take to make Australia a land of the fair go.

This report has been prepared on the back of research our team conducted in partnership with the South Australian Council of Social Service (SACOSS) just prior to the COVID-19 pandemic on the reason for growing inequities in South Australia. This was published in the report "SA: the Heaps Unfair State" . We have updated and extended our description of data trends presented in that report in relation to both the determinants of health and health status and health inequities in Australia. We have revised and updated material about the factors that were driving inequities.

Guided by our findings in the South Australian study we have also started an investigation into the ways in which privatisation of government functions and service provisions are affecting health equity. Some of the early findings from this work are included in this report.

Next Steps

Our next steps are to consult with actors from academia, civil society, and the public sector about their understanding of why economic and health inequities are increasing in Australia in relation to federal public policy and that of state and territory governments. We will do this in the following ways:

- Conduct interviews with key actors to gain their perceptions of the data and analysis of this report (2024)
- Hold face-to-face or online World Café events in each Australian jurisdiction to examine and receive further comments on the interim report (2024-5)

A key aim with our analysis of what is driving growing inequities is to show what factors are likely to stem this trend. So, based on existing knowledge of health and health inequities and the contents of this report we propose the following policy reform areas, priorities, and principles are likely to reduce health inequities and their underlying social and economic inequities.

- That health equity in policies reflects the gradient in health outcomes as well as the people in the most disadvantaged situations

- Re-distribution of wealth to the equity levels of at least the 1950s
- Affordable/free education from child care to university
- Affordable and sustainable housing policy reform
- Equitable urban planning
- Fair employment conditions
- Social security for all
- Just transition to net zero carbon emissions
- Understanding that within and across policy areas specific populations are impacted differently due to discrimination and oppressive structures: including Aboriginal and Torres Strait Islander Peoples, refugees and asylum seekers, regional and rural, women, people with a disability, LGBTIQA+ people
- Rebuilding the Australian Public Service (APS) to value and prioritise equitable policies and develop skills etc.
- Advocacy from civil society to build political will for these policy reforms

Happy Reading!

Best wishes

Professor Fran Baum AO (Restoring the Fair Go Project Director)

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ACKNOWLEDGEMENTS

The authors would like to acknowledge the following organisations and people for their contributions to the project:

- NHMRC Investigator Grant GNT2009323 for funding time of Fran Baum, Connie Musolino, Joanne Flavel, Julia Anaf and Toby Freeman.
- Dr Helen van Eyk for her contribution to 'SA, The Heaps Unfair State'.
- SACOSS including Ross Womersley, CEO and Dr Catherine Earl for their partnership on the pilot project 'SA, The Heaps Unfair State'.
- Interview and workshop participants from the SA, The Heaps Unfair State' project.

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Suggested citation: Baum, F., Musolino, C., Freeman, T., Flavel, J. and Anaf, J. (2025) Interim report to inform discussion about policy alternatives for reducing Australian Health Inequities. Stretton Health Equity, University of Adelaide, Adelaide, South Australia.

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CONTENTS

EXECUTIVE SUMMARY

The research findings in this report highlight the growth in health inequities in Australia since the late 1980s. The report examines the consequences of challenging global, national, and state factors for Australia over the past 30-40 years that have resulted in Australia's increasing health inequities despite continued increases in life expectancy.

Increasing health inequities

During the period from the late 1980s to the late-2010s, while life expectancy has increased, and premature mortality has decreased, socioeconomic inequalities in health outcomes have increased significantly.

This is best captured in the premature mortality rates (see Figure 2.1: in the report). The figure demonstrates a gradient in health whereby premature mortality differs according to socioeconomic status. A flat gradient suggests a more equal society, where a steep gradient suggests greater inequalities. The gradient of health inequalities in Australia has been getting steeper over the past few decades. This is reflected in a higher inequality ratio, rising from 1.55 in 1987-1991, to 1.60 in 2003-2007, 1.98 in 2013-2017 and 2.03 in 2016-2020.[2, 3] The rate ratio of 2.03 in 2016-2020 means that the rate of premature deaths in the most socioeconomically disadvantaged areas of Australia is over twice the rate of premature mortality in its most socioeconomically advantaged areas.

In other words, people in the poorest areas of Australia are twice as likely to die before their 75th birthday than people in the richest areas of Australia.

There have also been improvements in the following health outcomes, but worsening health inequalities in Australia:

- median age of death,
- deaths from avoidable causes,
- infant mortality,
- premature mortality from leading causes of the burden of disease including cancer, coronary heart disease, chronic obstructive pulmonary disease, and suicide and self-inflicted injuries.

There are also inequalities in self-assessed health by socioeconomic status and inequalities in mortality from COVID-19 by socioeconomic status.

Health inequities are growing faster in some states and territories than others.

Inequalities have increased in all states and territories, but at different rates (see Table 2.1 in the report). Despite improvements in premature mortality in all jurisdictions, inequality in premature mortality increased in all states and territories except the Northern Territory, with the largest increases in inequality being in South Australia and Tasmania, followed by Western Australia.

The key themes that have emerged from the research as drivers of inequities in Australia are:

Impact of de-industrialisation and the shift to a service economy in Australia, and trends in employment and income (including social security income).

A particular shock for the Australian economy, industry and employment was being hard hit by the global manufacturing shift from high to low- and middle-income countries since the 1970s and the global economic shocks over the same period. Notably, trends in employment and income over this time include:

- the decrease in manufacturing industry jobs and growth in the Health Care and Social Assistance industry in Australia.
- the overall rise in employment in Australia, coupled with its uneven distribution.
- a decrease in unemployment but increase in underemployment and underutilisation rates.

- the increase in part time and casual employment and industries in which part time and casual workers are employed.
- the stagnation of income and persistence of wealth and income inequities.
- the freezing of Newstart Allowance (now JobSeeker) since 1994 and its contribution to a progressive deepening of poverty for people in households relying mainly on that payment.

The impacts have been hardest felt by low-income workers, those reliant on social security payments and their families, especially youth, Aboriginal and Torres Strait Islander's, those re-entering the workforce and single parents.

Privatisation in education, health, public infrastructure, and housing sectors.

Since the early 1980s, economic rationalist policies have been dominant in Australia, and have led to the privatisation of key government services. The privatisation of public housing stock, the growth in private schools, and the growth of the private health and social service sector, including employment services and private health insurance, were highlighted as increasing health inequalities.

Decrease in public housing stock and quality and increase in housing and living costs.

The stock of public housing decreased from 1996 onwards, and despite the purchase of some public housing stock by community housing groups, growth in social housing has fallen well short of population growth. This decrease in public housing stock has affected the most disadvantaged areas of Australia.

This, in combination with decreasing housing affordability and rising living costs including energy, is entrenching poverty and inequality.

The politicisation and hollowing out of the state and federal public sector's capacity and expertise to respond to economic and social challenges.

The public sector across Australia from the 1980s has been influenced by New Public Management philosophy which focused on commercialisation, decentralisation of public services, corporatisation, contractualisation, marketisation, outsourcing and privatisation, and the creation of a contracted senior executive service. Interviews highlighted the impacts this has had on South Australia's public sector resulting in:

- an increasingly politicised public service.
- the undervaluing of public sector policy roles and the narrowing of policy processes.
- a shift away from addressing health equity undermining the success of a number of reforms intended to break down departmental silos within government and to encourage intersectoral collaborations.
- a loss of vision in the public sector, policy development and implementation expertise and its capacity to respond to South Australia's circumstances and growing inequities.

The erosion of democratic social justice values and disinvestment in community-based approaches to health and education.

The local and global trend towards individualism has manifested in Australia in a number of ways:

- the weakening of the welfare state as social security policies become more targeted and the processes to receive payments dehumanising.
- a shift to individual responsibility over state responsibility approaches in health and social public policies.
- a rise in consumerism.
- the funding criteria and competition between NGOs, community organisations and for-profit providers leading to erosion of collaboration, undervaluing of local knowledge and governance, a

growth in larger entities better positioned and resourced to participate in market processes, and a reduction in the ability of organisations to respond to community needs.

- loss of health and education movements embedded and present in local communities. The exception being the Aboriginal Community Controlled Health Organisations Australia wide sector, expanding and strengthening community-based approaches over this time (ACCHOs).

1. Introduction

1.1 Australia in a global context

Australia is one of the most economically advantaged countries in the world, and we are living in one of the most prosperous times in history. Life expectancy is increasing for all population groups, but average incomes are stagnating, and health is less equally distributed than in the past. The central concern in this report is that the distribution of health in Australia across the population has become less equal in recent decades.

This report discusses the reasons for these growing inequities based on an assessment of the changing nature and distribution of social and commercial determinants of health, insights from literature, and earlier research examining the factors explaining the increase in health inequities in Australia. Most importantly it will research the public policies that can be expected to reverse these trends, achieve a fair go, and examine what factors including civil society advocacy might encourage uptake of these policies.

The Australian continent was occupied for thousands of years by Aboriginal nations. Following colonisation by the British in 1788 and Federation in 1901, Australia faced the Great Depression of the 1930s which was followed by a post-World War Two 'boom', and growth in prosperity in the 1950s and 1960s. This was largely due to mineral resources and agriculture and extensive post war reconstruction.[4] This included major reforms to support housing and secondary industries, implementing the Commonwealth Employment Service, and devising immigration policies to boost national wealth. A widespread belief was that radical economic, political, social, and cultural changes in Australia and globally were necessary.[4] Such developments laid the basis for Australia to become and remain one of the richest countries in the world. In 2021, the median wealth per adult in Australia was the fourth highest in the world.[5] Yet the benefits of this wealth are not spread evenly in the population.

Globally, wealth and income inequality have been increasing in recent decades, reversing a trend of declining inequality post the Second World War (1945 onwards) until the early 1980s. From the year 2000, the top one per cent of global wealth holders have owned up to 50.1 per cent of all household wealth.[5] During the COVID-19 pandemic and cost-of-living crisis years since 2020, USD$26 trillion, or 63 per cent of all new wealth globally was gained by the wealthiest one per cent, while USD$16 trillion, or 37 percent was gained by the rest of the world.[6] In the last 30 years the growth in the incomes of the bottom 50 per cent worldwide has been zero, whereas incomes from the top one per cent have grown by 300 per cent.[7] This trend is common in many high-income countries, as documented by the economist Piketty.[8]

1.2 Growing Australian inequality and inequity

In Australia, in 2023 the average wealth of the highest 20 per cent wealth group was over five times that of the middle 20 per cent, and 90 times that of the lowest 20 per cent.[9] The average household after-tax income for the highest 20 per cent income group is over twice as much as that of the middle 20 per cent, and five times as much as that of the lowest 20 per cent.[9]

Unsurprisingly, in the wake of these growing economic inequities, health inequalities are increasing. The Public Health Information and Development Unit at Torrens University Australia (http://phidu.torrens.edu.au/) documents these increases in inequities.

Box 1.1: Health, social and economic data provided in

Appendix 1

Data on the social determinants of health to provide quantitative examination of underlying socioeconomic factors that might explain the increase in health inequalities in Australia between the late 1980s and the period 2016-2020. It covers:

Health Status
- Median age of death
- Premature mortality
- Deaths from avoidable causes
- Mortality from COVID-19
- Infant mortality rates
- Self-assessed health
- Leading diseases contributing to burden of disease
- Premature mortality from leading diseases
- Change in inequalities

Social determinants of health

Income
- Health by income
- Income distribution
- Distribution of growth in national income
- Income inequality
- Multidimensionality of income inequality

Wealth
- Wealth per capita
- Wealth distribution
- Wealth inequality

Housing
- Change in average house prices and average wages
- Distribution of tax deduction benefits
- Housing tenure
- Public housing and social housing
- Home ownership and affordability

Education
- Childhood development in school based skills
- Measures of learning at different levels of schooling
- Participation in school
- Participation in post-school education
- Literacy
- Interactions between education and employment

Employment
- Unemployment and labour force participation
- Underemployment
- Forms of employment
- Occupation and industry

Social inclusion
- Homelessness
- Digital inclusion
- Measures of social inclusion

The social and economic factors which shape our health have been shown in numerous studies and reports to be the most significant group of causative factors that determine how healthy a population is.[10-13] Explaining why one population, state or nation, is healthier than another primarily requires attention to these broad determinants. Access to health care counts but employment, education, housing, income and wealth distribution, and social support are more significant. These broader factors determine how health is distributed in a population. Some health inequalities may be a result of factors that can't be altered, such as genetic factors. But many more can be changed, and those that can are referred to as health inequities and are primarily a reflection of how the social and economic determinants of health are distributed. A detailed picture of the health status of Australians and social and economic trends is provided in

Appendix **1**. The data provided in the appendix is summarised in Box 1.1. The report discusses these trends and the extent to which they have contributed to growing health inequities.

Australia is second in league tables of national life expectancy. This achievement has been built on the back of significant social and economic reform. Many expect that our pattern of increasing life expectancy will continue. Yet improvement is slowing, and in the United States and the United Kingdom life expectancy is declining for some groups.[14] This may be a warning bell for Australia, where life expectancy has increased at a slower rate in recent years[15] and the life expectancy fell in Australia in 2020-2022 by 0.1 years due to the impact of COVID-19.[16] COVID-19 also highlighted health inequities in mortality in Australia by socioeconomic status, country of birth, and in death rates for Aboriginal and Torres Strait Islander people.[17]

Box 1.2: Differences between inequalities and inequities

Much of the literature on health differentials uses the terms 'equity' and 'equality' interchangeably, but their different meanings have implications for policy action: equality is concerned with sameness; equity with fairness. Policies are unlikely to be able to make people the same, but they can ensure fair treatment. The Commission on Social Determinants of Health defined health inequity as 'Where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair. It is this that we label health inequity'.[11]

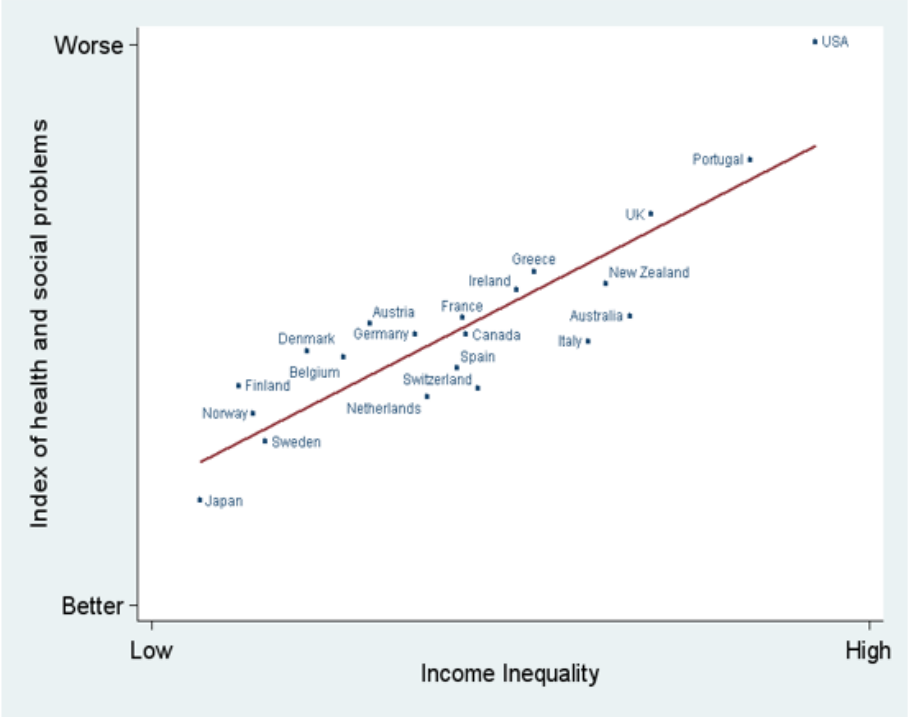
Source: Baum (2016: 308)[18]

1.3 Why inequities matter

Wilkinson and Pickett's[1] research has become very well known for pointing out that less equal societies are also those that are less successful on a variety of measures. This is shown in Figure 1.1, which shows the distribution of an index of health and social problems (listed adjacent to the Figure) by the Gini co-efficient measuring how equally income is distributed. It indicates how higher levels of income inequality are associated with greater rates of health and social problems. The US scores high on both health and social problems and income inequality and these factors likely to feed into its falling life expectancy which has fallen by 2.4 years between 2019 and 2021.[19, 20]

Figure 1.1: Health and Social Problems are worse in more unequal countries

Index of:
- Life expectancy
- Math & Literacy
- Infant mortality
- Homicides
- Imprisonment
- Teenage births
- Trust
- Obesity
- Mental illness – incl. drug & alcohol addiction
- Social mobility



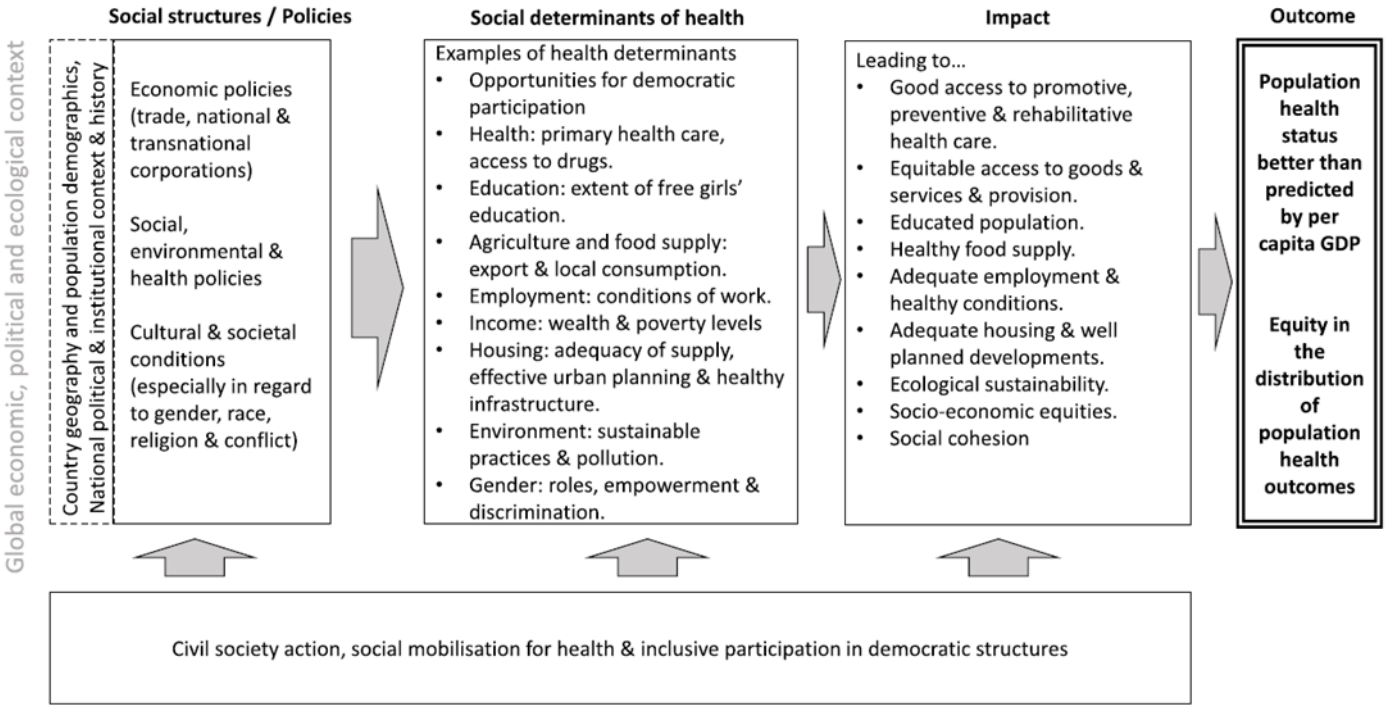
Source: Wilkinson and Pickett (2009)[1]

1.4 Our research

This research is funded by an NHMRC Investigator Fellowship grant which is entitled "Restoring the Fair Go: which policies and practices are likely to reverse growing health inequities in Australia post-COVID-19"?[1] This grant built on a research network we established - the Punching Above their Weight (PAW) Network in 2018. This network was formed to advance thinking and research about why some countries do much better or much worse in terms of life expectancy than would be predicted by their economic status. It builds on previous research that has focused primarily on health sector performance, examining more closely the political, social, environmental and economic processes that drive good or poor performance in promoting population health and health equity. This work includes comparison of country performances in the COVID-19 pandemic,[21, 22] an in-depth comparison of Ethiopia, Brazil, and the US,[23] and an assessment of the different drivers of gender disparity in life expectancy.[24] In the final two years of the project we intend to compare Australia's performance on the determinants of health inequity with other OECD countries.

The project draws on the framework (see Figure 1.2) developed by our Punching Above Weight Network which in turn drew on the work of the Commission on the Social Determinants of Health (2008)[11] and subsequent work of others.[14, 25]

Figure 1.2: Framework to investigate why some countries punch above their weight in terms of health and health equity (Source: Freeman et al, 2020)[23]



Our research is doing the following:

1. Compiling the data on health inequities and the social and economic determinants of health which drive population health outcomes.

[1] While the research was titled Restoring the Fair Go, Aboriginal participants have rightly pointed out that Aboriginal and Torres Strait Islander peoples have historically been excluded from the fair go, and we do not wish to imply the Australian ideal of the fair go has been extended to different groups to the same degree.

2. Preparing this interim report on reasons for the increases in health inequities in Australia
3. Examining the impact of privatisation on the public sector and its ability to work to reduce health inequities
4. Interviewing people with long-term experience in sectors that especially affect health and equity. They will include current and former senior state and federal public servants, politicians, academics, and policy advocates in NGOs about factors accounting for increases in health inequities and the policies that could be adopted to reverse these trends
5. Interactive events using a World Café format will be held in selected States and Territories to develop discussions on what can be done to reverse the growing health inequities. These events will be attended by representatives from government, policy makers, NGOs, community members and academics.
6. Producing a final report on what will make Australia a more equitable country

1.5 Report Structure

The following section and

Appendix **1** (see Box 1 for content) describes the Australian trends in health inequities. Then the macro-economic changes that have occurred in the world in our period of interest (from the late 1980s to the mid-2023) are described, followed by an examination of key factors that have emerged as important drivers of rising inequities, beginning with an assessment of the Australian economy, the impact of de-industrialisation, and trends in employment and income. The next major trend examined is towards privatisation in education, health and housing. We then describe the declining capacity of the public sector to respond to challenges including the increase in out-sourcing of government functions to private consultancy firms, and finally consider a trend towards a withdrawal from collectivism towards individualism. The trends we focus on have been derived from the literature on factors causing inequities and the study – SA: the Heaps Unfair State - we conducted in South Australia.[26]

2. Health Inequality Data

2.1 Overview

This report draws on publicly available data on health and health inequalities in Australia and data on the social determinants of health. The primary source used to measure inequalities is the Social Health Atlas developed by the Public Health Information Development Unit (PHIDU), which has compiled current and historical data at national, regional and small area levels for Australia from sources including the Australian Bureau of Statistics, the Department of Health, and the Australian Institute of Health and Welfare.[27] These data have been supplemented by publicly available data and statistics from the ABS, the AIHW, and relevant reports published by government and non-government organisations.

While the dates for which data are available vary, we are primarily focusing on the period from the late 1980s to 2023.

During this period, health outcomes have generally improved; life expectancy has increased, and mortality has decreased. However, these gains have benefitted some Australians more than others.

The increase in socioeconomic inequalities in health outcomes is captured well in avoidable mortality and the premature mortality rates presented in Figure 2.1.

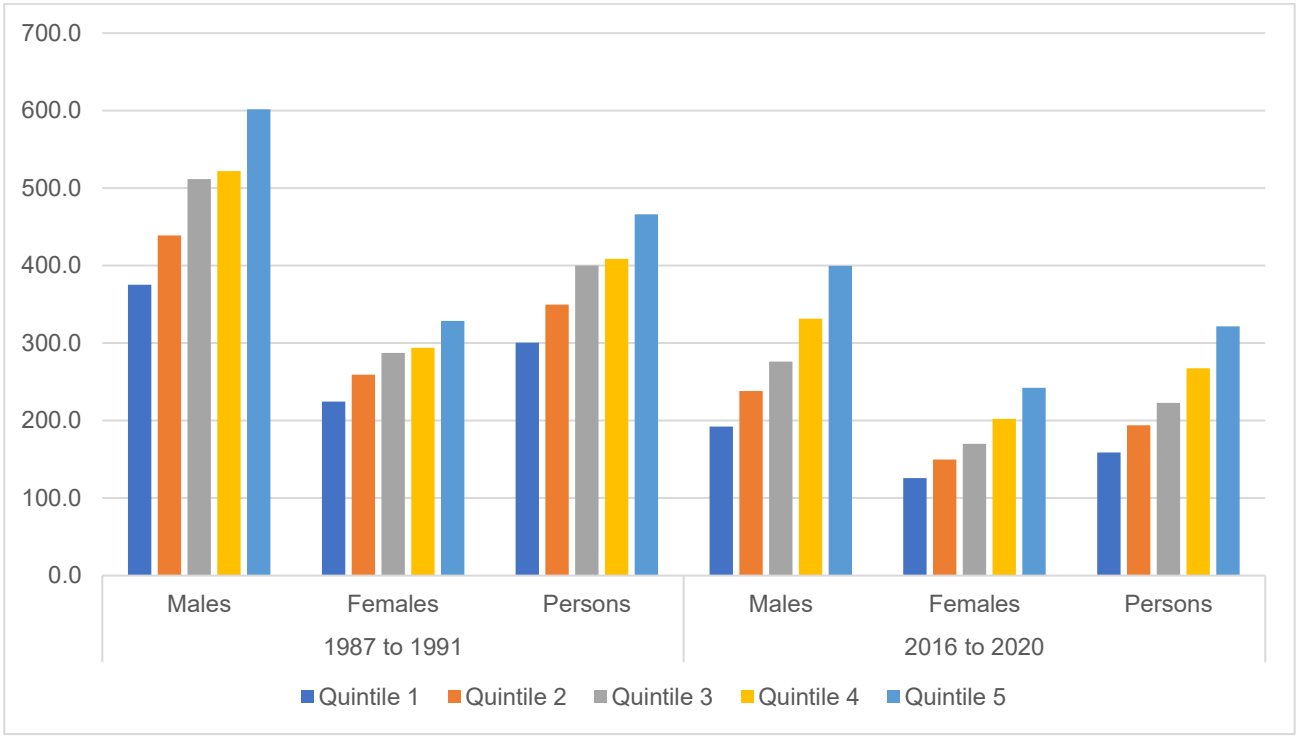


Figure 2.1: Average Annual Age-Standardised Rates of Premature Mortality per 100,000 in Australia, ages 0 to 74, by quintile of socioeconomic disadvantage, 1987-1991, and 2016 to 2020 (Data source: Social Health Atlas, PHIDU, 2022)

The figure demonstrates a gradient in health whereby mortality differs according to socioeconomic status. Quintile 1, the least disadvantaged socioeconomic quintile, has the lowest rate of premature mortality and the rate of premature mortality increases with increasing disadvantage. A flat gradient suggests a more equal society, whereas a steep gradient suggests greater inequalities. The gradient of health inequalities in

Australia has been becoming steeper over the past decades since the 1980s. The gradient has also become steeper for men than women (

Appendix **1**).

Socioeconomic disadvantage is primarily measured by socioeconomic quintile throughout the report. Socioeconomic status is based on the ABS Index of Relative Socioeconomic Disadvantage for data sourced from PHIDU (see **11. Explanatory notes** at end of the report).[27] The quintiles represent the socioeconomic status of the area in which the population is living, and each quintile comprises 20% of the population.

Box 2.1 Inequality ratios

Inequality ratios are the primary measure of inequality in the report, and these are the ratio of the rate for the 20 per cent of the population living in the most disadvantaged socioeconomic status area to that for the 20 per cent living in the least disadvantaged socioeconomic status area. For overall premature mortality, the social gradient has worsened, as represented by a higher inequality ratio (2.03 in 2016-2020 compared with 1.55 in 1987-1991). An inequality ratio greater than 1 represents inequality in the case of undesirable outcomes (e.g. premature mortality and avoidable deaths). For example, an inequality ratio of 2.03 for premature mortality means that the rate of premature mortality for quintile 5 is more than 2 times the rate of premature mortality for quintile 1.

Similar to premature mortality, there have been overall improvements in health outcomes, but worsening health inequalities in Australia, for:

- median age of death
- deaths from avoidable causes,
- infant mortality,
- premature mortality from leading causes of the burden of disease including cancer, coronary heart disease, chronic obstructive pulmonary disease, and suicide and self-inflicted injuries.

There are also inequalities in self-assessed health by socioeconomic status and inequalities in mortality from COVID-19 by socioeconomic status.

2.2 Health inequalities are growing faster in some states and territories than others

Inequalities have increased in all states and territories but at different rates (see Table 2.1). Tasmania, South Australia, and Western Australia had the highest percentage increases in inequality ratio for deaths from avoidable causes between 1997-2001 and 2016-2020. The increase in inequality ratio was well above the national average for Tasmania, South Australia, and Western Australia. The percentage increase in inequality ratio in Victoria was also above the national average, as was the increase in the ACT. The percentage increase in the inequality ratio was smallest in the Northern Territory, Queensland, and New South Wales, but the Northern Territory had a much larger inequality ratio than all other states and territories. The very large inequality ratio for the Northern Territory in 1997-2001 means that even though the increase in the inequality ratio was larger between 1997-2001 and 2016-2020 than in all other jurisdictions, it was a smaller percentage increase in the inequality ratio in the Northern Territory because the 1997-2001 inequality ratio was already larger than in the other states.

Table 2.1: Changes in the Health Inequality Ratio from 1997-2000 to 2016-2020 for Deaths from all Avoidable Causes (Data source: Social Health Atlas, PHIDU, 2022)

State	Health inequalities ratio 1997-2001	Health inequalities ratio 2016-2020	% Increase in inequality ratio
New South Wales	1.59	2.23	39.8%
Victoria	1.32	1.96	48.7%
Queensland	1.58	2.08	31.5%
South Australia	1.52	2.30	52.0%
Western Australia	1.64	2.49	51.8%
Tasmania	1.40	2.14	53.4%
Northern Territory	3.50	4.48	28.0%
Australian Capital Territory	1.39	2.00	42.7%
Australia	1.55	2.20	41.8%

2.3 COVID-19 is contributing to health inequities in Australia

The percentage of deaths due to COVID-19 rises with increasing disadvantage (see Table 2.2). The percentage of overall deaths that were due to COVID-19 was 2.6 times higher for the most disadvantaged quintile for men compared with the least disadvantaged quintile, and 3.3 times higher for the most disadvantaged quintile for women compared with the least disadvantaged quintile. Research has found that the incidence of COVID-19 infections in Victoria in 2020 was higher in postcodes where a larger proportion of people were unemployed, experiencing mortgage or rental stress, did not have paid leave benefits, areas with higher population density, and areas with larger proportions of people who speak languages other than English at home.[28]

Table 1.2: SEIFA (IRSD) quintile of those who died from COVID-19

SEIFA Quintile	Male deaths	% COVID-19 deaths	Female deaths	% COVID-19 deaths
1 (most disadvantaged)	2,277	31.3	1,899	32.3
2	1.614	22.2	1,394	23.7
3	1,323	18.2	1,127	19.1
4	1,122	15.4	833	14.1
5 (least disadvantaged)	871	12.0	583	9.9
Total	7,207	99.1	5,836	99.1

Source: Australian Bureau of Statistics

Note: Index of Relative Social Disadvantage quintile of those who died from COVID-19, deaths registered to 28 February 2023. Only includes deaths from COVID-19 (not deaths with COVID-19). Does not total to 100% because not all deaths can be assigned to a SEIFA score.

Death rates from COVID-19 also differed by country of birth, with much higher death rates for migrants from North Africa and the Middle East and Southern and Eastern Europe. Age-specific COVID-19 death rates were

also higher for Aboriginal and Torres Strait Islander people compared with non-Indigenous people for every age bracket for COVID-19 mortality as at 28 February 2023.

2.4 Population groups and health inequities

Aboriginal and Torres Strait Islander health inequities

Aboriginal and Torres Strait Islander people experience well documented health inequities arising primarily from historic and ongoing colonisation. Australia is on track to reach only a few of the Closing the Gap targets (on early childhood education and employment rates for 25-64 year olds, but not for child mortality, school attendance, life expectancy, reading and numeracy).[29]

Increases in life expectancy for non- Indigenous Australians and Aboriginal and Torres Strait Islander people are shown in Table 2.3. There has been modest progress in life expectancy for Aboriginal and/or Torres Strait Islander people: from a 13% difference between non-Indigenous and Aboriginal and/or Torres Strait Islander females and 17% difference for males in 2005-2007, to a 10% difference for females and 12% difference for males in 2015-2017. This does, however, leave a significant gap still to be closed.

Table 2.3. Increases in life expectancy in Australia. Data Source: AIHW (2019)[30]

	2005-2007	2010-2012	2015-2017
Females, non-Indigenous	82.6	83.1	83.4
Males, non-Indigenous	78.7	79.7	80.2
Females, Aboriginal and/or Torres Strait Islander	72.9	73.7	75.6
Males, Aboriginal and/or Torres Strait Islander	67.2	69.1	71.6

***Despite these overall gains, inequalities in health outcomes between non-Indigenous and Aboriginal and Torres Strait Islander peoples persist*.**

The ongoing effects of colonisation are evident in a range of socio-economic data. Imprisonment rates in Australia were 12 times higher in 2023 for the Aboriginal and Torres Strait Islander population compared with the overall imprisonment rate.[31] In Australia in the June quarter of 2022, young Aboriginal and Torres Strait Islander people aged 10 to 17 were 26 times as likely as non-Indigenous youths to be in youth detention, with the rate fluctuation between 16-26 times the non-Indigenous rate between 2018 and 2022.[32] The rate of Aboriginal and Torres Strait Islander children under care and protection orders in South Australia was more than 10 times the rate of non-Indigenous children as of June 30 2022.[33] In 2020-21, the rate of Aboriginal and Torres Strait Islander children admitted to out-of-home care was 13 per 1,000 children, much higher than the overall rate of 2 per 1,000 children.[34]

Migrant and refugee health inequities

While health outcomes vary between cohorts of migrants, international literature indicates that the health and health service needs of people from migrant and refugee backgrounds are more complex than those native born.[35-37] In particular, refugees and asylum seekers have worse health outcomes than those native born, particularly for mental health.[38, 39] Recent research has documented the health, wellbeing, housing, employment, and resettlement issues faced by people from refugee and asylum-seeking backgrounds when settling in Australia.[40-44]

Gender inequities

While it is well recognised that males have a lower life expectancy than females, there are important gender considerations across many social determinants of health, and determinants may affect males, females and gender diverse people in different ways.[24] For example, women have lower average incomes compared to men, and are less likely to own their home. Girls on average have higher educational achievement than boys. The labour force participation rate has increased for women over the past few decades but is still lower than the rate for men. Women have higher rates of part time employment and higher rates of underemployment. A higher percentage of women are casually employed compared with men.

Due to gender norms concerning caring responsibilities, women make up a far greater percentage of sole parent families and carers, and this affects employment and income opportunities and puts them and their children at greater risk of poverty.[45] This was particularly pertinent during the first two years of the COVID-19 pandemic.[46] Women provided more unpaid and domestic care for children and others, as well as being primarily responsible for home education during lockdowns.[47,48] This has had ongoing implications for employment, income, and housing, as well as the mental health of primary carers.[49,50] During COVID-19 the precarious, casualised and low paid working conditions of formal care workers, who are primarily women, contributed to the higher risk of COVID-19 infection among them, and they also reported overwork, burnout, and worsening mental health.[47, 51]

National data on gender are rarely collected beyond the male/female binary characteristic, excluding the experiences of non-binary and trans people. Private Lives 3[52] is Australia's largest national survey of the health and wellbeing of lesbian, gay, bisexual, transgender, intersex and queer people. The 2019 survey found that overall LGBTIQ+ participants reported lower self-rated health than the general Australian population. Broken down by gender, the survey found two fifths (40.0%; n = 926) of cisgender men rated their health as very good or excellent compared to less than one third of cisgender women (29.3%; n = 858), one quarter of trans women (26.3%; n = 75) and one fifth of trans men (19.8%; n = 59) and non-binary participants (20.1%; n = 184).[52]

Regional and remote health inequities

In Australia, people living in rural and remote areas have a lower median age of death, and higher premature and avoidable mortality.[53] Inequality in premature and avoidable mortality has increased in recent decades within non-metropolitan areas, but inequality in infant mortality has decreased.

While premature and avoidable mortality are correlated with socioeconomic disadvantage, some rural and remote local government areas were ranked as less disadvantaged than many major city local government areas and had lower premature and avoidable mortality.[54] This is illustrated in Figure 2.2 which presents average annual age-standardised rates of avoidable mortality by Index of Relative Socioeconomic Disadvantage for each Local Government Area and by remoteness category. Higher ranked and less disadvantaged LGAs generally had lower rates of avoidable mortality, and LGAs in major cities are among the least disadvantaged but this was not generalisable to all LGAs. Some rural and remote local government areas had better rates of avoidable mortality and premature mortality despite being ranked as more socioeconomically disadvantaged.[54]

Figure 2.2: Average annual age-standardised rates of avoidable mortality per 100,000 by ABS IRSD ranking and LGA remoteness category, Australia, 2014-2018

Intersections between different population groups

The population groups considered above are not discrete categories. Rather, there is cross-over between them. The term "intersectionality" focuses on the relationships and interactions that must be understood to explain the structural dynamics that create social inequities.[55] In health research, intersectionality aids understanding of the complexities of people's lives and how different forms of privilege and disadvantage contribute to unequal health outcomes.[56, 57] Factors such as race, gender, disability, rurality, Aboriginality, and socioeconomic status interact to cause and compound injustice and inequality. For example, insecure employment, income, racism, and gender norms underpin the persistence of gender inequalities globally, contributing to social and health inequalities.[58, 59] Within each of the groups outlined, we acknowledge that there are multiple and often intersecting factors which underpin their health inequities.

3. How the world has changed since the 1980s

Along with increasing inequities in wealth and income, what else has changed in the world since the 1980s that has had an effect in Australia? We have identified these 5 key overlapping themes that have affected Australia and are likely to have resulted in increased inequities:

- global dominance of neo-liberal economics and policies
- growth in the power and influence of Trans-national Corporations (TNCs)
- shift of global manufacturing from high to low- and middle-income countries
- retreat from a universalist to a residual welfare state
- unequal impact of the COVID-19 pandemic
- unequal impact of natural and climate change related crisis.

3.1 Neo-liberalism

The most significant change since the early 1980s has been that much of the world has had a love affair with neo-liberal economics. In our earlier SA study this was seen as resulting in significant changes in the ways in which the state and the market relate to each other. The opening up of the Australian economy to global trade, the privatisation of key government services, and the growth of economic inequities have all been linked to neo-liberal policies. In the 21st century, the Global Financial Crisis led to austerity politics, such as cuts to public services to reduce government budget deficits. Recent inflation has resulted in a cost of living crisis; a major part of which is a result of dramatic changes in the housing market and an increase in the share of national income going to profits.

Box 3.1 Defining Neo-liberalism

Neo-liberalism is an ideology and policy model that views competition as fundamental to human relations and the market as the mechanism that will most effectively deliver benefits to consumers. It is characterised by policies that support replacing public good with individual responsibility, strong private property rights, free markets, and free trade.[60] The policies associated with neo-liberalism have been: lowering of trade barriers; deregulation of the labour market; privatisation or contracting out of public services; the use of the private sector's management techniques within public sector organisations; low taxation; and policies to reduce state funding for health, education, welfare, housing, arts and public transport.[18]

Neo-liberal ideas and assumptions have become part of everyday language and expectations in Australia.[61] This has meant the extension of free-market ideas into aspects of life that were traditionally governed by non-market norms.[62]

Trade

One of the most significant areas of change has been the opening up of national economies to competition and the introduction of free trade between nations. Australia was one of the early adopters of this policy from the 1970s. This had implications for Australian manufacturing industries as discussed later in the report.

Privatisation of previously state-owned assets

The policy of privatisation of key areas of the economy has been advocated by monetary institutions such as the World Bank since the 1980s. Around the world, electricity, water, financial sectors, education, health and social care and housing have been privatised and Australia is no exception. In addition, many functions of government including policy making have been outsourced to private consulting companies. This has reduced the capacity of the public sector to plan over the longer term on issues including reduction in inequities. We discuss the impact of privatisation in section 6 of this report.

Changing nature of the public service

This includes changes to the nature of and cutbacks to the public service. These changes appear to have weakened the capacity of the Australian public service to be innovative and creative in devising new policy directions. This issue is discussed in more detail in section 6 of this report.

The era of marketisation and economic rationalisation has seen a growth in wealth and income inequality in Australia. The privileging of capital under neo-liberalism has meant that those who own capital have been able to increase their share and so widen inequities. Figure 3.1 shows the dramatic reversal in which sections of the population benefit from economic growth comparing the 1950s to more recent periods of economic growth.

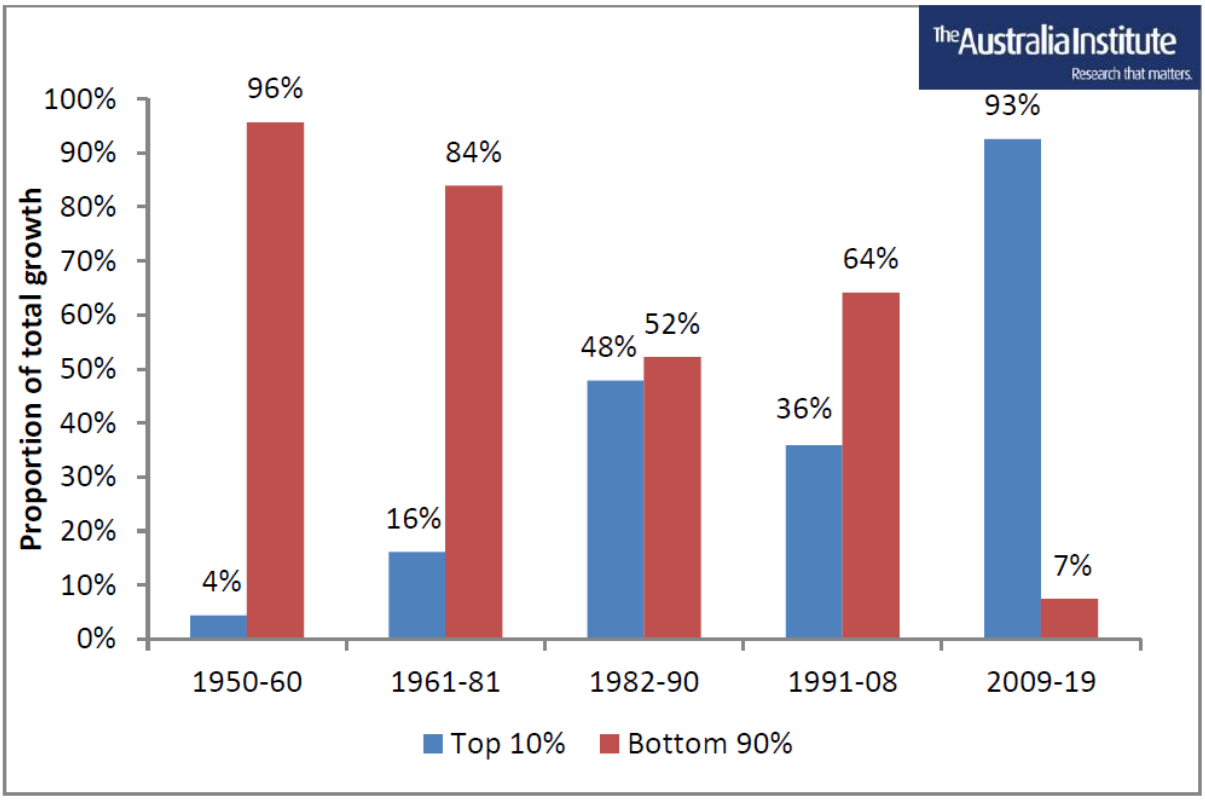


Figure 3.1: Per adult real economic growth: Share of growth (%) going to the top 10% and bottom 90% (Source: the Australia Institute)[63] See Figure A27: Per adult

3.2 The growth in the power and influence of Transnational Corporations (TNCs)

The adoption of neo-liberal policies by so many rich countries' governments has enabled the spectacular growth of TNCs. An increasing body of literature is demonstrating the impact they have on population health and their lack of governance in the interest of public health globally.[64] Such is the concern about this health impact that in 2023 The Lancet published a series of papers about the commercial determinants of health.[65] One of these noted "how the shift towards market fundamentalism and increasingly powerful transnational corporations has created a pathological system in which commercial actors are increasingly enabled to cause harm and externalise the costs of doing so."[66] This impact is felt in all countries and results from both the products corporations produce and some of their processes. Unhealthy products include tobacco, alcohol, ultra processed foods, gambling, and fossil fuels. Unhealthy processes include the massive lobbying power of corporations[67] to minimise regulations and encourage the privatisation of public sector functions, the use of manipulative advertising to create demand for unhealthy products, the growth in salaries for TNC

executives which are significantly higher than those for other workers, using research funding to gain influence over scientific findings,[68,69] and the reliance on unhealthy employment practices including gig and casual work.

Australia has not been immune to these trends. For example, the poor practices of Australian banks in relation to their customers was demonstrated by the report of the Royal Commission[70] into the Misconduct in the Banking, Superannuation and Financial Services Industry. The growth in overweight and obesity has been directly linked to the increased availability, marketing and advertising of ultra-processed foods[71] and sugar-sweetened beverages in many countries including Australia. The impact of such dietary changes are most evident in lower socio-economic groups,[72] thus fuelling inequities as well as contributing to the overall burden of non-communicable disease.

3.3 Decline of manufacturing as production shifted from high to low- and middle-income countries and as service industries grew

Manufacturing peaked as a share of the Australian economy in the early 1960s, when the sector grew to 30 per cent of the economy. Since then, the shares of manufacturing in value added and in employment have declined.[73] The impact of neo-liberal reforms, including tariff reduction, had a particularly dramatic effect on the shape of the Australian economy. The Productivity Commission notes that the role of the manufacturing sector in the Australian economy has changed fundamentally over the past half century. The loss of protection for manufacturing industries and the rapid development of such industries in many low- and middle-income countries has driven this change. At the start of our period, South Australia and Victoria were home to five major car manufacturing plants: Mitsubishi and Holden in Adelaide and Ford, Toyota and Nissan in Victoria. By 2019, all of these plants had closed with the loss of relatively high quality, full time and permanent jobs. The Australia Institute has reported that manufacturing continued to decline both in terms of employment and output from 2000 to 2016 with an accelerating loss after the 2008 Global Financial Crisis.[73] In 2022 the Albanese Labor government committed to increasing the amount of manufacturing done onshore in Australia. The impact of this policy on equity is hard to discern but will likely not be able to offer as many unskilled blue collar jobs as there were in the 1960s through to the 1980s.

3.4 The state's role in the provision of welfare

There has been a retreat from the state's role in the provision of welfare in many western democratic countries. While in Australia this trend hasn't been so evident, there has been a retreat from the development of innovative services which were a hallmark of Australia in the 1970s and 1980s, and a trend to privatising the provision of services. In South Australia, those decades saw a period of reform of and innovation in social and health services. One respondent in the South Australian pilot project noted:

> *There was a genuine interest in innovating new sets of relationships, new ways of organising a community. There was a strong tradition of community development in place and people were seeing where there was social services effort that their job was to actually work closely with community to build the things that they were interested in.* (Social services expert)

This spirit of innovation had led to many reforms across Australia in prisons and welfare services, services to people with disability, women's health services, women's advisors to governments, and the development of community health centres and Aboriginal community-controlled health services. The importance of these reforms in contributing to the period of greater equity in the 1970s until the early-1980s is detailed in other parts of this report.

In the past two decades, most income support payments, in particular Newstart (now Job Seeker) and Youth Allowance, have not increased to keep pace with inflation (with the exception of the age and disability pensions). This is likely to have contributed to an increase in inequities. Poverty affects health in many ways. People cannot afford to buy medication or to heat or cool their houses or pay rent. Our analysis of data on the shape of inequities in Australia indicates that those in the bottom quintile are doing particularly badly (see data in

Appendix **1**). This is shown in terms of educational outcomes, employment, and housing insecurity. These trends in the context of a weakening welfare state are extremely bad for population health and health equity.

4. Rise of the market and decline of collectivism: Erosion of social justice, community, and collective centred values and approaches

> *I think the big story really here is, an intellectual story about the rise of neo-liberalism and the collapse of social democracy.* (SA public policy academic)

Reflecting on their long-term experience in public, academic, community and NGO sectors, our SA interviewees and workshop participants painted a narrative of the erosion of democratic social justice values and community approaches to health and wellbeing and the expansion of neo-liberal individualism ideas both locally and globally. They contrasted this with period from the 1970s to the early 1980s which saw the introduction of reforms that were very pro-equity including the 1973 Supporting Mother's benefit, The Australian Assistance Plan (AAP), free tertiary education, Commonwealth government funding of childcare in 1972, establishment of the Family Law Court, Aboriginal land rights, ,the Community Health Program from 1973 and the introduction of Medicare in 1984. The above interviewees' concerns were mirrored in academic literature noting a strong link between neoliberalism and individualism.[74] The following sections outline some of the ways this has occurred in Australia.

4.1 Growing restrictions on civil society threaten democracy

One way social democracy values and structures are being eroded is through laws and regulations restricting civil society organisations' rights to advocate against government and business practices and right to assemble and protest in Australia. This matters because the voices highlighting the cause of increasing equity are usually spearheaded by civil society organisations. During the COVID-19 pandemic, many countries increased restrictions on civil society organisations' freedoms. This was occurring while civil society organisations were rallying to bring attention to the unequal impacts of public health mandates on particular population groups, especially on those from poorer and non-English speaking backgrounds.[75] There have also been crackdowns on the right to protest in most Australian states and territories in the last few years.[76] The CIVICUS monitor,[77] reporting the Human Freedom Index, showed most countries becoming less open comparing 2019 to 2022, including Australia which went from 'Open' to 'Narrowed'.

The Human Rights Law Centre and Australian Democracy Network note in the last 20 years, 34 different bills that impact or erode our right to protest have been introduced into Parliaments around the country by Labor and Liberal-National Coalition state, territory, and federal governments. Of these, 26 have passed into law.[78] These changes undermine the role that civil society organisations and the community play in a healthy democracy, and in promoting the rights of less powerful groups in society, and the health and wellbeing of individuals and communities.

4.2 Individual responsibility over collective responsibility

The trend towards individualism has been noted globally.[79] This ideological shift has manifested in public policy and approaches to health and wellbeing in a number of ways. With the rise of individual responsibility as a policy strategy in many sectors, there has been a move away from collective responsibility as a strategy for improving health and wellbeing, as demonstrated by a disinvestment by the federal and state governments in health promotion and community development.[80] Individualism supports approaches to health equity which suggest that if people suffer worse health than others it reflects their personal behaviours rather than structural factors.[81] Furthermore, the privatisation in a range of sectors (outlined in

more detail below) including job services reflects not only neo-liberal austerity measures, but also a shifting of responsibility to care for people who need support away from the collective public realm.

> *I think that's a really important one as well because essentially it was the first time that we really turned the key on what used to be the CES and the Commonwealth's responsibility. It was the Commonwealth's job to make sure that people were well supported and we outsourced it.* (SA Social services expert)

One interviewee highlights how neo-liberal individualism doesn't equate to an increase in individual control, but rather what is evident *"is more centralised control. So, there is this individual responsibility but centralised control. We're forever, aren't we, having to send information into some central bureau"* (SA education sector academic). This is highlighted by the increasing conditions placed on job seekers and penalties if they do not meet those criteria.

4.3 Choice and consumer society: everything is framed within the market framework

Interviewees in the SA pilot study were concerned that essential public services have been increasingly framed through a consumerist lens in which value is only seen in economic terms. Through the example of increasing tertiary education costs, one interviewee highlights how consumerism has become the norm in the education sector:

> *It's treating everyone more like a consumer. The teacher is a service provider. They're not an educator, they're a service provider. And if I was to look at the progress of education and policy, I would say we could well find more pre-packaged program curriculum materials produced by some organisation that is just implemented by the service provider, a.k.a. teacher.* (SA education sector academic)

A consumerist framework can also be seen to be underpinning the development of the National Disability Insurance Scheme (NDIS). As an interviewee noted, "*there's a lot of individualism built into there*" and *"choice"* is commonly used as a vehicle for individualism and responsibility placed on the individual to navigate the service. Whereas the founding idea for the NDIS "*was actually about making things personal. That really what people are looking for is highly personalised services so that they actually do attend to who they are and they are knowledgeable about who they are"* (SA Social services expert). McKenzie and Smith-Merry [82] argue that with schemes such as the NDIS, 'personalisation' however, "sits at the intersection of discourses of autonomy and choice and market-based approaches to service provision". Many argue the marketisation of services under the personalisation model of the NDIS has reduced collaboration and increased competition between organisations, undermining effective coordinated care, especially for clients with complex needs. [82-84]

Making the connection between consumerism, individual responsibility and the breakdown of the collective, one SA education expert argued this shift is *"a stealing of what is common. It's a stealing of what we have that makes us, us… the responsibilities we have for each other is lost in this grab to be a consumer."*

4.4 Services are driven by funding rather than need, leading to an erosion of local knowledge and community representation

A number of the SA interviewees and workshop participants noted how the re-configuration of community, social services and NGO sectors to be increasingly funded by the government has taken away the ability of these organisations to set their own agendas and respond to local population needs. One interviewee explained:

> *What we see emerge in the '80s particularly is a huge number of new programs and new services that are to be delivered by non-government organisations, but that are essentially wholly, or, if not wholly, very substantially funded by government.* (SA social services expert)

This has encouraged some NGOs to tailor their programs and work to the criteria of their funders: *"it really shifted the dynamic around so that it was organisations then doing the government's bidding rather than the government doing the bidding of the community"* (Social services expert). This has meant often compromising the advocacy role which has been central to many NGOs. In addition to the diminishing capacity of organisations to advocate for the community, under this regime the pressure to compete with each other for limited funding has broader implications for collective responsibility and collective and collaborative responses to the community. The impact, as one interviewee described, has been:

> *… profound, because it separated out the reality of disadvantage and it's made it all a little bit more distant and it's kept the people a bit more distant from … and as we've embraced managerialism, we've lost our connection to the people and the real stories. We get so busy dealing with things like our quality accreditation system or our health and safety system or whatever it is, we miss the reality of day-to-day life and the consequences of that. Then our programs and the policies that we end up setting don't bear relationship to the people who are most vulnerable.* (SA social services expert)

This not only results in a detachment from the local, but has also eroded the knowledge and capacity of many organisations to respond to community needs:

> *People at a local level have less and less authority and therefore the intelligence that they have about what's going on locally is not being afforded the same level of respect, it may not even be being sought. And so, as a consequence, we get programs that are not designed to be for the local situation.* (SA social services expert)

4.5 Loss of community health and education movements

A notable loss in the health and public services landscape across most states and territories in Australia is the disinvestment in community health and education movements and activities. These movements were important in keeping a focus on health equity in both service delivery and policy. In South Australia interviewees interpreted this as a wearing-away of democratic and social justice values, and a missed opportunity to address the social determinants of health and health inequities.

> *Back in the '80s, late '70s-'80s, we had very substantial investments in the development of a network of local community health services. That too involved mixed professional groups, so they were multidisciplinary. And they were positioned in communities that were often experiencing hardship, parts of the community often had high levels of hardship*. (SA social services expert)

> *I think somewhere probably getting closer to 2000 while I think, so there was a period where the investment in those activities and those instruments or those mechanisms and social infrastructure was increasing, but at some point we hit a wall and that seemed to almost turn off the tap. So, in the health sector what we started to see is the withdrawal from those investments and back to tertiary services; the withdrawal from giving real priority to some of the social determinants of people's health.* (SA social services expert)

These comments highlight a growing concern for the disintegration of community cohesion and collective responsibility for persons in disadvantaged circumstances. The erosion of social democratic values, including those of community control and participation, was highlighted to be one factor which has led to the increase

in health inequities in Australia. At the same time as this reorientation in South Australia, there were also similar cuts to health promotion in Queensland.[85]

Community and collective models were at the heart of the development of the community health movement in Australia. The 1973 Community Health Program started by the Whitlam Government was underpinned by a set of core principles aimed at addressing the increasing health inequities in the Australian population post World War 2, through disease prevention and health promotion approaches, and addressing the social determinants. Much of these principles have been eroded or lost in subsequent decades.

Since the introduction of the 1973 Community Health Program community health services have developed in different ways in each State and Territory. Many continue to provide a wide range of services and programs in Australia, but their role and extent is not well understood by governments. Apart from the Aboriginal Community Control Health Organisations (ACCHOs) across Australia and the 24 independent Victorian community health services, community health centres and services have been severely eroded. There is still a strong health promotion workforce in New South Wales. In the South Australian pilot study, the lack of similar positions was seen as a potential determinant of growing health inequities in that state:

> *[In NSW] in their area health services they still have a strong presence of people whose job it is to promote health and prevent illness. I think they mentioned they have 330 health promotion workers or something. Well I don't know how many we would have in South Australia, but it would be a handful, you know, people who could say that in the public sector, in local health networks whose job it was to do that.* (SA health policy expert).

ACCHOs emerged in the early 1970s, with the first, the Aboriginal Medical Service Co-operative opening in Redfern, NSW in 1971. The services were established as part of a social movement emphasising community control and self-determination for Aboriginal and Torres Strait Islander peoples. Currently, 145 Aboriginal Community Controlled Health Services across Australia have continued to grow in strength, and embody the principles of the original CHP, mainly with federal funds. There is plenty of evidence that Aboriginal community-controlled health services are the most successful and comprehensive models of primary health care in Australia.[86-88] This is partly due to a focus on community control, community development, community participation and self-determination built into the organisational model.

5. A toxic mix: Deindustrialisation, structural changes to employment opportunities, and unequal incomes and wealth

The deindustrialisation of the Australian economy since the 1980s has resulted in increasing job insecurity, and increased income and health inequities.[89] Average incomes in manufacturing are higher than in other jobs, and the job loss from deindustrialisation was a loss of full-time, high-paying jobs that contributed to the unprecedented slowdown in national wage growth in the past decade.[73]

Manufacturing employment was at its peak in Australia in the 1950s when it accounted for between 25 and 30% of employment.[90] In 1996, Manufacturing was still the industry with the highest number of jobs, representing 12% of employment. In 2021, manufacturing was the 8th largest industry in terms of employment and made up just under 6% of Australian jobs. Victoria and South Australia were the jurisdictions where manufacturing represented the highest share of overall employment in 1996.[91] In 2021, the percentage share of manufacturing jobs in these states was less than half what it was in 1996, falling from 15.7% and 14.5% of jobs in Victoria and South Australia respectively in 1996 to 7.0% and 7.2% of jobs in 2021. At the same time, industrial protections and conditions have been eroded and employment has become more insecure for a growing number of Australians.

> *We lowered our tariffs and non-tariff protection much faster than most of [the] other competitive nations … From a fair trade point of view, it's a foolish thing really, we didn't have to do it as quickly as that. And the harm caused by an overzealous application of neo-liberal trade policy was the decline of manufacturing over that period of time. And the liberal creation of the view that a service economy called the 'new economy' would be superior to that previous model of economic and industry development. But, as we know, the new economy as it unfolded has been characterised by the precarious forms of employment, which is the foundation for growing inequality.* (Economist in SA interviews)

The South Australian economy has been more vulnerable than the economies of other Australian states to the negative consequences of a globalised market economy and neo-liberal economic policies, including the effects of global and national recessions, labour market restructuring and government austerity measures. Interviewees from the SA study repeated a similar narrative: that with a relatively small economy and population compared to other states, South Australia has been less likely to withstand economic shocks and downturns, which have adversely impacted low income and unemployed people and their families. Dean[92] points to the failure of fiscal and employment policies in South Australia to adequately invest in innovation and diversification of industries to adapt to the changing labour market.

One positive aspect concerning employment and adaption is the growth of renewable energy initiatives in Australia. Public policies are required to share the benefits of Australia's energy transition equally. This is discussed in more detail in section 7 on inequities in urban planning and the transition to zero carbon.

5.1 Deindustrialisation and structural changes to industry type

Manufacturing was a key industry in Australia in the 20th century, along with mining and agriculture. Federation in 1901 created a larger 'common market' as opposed to multiple colonies, with a uniform federal tariff and the introduction of the first protectionist tariff in 1907 which required employers to pay 'fair and reasonable wages.'[90, 93] Key developments were World War I providing stimulus to the steel industry, with BHP Steelworks opening in 1915 [90] in Newcastle, General Motors and Ford setting up subsidiaries in the 1920s [90] and the expansion of metal works and machinery industries in the 1930s. Manufacturing peaked after World War II in the long boom, reaching 28% of national output in the 1960s.[93]

Australian manufacturing made advances in the decades following World War II, but due to the inward looking protectionist operating environment in Australia manufacturers were poorly prepared to adapt to structural shifts that resulted from newly industrialising countries competing with Australian manufacturing.[90] Competition with newly industrialising Asian countries and the mining boom put upward pressure on the exchange rate, making manufactured imports cheaper and Australia's manufactured goods more expensive.[90] Deindustrialisation of the Australian economy led to the closing down and moving offshore of manufacturing work, which occurred through a number of waves. Global recessions in the late 1980s and early 1990s resulted in substantial retrenchments and closures in manufacturing businesses in Australia. State and Federal governments in the 1990s allowed markets to determine industry policy which, together with the global trends discussed above, resulted in the decline in manufacturing. The implications have been long-term damage to the livelihoods of low-income blue collar workers and the unemployed.

An SA interviewee noted that recessions are devastating for people with low educational attainment and on low incomes, as *"people lose their jobs and find it very hard to get new jobs, and to get jobs that are anything like the ones that they've lost in terms of pay and status and security."* A 2016 study evaluating the impact of retrenchment at Mitsubishi in the south of Adelaide confirmed this, finding that many ex-employees struggled to find full-time employment and had to settle for casual or part-time contract positions and over 30% of respondents to that study were not participating in the workforce 12 months post-redundancy.[94]

The changes to the economy have meant the loss of manufacturing jobs in large corporations which offered secure and long-term full-time employment. These have been replaced by a growth in less secure, lower income service jobs.[40] There has been substantial growth in the Health Care and Social Assistance industry which has become the largest industry in Australia in terms of workers (See Employment by industry
As one SA labour market expert explained:

> *The vulnerability at the lower end of the income spectrum is being manifoldly, I think, reinforced by the quality of jobs that are available and rise in the precariousness that we've seen. And that is very difficult to counter because of the nature of the employment growth that we're experiencing. So, all the growth, nearly all the growth is concentrated in those sectors that generate part-time/casual short term jobs.*

Service industries such as health care and social assistance and retail trade have had the highest growth in number of workers employed between 1996 and 2021.

The closure of the Ford, Holden, and Toyota manufacturing plants in 2016 and 2017 resulted in one of the most significant structural adjustments in Australian manufacturing, particularly when the flow on effects to supply chain companies are considered.[95] The communities that these former manufacturing industries were located in are impacted the most by the economic change as seen in other countries such as the UK.[41] An interviewee explained:

> *The labour market for many factory workers in particular, and households that were exposed to that, exacerbated inequalities in those households concentrated in the north and south of Adelaide. We saw a hundred thousand manufacturing jobs lost nationally, and here in South Australia we saw thirty thousand manufacturing jobs lost and we never recovered from that really.* (SA labour market expert)

While manufacturing is still a major employer in Australia, the continued lack of interest in investing in sustainable advanced manufacturing, like many other high- income nations (e.g. South Korea, US, Germany, and UK)[43-45] have been doing for decades, has led to a number of missed opportunities for employment and business development in Australia. On coming to power in 2022 the Albanese Labor government committed to revitalising manufacturing with a focus on high quality products.

5.2 Employment conditions and characteristics

This section summarises the key employment trends which are elaborated on in

Appendix **1** likely to affect health equity

Unemployment and labour force participation

The unemployment rate declined steadily in Australia from the early 1990s until 2022, with the exception of temporarily higher unemployment during the Global Financial Crisis and at the onset of the COVID-19 pandemic. In 2022, the overall unemployment rate of 3.4% was the lowest it had been in many decades. The decrease in unemployment between 1986 and 2021 was higher for more disadvantaged quintiles compared with less disadvantaged quintiles, with a decrease in the inequality ratio from 3.0 in 1986 to 2.5 in 2021.[63] While there is still a social gradient in unemployment, it is less steep in 2021 compared with 1986.

Underemployment has followed the opposite trend to unemployment, with underemployment increasing in the past four decades. In 1978, 1.9% of men were underemployed and 4.5% of women were underemployed. The underemployment ratio rose between 1978 and 2019 to 6.9% for men and 10.2% for women, and more than 800,000 people were underemployed in 2022 even though underemployment had declined in 2022 to the lowest underemployment ratio since before the Global Financial Crisis.

Unemployment and underemployment are higher for younger people aged 15-24, and underemployment is higher for women compared with men. Unemployment is also higher for recent migrants, people with lower levels of education and Aboriginal and Torres Strait Islander people. However, the unemployment rate for Aboriginal and Torres Strait Islander people has improved and the gap between the unemployment rate for Aboriginal and Torres Islander people and the non-Indigenous unemployment rate has decreased.

The labour force participation rate increased from the 1960s until now, mainly due to increasing labour force participation for women. In the 1960s, labour force participation was 84.2% for men and 36.6% for women. In 2022, labour force participation had decreased for men to 71.2% and increased for women to 62.3%. The increase in labour force participation between 1986 and 2021 favoured less disadvantaged quintiles, with only small increases in labour force participation for the more disadvantaged quintiles (see

Appendix **1** for details).

The social gradient for female labour force participation is steeper than the social gradient for overall labour force participation. Female labour force participation increased by 3.5 percentage points for the least disadvantaged quintile but the increase for the most disadvantaged quintile was only 1.2 percentage points.

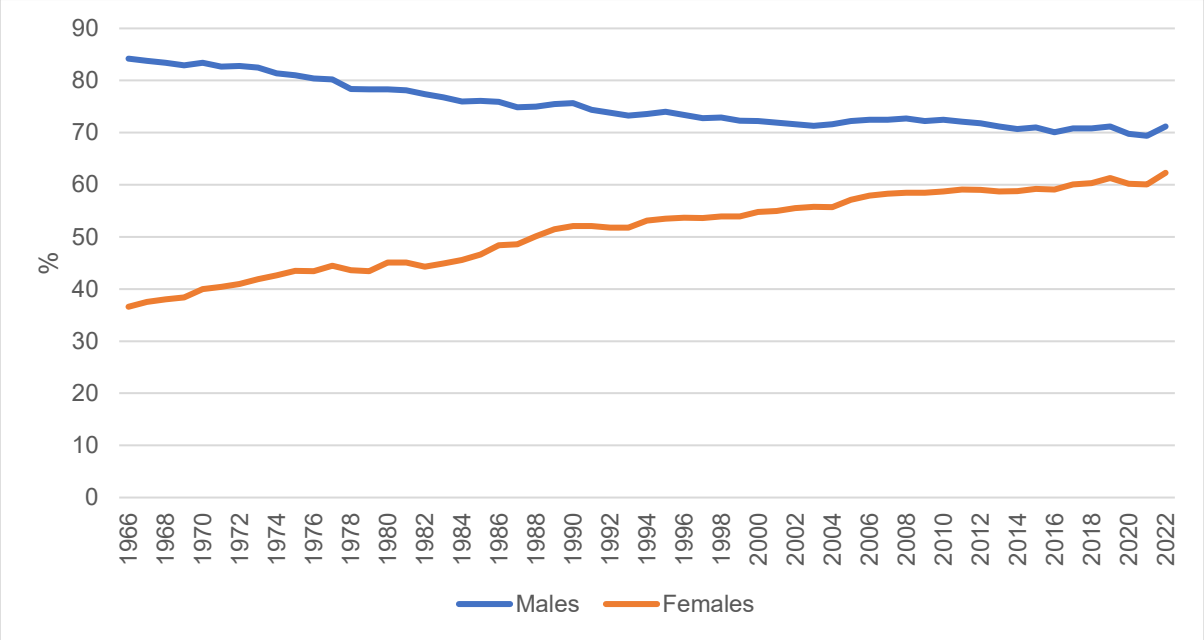


Figure 5.1: Labour force participation rate, South Australia and Australia, 1991 to 2017 (per cent) (Data source: Labour Force Australia, ABS, 2018)

Increase in part-time and casual employment

> *Over the last 20, 30 years we have had a collapse of the youth full-time labour market, and that's worked through the economy now, so that we have significant increases in the casualisation of the labour market, and I would say a squeezing of the full-time age demographic.* (SA NGO sector expert)

Full-time and permanent employment was once the norm for men, with 90.5% of men employed full-time in 1992 and 75% overall employed full-time. Employment grew by 58% between 1996 and 2021, but full-time employment only grew by 37% compared with growth of 94% for part-time employment between 1996 and 2021. Full-time employment for men fell from 90.5% in 1991 to 81% in in 2022. The decline in full-time employment was smaller for women, decreasing from 59% in 1991 to 52.8% in 2016 before increasing to 56.6% in 2022. There has been a rise in part-time employment from 22.8% in 1991 to 30.6% in 2022. The increase in part-time employment has been larger for men compared with women over this period.

Casual employment grew strongly in Australia in the 1980s and 1990s. In 2022, just over a quarter of women and 21.4% of men were casually employed. Casual employment is concentrated amongst people earning the lowest incomes, with around 80% of the bottom 10% of earners being casually employed and almost 60% of the bottom 25% of earners estimated to be casually employed.

In 2013, Australia was ranked as having the third highest level of non-standard (i.e. self-employed, part time or casual) employment in the OECD.[96] More recent OECD Employment Outlook publications have ranked Australia as having the second highest rate of part-time employment in the OECD,[97] the fourth highest rate of short part-time employment, and it has been observed that job security has decreased in Australia.[98]

The literature on precarious work and low quality jobs has debated whether precarious work can be a stepping stone to eventual secure employment, but although one study found precarious work to be better than joblessness as a stepping stone to secure employment, there is substantial continuity of precarious

employment with employees trapped in casual work in heavily casualised industries including accommodation and food services.[99] Casual work is associated with employment insecurity, not just potential job loss but loss of hours, earnings insecurity, and working-time insecurity. The growth of gig work has been suggested to be the normalisation of poor working conditions.[100]

However heterogeneity of casual employment must be acknowledged with different patterns of employer use of casual employment by industry and skill factors.[99]

Entering and re-entering the workforce: young people and the labour force

In 2022, the unemployment rate for 15-24 year olds was the lowest it had been in at least 35 years, 8.5% for male unemployment and 6.5% for female unemployment. Despite this relatively lower unemployment in historical terms, the unemployment rate for 15 to 24 year olds was still more than double the overall unemployment rate for men, and close to double the overall unemployment rate for women. Younger people also have a much higher rate of casual employment compared with other age groups.

Young unemployed people living alone, particularly those reliant on Youth Allowance or Jobseeker, live below the poverty line.[101, 102] In addition, the Productivity Commission's report on rising inequality in Australia reported that young people now have considerably lower incomes than they used to.[103] Higher underemployment rates and higher rates of casual employment will have contributed to lower incomes for young people.

There was a steep social gradient in receipt of unemployment benefits in 2008 and in 2022, with receipt of unemployment benefits rising with increasing disadvantage (Figure 5.2), and between 2008 and 2022 inequality increased.

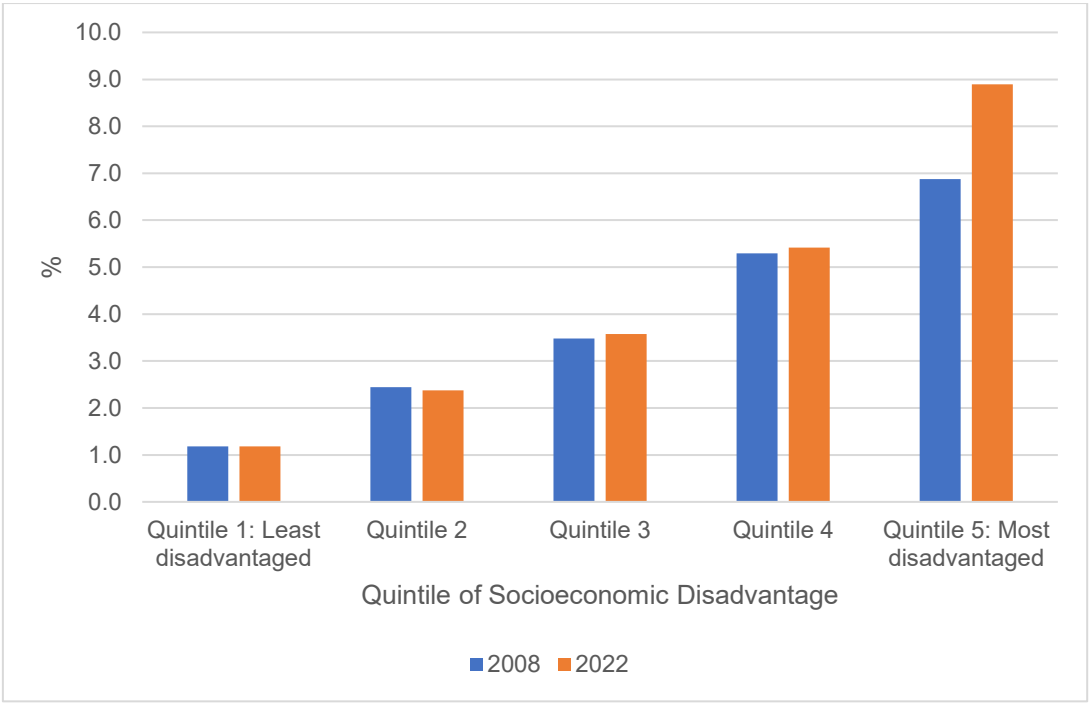


Figure 5.2: Young people aged 16 to 24 receiving an unemployment benefit by quintile of socioeconomic disadvantage of geographic area in which the cohort lives, 2008 and 2022, Australia (Per cent) (Data source: Social Health Atlas, PHIDU, 2023)

5.3 Industrial relations policies: increasing the precarious nature of work

Alongside the economic and fiscal policies and restructuring described above, workplace and industrial relations policies from the 1980s have impacted industrial protections and added to the changing working conditions for many Australians.

Historically in Australia wages have been set on an industry-wide basis. Changes in industrial relations and protections for workers beginning in the late 1980s under the Labor Hawke and Keating governments introduced enterprise bargaining. In 1987, the Australian Conciliation and Arbitration Commission sanctioned agreements at the enterprise level, covering issues such as performance-based pay, multi-skilling and new shift arrangements. The Australian Industrial Relations Commission, established in 1988, encouraged enterprise-by-enterprise bargaining and individual contracts. The Industrial Relations Reform Act 1993 allowed workplace disputes to be settled by enterprise bargaining between employers and unions in the workplace.

The changes in the 1980s and 1990s weakened the bargaining power of employees, and union membership declined from 2.5 million workers in 1976 (51% of total employment) to 1.5 million workers in 2016 (14% of total employment).[104] The same period has seen a drop in industrial disputes. Between 1974 and 2019 the wages share of GDP declined, and it is currently at a near record low at the same time that the profits share of GDP is at a record high.[105]

The industrial relations changes of the Howard period weakened workers' bargaining positions and contributed to a long period of income stagnation.[106,9] The Fair Work Act 2009 gave employees a guaranteed safety net of minimum terms and conditions through National Employment Standards, Modern Awards and National Minimum Wage orders. The Morrison Government passed an amendment to the Fair Work Act in 2021 which broadened the definition of casual employment, further increasing the risk of precarious employment.

The Albanese Labor government from 2022 has changed employment policy to increase bargaining power for workers and passed legislation designed to improve conditions for migrant workers, gig economy and casual employees.

5.4 Income stagnation and income and wealth inequality

Low wage growth was deliberate Coalition policy from 2013 until 2022,[107] and resulted in the income stagnation that persisted throughout this period. Historically low wage growth meant a decline in living standards and increasing social and health inequities particularly for people in low-income jobs whose incomes did not keep pace with rising utility bills and housing costs. The Albanese government has acted to increase wage growth particularly for workers on minimum wages and aged care workers. This effect of this on the average increase in wages growth is evident in Figure 5.4.

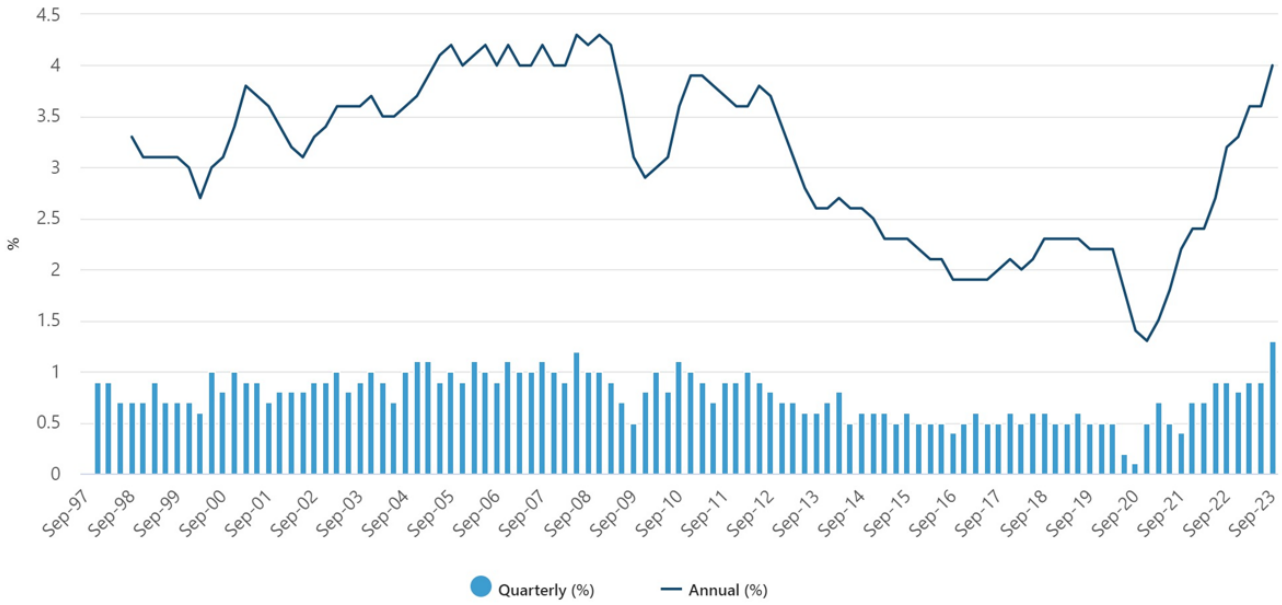


Figure 5.4: Wage Price Index, quarterly and annual movement (%), seasonally adjusted from September 1997 to September 2023 (Data source: ABS Wage Price Index, Australia, September 2023)

Increasing wage growth was crucial with the rapid increase in inflation in 2022, with inflation peaking at 7.8% in December 2022.[108] Annual inflation declined to 4.3% in November 2023, still well above average growth in wages for most workers. Workers have been experiencing real (adjusted for inflation) cuts in wages which have resulted in a cost- of- living crisis, with people needing to choose between purchasing food, paying bills, and doctors visits. The cost- of- living crisis is expected to have further increased inequities with greater impacts on people on lower incomes, and is likely to have increased poverty rates.

According to ACOSS estimates, more than 3.3 million people lived in poverty in 2019-2020. There are higher poverty rates for some groups: poverty rates were 62% for people in households where the main income earner was working age and unemployed, 72% for those receiving Parenting Payment, 34% for people in households receiving Youth Allowance, 43% for households receiving the Disability Support Pension, and 39% for households receiving the Carer Payment.[101] In addition, 34% of sole parent households were in poverty in 2019-20.[101] High poverty rates lead to higher health and social inequities.

Income inequality is higher than it was in the 1980s, with the share of income having increased for the top 1% and top 10% from the early 1980s.[109] Income inequality grew particularly during the boom from 2000 to 2008 and has not declined since, with the top 20% receiving 6 times the income of the bottom 20% in 2021.[101, 105] Income inequality temporarily fell to the lowest level in 20 years in 2020 when Jobseeker was increased in response to the onset of the pandemic but increased back to pre-pandemic levels in 2021 when the pandemic income supports were withdrawn.[101]

ABS statistics estimate the highest quintile held 62.8% of total household wealth in 2019-20, with share of wealth decreasing in each quintile and the lowest quintile only holding 0.7% of total household wealth. Wealth inequality increased sharply between 2003-04 and 2018-19. ACOSS estimated that the wealth of the top 1% increased by an average of 84% (after inflation), the wealth of the top 10% grew by an average of 65%, and the wealth of next 30% grew by an average of 44% and the wealth of the bottom 60% only grew by an average of 20%.[101]

One factor related to income that exacerbates inequalities is energy prices. Energy price rises significantly exceeded change in household income from 2008-09 to 2018-19, with energy prices peaking in 2018-19 (Figure 5.5). Rising electricity prices impact low-income households more, with low-income households typically spending double the percentage of disposable household income on electricity and gas compared with average-income households.[110] The cost of energy rose again in 2021-22 and was rising sharply with the impacts of the war in Ukraine driving up energy prices. The Albanese government implemented a 12 month price cap on gas prices in response, and a price cap on coal for electricity generation in NSW and Qld to reduce the increase in energy costs.[111]

The high percentage of disposable household income spent on energy costs for low-income households is exacerbated by inequities in renewable energy schemes. Research has found inequities in Australia's small-scale solar schemes, with larger subsidy receipts for households with higher wealth. The top household wealth decile had higher subsidy receipts than any of the bottom seven deciles for both subsidy schemes.[112] There was persistent inequality in solar panel uptake from 2012 to 2020 by net wealth of home owners. Average uptake of solar panels improved for home owners with household net worth just below the median between 2012 and 2020 but there were shortfalls for the bottom twenty percent of home owners, particularly for the lowest decile.[113]

ACOSS has noted that there are concerns that the future energy market will create a two-tiered system favouring those who can afford renewable energy resources (such as solar panels) and those who cannot.[114] This will increase inequities.

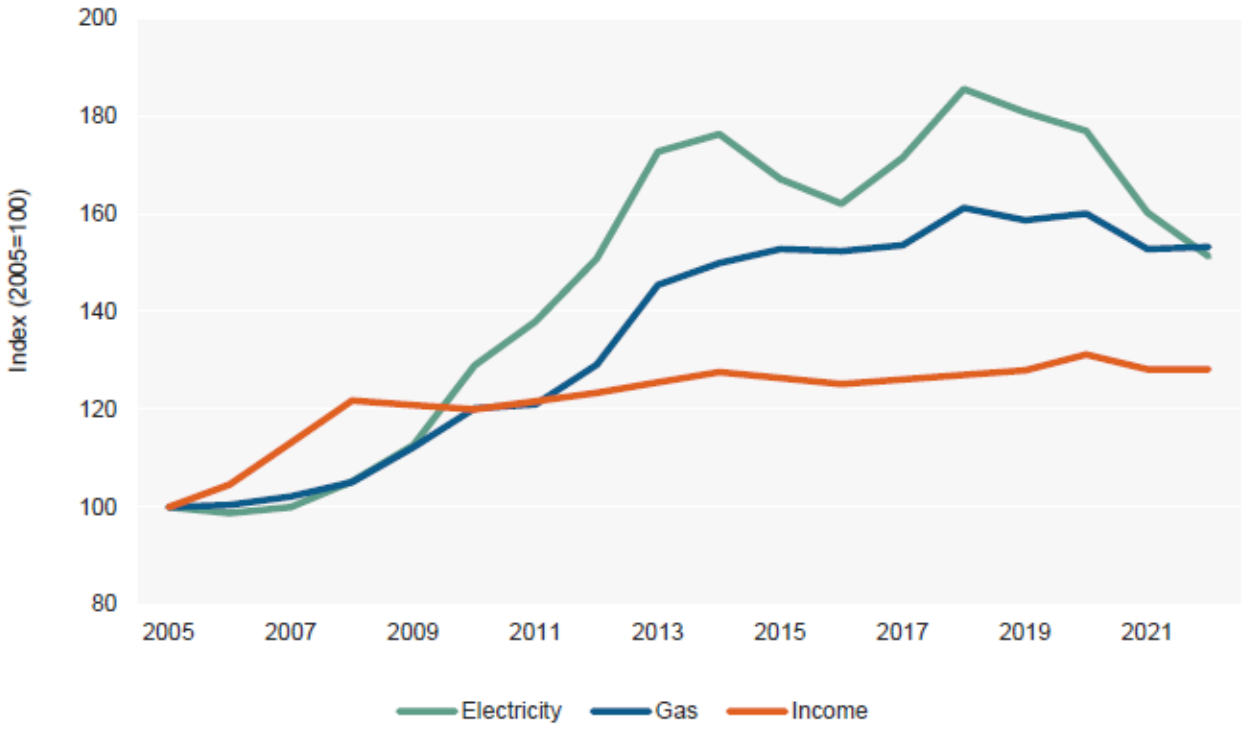


Figure 5.5: Long term trends in energy prices and income (adjusted for inflation) (Data source: Annual retail markets report 2021-22, based on Electricity and gas index – ABS, Consumer Price Index, various years and income index – ABS, Household Income and Wealth, Australia, various years)

5.5 Social security income support: from social responsibility to individual privilege

Australia's social security system has always been conditional on undertaking training or work.[115, 116] But mutual obligations were strengthened in the 1990s. The introduction of financial sanctions for non-compliance coincided with weakened labour market opportunities.[116]

Political statements made during the periods of the Coalition government since the late 1990s made it clear that the purpose of income support payments and poverty alleviation, has been displaced by a goal of labour force participation.[117] The Labor government has also played a part in this, with the Gillard government responsible for the 2013 change which completed the Howard government's 2006 change to move single parents with children aged eight or older onto unemployment benefits, which affected 80,000 sole parents. The rate of poverty among unemployed sole parents rose after many in this group were transferred to Newstart Allowance.[102]

The unlawful Robodebt scheme implemented under the Abbott, Turnbull and Morrison governments reflected the demonisation of welfare recipients and is fully explained in Box 6 in the following section. The Albanese government has made some positive changes related to social security since being elected. The hotline the Morrison government funded for employers to report jobseekers if they turned down jobs or submitted inappropriate applications was decommissioned in early 2023.[118] The ParentsNext scheme which required parents and carers with children under the age of six receiving welfare to undertake punitive mutual obligations was axed in the 2023-24 Federal budget.[119]

The Albanese government's review found that the privatisation of Australia's employment services system has failed and has recommended the establishment of a commonwealth job agency, creation of a watchdog for employment services, axing of a costly privatised training program, and an overhaul of mutual obligations.[120]

The demonising of recipients of unemployment benefits that escalated from the late 1990s onwards is at odds with community attitudes about poverty and inequality. A survey of community attitudes conducted in 2023 by ACOSS found that the majority of people in Australia agreed that poverty is a big problem in Australia, nobody deserves to live in poverty, people receiving unemployment payments should have enough income to cover meals and doctor visits, and that governments can cause and solve poverty.[121] Most people agreed that the current rate of unemployment payments is not sufficient, however 86% agreed nobody deserved to live in poverty and this support fell to 59% when the question asked views on people who receive unemployment benefits.[121]

The percentage of children in low-income, welfare-dependent families in Australia in 2022 has decreased in each quintile of socio-economic area disadvantage between 2006 and 2022, corresponding with increasing employment over this period (Figure 5.6). However, the socio-economic profile of low-income welfare dependence has become even more unequal. The inequality ratio of children in low-income, welfare dependent families increased from an already high 3.13 in 2006 to 5.99 in 2022. Children aged under 16 years who are living in the most disadvantaged areas are six times as likely to be in low-income, welfare dependent families in 2022 compared to those living in the least disadvantaged areas.

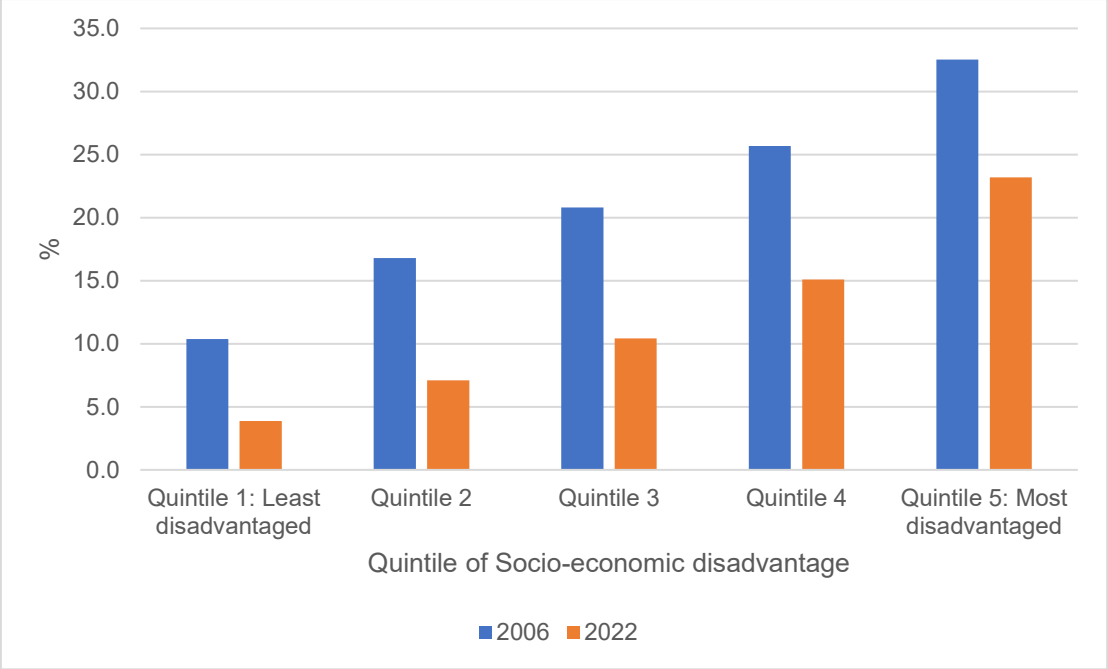


Figure 5.6: Percentage of children in low-income, welfare-dependent families in Australia by quintile of socioeconomic disadvantage of geographic area in which cohort lives, 2006 and 2022 (Data source: Social Health Atlas, PHIDU, 2023)

The percentage of children in low-income, welfare-dependent families is larger than the percentage of families that are low-income and welfare-dependent. This is consistent with ACOSS' estimate that poverty affects 1 in 8 people in Australia but affects 1 in 6 children.[101] If children are over-represented in poverty, this creates a risk that poverty will have intergenerational impacts, as a greater proportion of the current generation of children are being raised in poverty.

Interviewees and workshop attendees from the SA study repeatedly noted the direct negative consequences that low social security payments have on the health of the poorest Australians, many of whom they see daily in their workplaces. Since then, the rate for Jobseeker, Youth Allowance and other payments temporarily doubled in 2020 in response to the pandemic,[122] which was reported to have many positive benefits. The Coronavirus income support supplement was withdrawn in 2021 whereas its continuation would likely have contributed to a reduction in health inequities.

The Albanese government increased Jobseeker, Youth Allowance and other payments by $40 per fortnight in the 2023-24 Federal budget,[123] the equivalent of $2.80 per day, much lower than the increase recommended by the government's own interim economic inclusion advisory committee and the increase ACOSS' raise the rate is campaigning for, which ask for Jobseeker to increase to the equivalent of 90% of the pension.[124]

People receiving Jobseeker, Youth Allowance and other payments make up a greater proportion of the lowest quintile in Figure 5.6. ACOSS argues that the freezing of Newstart (after inflation) from 1994 to 2021 contributed to a progressive deepening of poverty for people in households relying mainly on that payment.[102] Furthermore, they argue that the social security policy changes since the Global Financial Crisis have increased child poverty instead of reducing it, especially in sole parent families. In 2009, the Parenting Payment was excluded from the pension increase, and Family Tax Benefits (FTB) were frozen.[102] The rate of

poverty among unemployed sole parents rose after many in this group were transferred to Newstart Allowance.[102]

Figure 5.7 shows that those receiving unemployment benefit are more likely to live in areas of disadvantage. There was an increase in the long-term rate of receipt of unemployment benefits over this period in every quintile. The inequality ratio is very high, 4.07 in 2006 and 4.82 in 2022, indicating that those living in the most disadvantaged socioeconomic areas are almost five times as likely to be in long-term receipt of unemployment benefits compared with those living in the least disadvantaged socioeconomic areas. The increase in the long-term receipt of unemployment benefits can be partially attributed to the 2006 and 2013 changes which moved single parents with a child aged eight or older onto unemployment benefits. The period from 2006 to 2022 coincided with the escalation in mutual obligations and weakened labour market, with people receiving long-term unemployment benefit facing the most difficulty in re-entering the changed labour market.

The Albanese government expanded access to the Parenting Payment for single parents in the 2023-24 Federal budget, raising the age-cut off from 8 to 14 which will have reduced the percentage of people receiving unemployment benefits long-term. The expanded access to the Parenting Payment came into effect in September 2023 and increased the income for single parent families, a positive move for health equity.

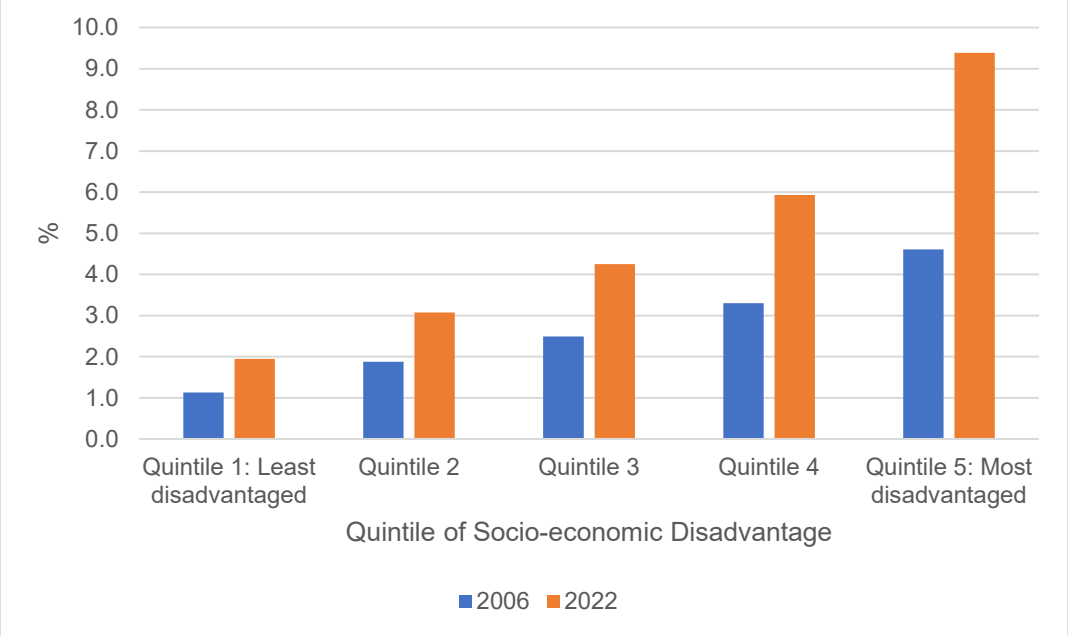


Figure 5.7: People receiving an unemployment benefit long-term by quintile of socioeconomic disadvantage of geographic area in which the cohort lives, 2006 and 2022, Australia (per cent) (Data source: Social Health Atlas, PHIDU, 2023)

SA study interviewees discussed unemployment and social security within a broader narrative of a shift from social security being a social responsibility and citizen's right before the 1980s, to being increasingly framed in public policy and public discourse as a conditional safety net for a narrowing number of "*deserving*" people. This has implications for the health of the people receiving benefits, both because they lack funds for

necessities and because of the demeaning nature of the welfare system. A number of interviewees shared their concerns:

> *So, I think if we looked at just the whole nature of the discourse over unemployment benefits, we would see a demonisation of people that are receiving benefits of any sort. And, you know, that's evident in public policy where we have had the unemployment rate not increasing in real terms for 24, 25 years to the stage where even the business lobbyists are starting to say raise the rate.* (SA NGO sector expert)

> *Even if you've got income through the welfare system, it is designed to be pretty mean deliberately. So it's not an attractive alternative to working ... And that's by design. And, you know, what does it do to your self-esteem? And if you've got low self-esteem and you're being told constantly that you're not able to earn a living, there's something wrong with you, you know, that's not good for your health.* (SA Economist and labour market expert)

The cost- of- living crisis for those in receipt of sole parent and unemployment payment is therefore even more concerning as it amplifies inequalities and adversity faced by groups who already experience heightened disadvantage. In addition, public policy driven by a conditional rather than citizen's rights view of the welfare system led directly to the Robodebt scandal described in Box 6.1 below.

6. Privatisation of public services exacerbates inequities

One of the key effects of the dominance of neo-liberal policies and ideas in Australia and globally has been the privatisation of previously public services and utilities often into quasi-market structures, or the outsourcing of roles and functions to the private sector. The link between privatisation, outsourcing, and growing health inequity in Australia was a major emerging theme in our SA Heaps Unfair research. Privatisation and outsourcing have occurred in many different sectors, including health and social services, housing, infrastructure, education, correctional services, immigration detention services, and employment services.

The recipients of government contracts for outsourced public sector roles, both policy-related and service delivery, have mainly been large global consulting firms. These are known as the Big Four and the Big Three. The four largest professional services firms are Deloitte, EY, KPMG, and PwC. They offer a wide range of services including auditing and taxation advice to private entities and governments. The three largest global consultancy and strategy firms are McKinsey and Co, Boston Consulting Group, and Bain and Co. Their work focuses on general strategy, organization, marketing, and operations.

In the 2021-2022 financial year alone, global consultancy firms received Australian government contracts worth AU $20.8 Billion, the equivalent of almost 54,000 full-time staff, or 37 per cent of the Australian Public Sector workforce.[125] The exponential growth of private consultancies has undermined democracy by 'hollowing out' the capacity of the public sector, leading to government decision-making that is less likely to be in the public interest. Consultants have conflicts of interest between fostering private sector gains and supporting public health and equity. Their recurring contracts are not conducive to taking the longer-term view required to place health equity into public policy. They are poor substitutes for 'frank and fearless' public servants. [126]

While global companies are major players in the delivery of outsourced services in Australia, the not-for profit sector has also increasingly embraced provision of government service delivery. In doing so it can lose its capacity to advocate on behalf of traditional clientele, often very vulnerable people, and for engaging in inter-agency collaboration in the process to optimise outcomes. [127]

> *"The first thing I'd do is make less use of private consultants and [only] use them when it's clear that the capability doesn't exist in the public sector"* (Public sector administrator)

Box 6: Robodebt

The role of large global consultancy firms, which have undertaken outsourced government roles for decades, became prominent during 2023 through scandals reported in the media and the Royal Commission into the Robodebt scheme.[128] This was the informal name given to a debt recovery program beginning in 2015 that often falsely accused welfare recipients, many of whom were highly vulnerable, of owing money to the government. The scheme automatically issued debt notices through a process of income averaging which distorted true liabilities. Although similar processes had been used previously, the scale was unprecedented. Evidence before the Royal Commission into the Robodebt scheme revealed deficiencies in documenting the vulnerability indicators on client files leading to negative mental health impacts.

The global consultancy firm PwC was engaged by the Department of Human Services in 2017 to review the scheme. The 2023 Royal Commission[128] into the scheme found that PwC failed to question the legality of the scheme or deliver a full report. PwC's role in the Robodebt scheme affected welfare recipients negatively by not exposing the injustice and illegality of the scheme, thus allowing the Department of Human Services to continue to pursue debts that were neither valid nor accurate. PwC also benefitted by receiving almost $1 million for an unsubmitted report which may have embarrassed the government, but which it repaid following the Royal commission into Robodebt.

In 2023 PwC was also implicated in a taxation scheme whereby it shared its privileged government information to partners and other clients, thus revealing clear conflicts of interest. These conflicts likely resulted in undermining the taxation revenue base that could have boosted health and social investment, and helped address health inequities.[129] The firm featured in many public submissions and appeared before two parliamentary inquiries[130, 131] in 2023 into the integrity and accountability of large consultancy firms which are yet to report their findings and recommendations.

6.1 Housing

> *I think housing is probably the big one, one of the big ones. The fact that from the early 1980s we had an active attack on public housing from the private sector and so we've had policy move away from public housing provision to private provision and maximising returns to investors.* (SA NGO sector expert)

The count of occupied dwellings rented from the State or Territory Housing Authority in Australia fell from almost 330,000 in 1996 to less than 278,000 in 2021 according to Census data, a reduction of more than 50,000 occupied public housing dwellings.[132] Figure 6.1 presents PHIDU data on the percentage of dwellings in Australia rented from the government housing authority by quintile of socio-economic area disadvantage in 1986 and 2016.The smallest reduction was for the least disadvantaged quintile, the quintile with the lowest need for public housing. The reduction for the most disadvantaged quintile was larger compared with the least disadvantaged quintile, but the largest reductions nationally were for the fourth quintile, followed by the third, then the second. While this has been partially offset by an increase in non-government social housing, the stock of social housing only grew by 4% from 1996 to 2016, much lower than the 30% growth in the number of households in Australia.[133]

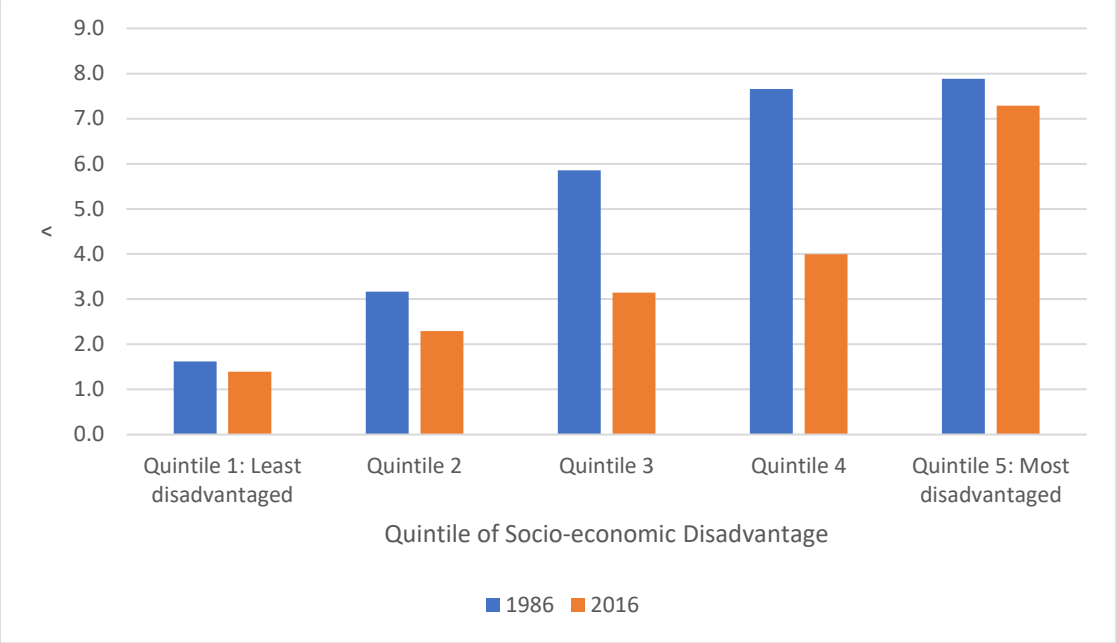


Figure 6.1: Percentage of dwellings rented from the government housing authority by quintile of socioeconomic disadvantage of geographic area in which the cohort lives, 1986 and 2016, Australia (Data source: Social health atlas, PHIDU, 2023)

The decline in public housing dwellings differs by jurisdiction, with South Australia and the ACT by far the most impacted. South Australia was particularly hard hit because it had been such a strong public housing provider previously,[134] so the decline was more dramatic:

> *The [SA Housing] Trust role in South Australia … at its peak was higher than ten per cent, than any other state. So therefore, the decline probably has had a bigger impact here actually.* (Public policy academic)

The percentage of dwellings in South Australia rented from the state government housing authority decreased drastically between 1986 and 2016, which most affected the most disadvantaged areas of South Australia (Figure 6.2).

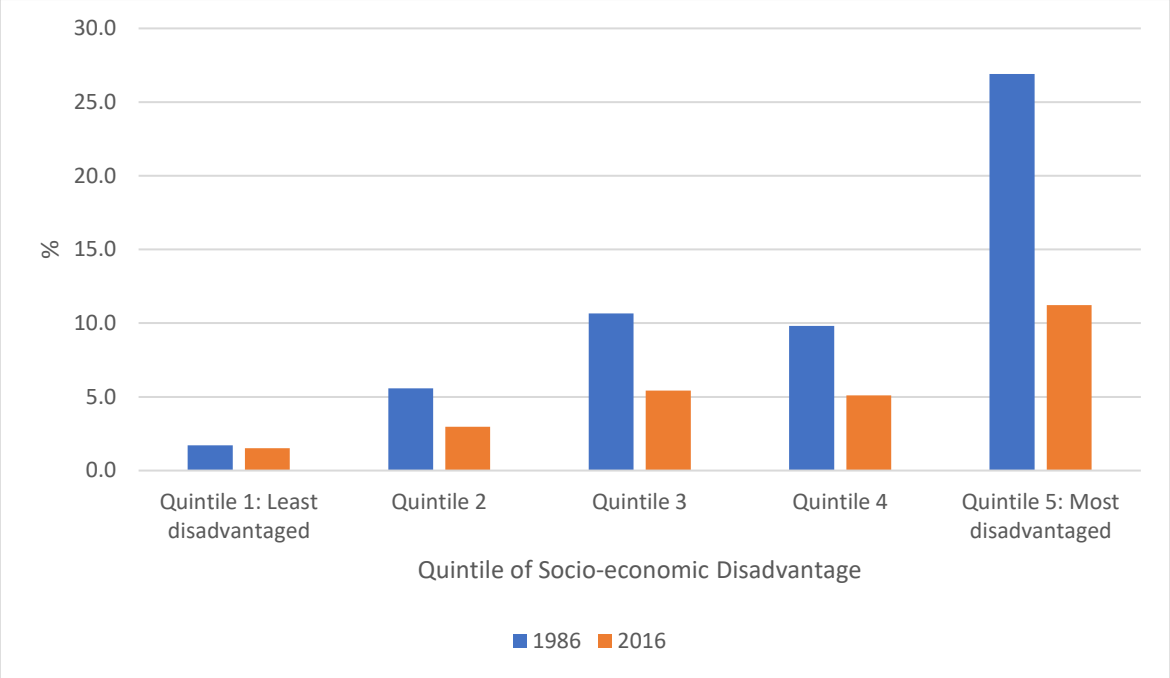


Figure 6.2: Percentage of dwellings rented from the government housing authority by quintile of socioeconomic disadvantage of geographic area in which the cohort lives, 1986 and 2016, South Australia
(Data source: Social health atlas, PHIDU, 2023)

Changes in policies in other sectors – notably the deinstitutionalisation of mental health services – led to increases in demand for public housing while actual housing stock was declining. In addition, while public housing has decreased, affordability of housing has also decreased, meaning there is "*a whole group of people*" on "*low and moderate incomes*" who are falling through the gaps between having access to public housing, which "*is only available for the very poor*", and being able to afford housing (PSA public policy expert).

The reduction in social housing in SA and the ACT and growth in social housing not keeping up with growth in the number of households in the rest of Australia has led to huge waiting lists for social housing[133] and pushed people on low incomes into the private rental market. Per Capita note that housing costs are a much higher percentage of disposable income for the lowest income quintile and rose from an average of 22% of disposable household income in 1994-95 to an average of 29% of disposable household income in 2017-18,[133] which is on the threshold of the 30% of disposable income that is classed as being in housing stress.

Housing in Australia was rated as affordable in 1990 but has been rated as severely unaffordable since the early 2000s.[135] Growth in house prices began to diverge from growth in wages in the late 1990s, specifically from 1999 when the Capital Gains Tax discount was introduced.[133] This change in housing policy resulted in a sharp increase in house prices in Australia, and benefits from housing related tax reductions are concentrated amongst the highest income earners, transferring wealth from the general population to the already wealthy, and from young to old.[133]

Housing policy shifted from the 1990s from the government directly supplying and building housing to subsidising both individual renters and private developers to supply rental housing to people on lower incomes. There have been declines in percentage of home ownership, declines in public housing, and growth

in the percentage renting from a private landlord.[136] Unaffordable house prices have led to lower home ownership rates for successive birth cohorts according to AIHW data,[136] and those who are able to pursue home ownership in younger cohorts are the wealthiest, with intergenerational wealth transfers and class playing much more of a role in home ownership now than 30 years ago.[137, 138]

The unmet need for social housing in Australia in 2016 was estimated to be a shortfall of 433,000.[139] Two studies have estimated the need for social housing by 2036 taking population growth into account, providing very similar estimates of 726,000 and 728,600 new social housing properties needed by 2036 (starting from 2016).[139, 140] Meeting this need for social housing would require 36,000 new social housing dwellings per year starting from 2016.[133] The number of public sector dwelling approvals in each year from 2016 has been less than a tenth of the 36,000 new social dwellings needed per year to meet need in most years, only approximately 3100 in 2016, 2,800 in 2017, 2,500 in 2018, 2,400 in 2019, 3,400 in 2020, 3,700 in 2021, and 4,500 in 2022.[141] The Albanese government's pledge to deliver 30,000 new social and affordable rental homes in the next five years[142] will not be nearly enough to meet the need for social housing, and pledges from states and territory governments are likewise not enough. In the 1970s and 1980s more than 50,000 public housing dwellings were built every 5 years.[143] While public housing is not the only social housing, most social housing dwellings in Australia are public housing. The number of community housing dwellings in Australia more than tripled between 2006 and 2022 to 112,800 dwellings, but most of the increase in community housing dwellings has been due to a transfer of management or ownership of public housing dwellings to community housing organisations rather than building new social housing dwellings.[144]

The much lower than needed growth in social housing and increase in percentage of disposable income spent on rent by the lowest income quintile points to the failure of the change in housing policy subsidising private developers to supply rental housing to people on low incomes. The most effective way to increase the supply of affordable rental housing for people on low incomes is direct investment from governments to build public housing.[145]

6.2 Health Services

> *I think it's a bit like pissing against the wind. The country ended up being in the grip of – when you look at the last few decades – of neo-liberal policies and programs that made it impossible for health services to even cope*. (SA health policy expert)

There are several trends in health care over the time that may have had detrimental effects on health equity.

Private health sector

Australia has a complex mix of private and public health services. For example, in Australia, over 40% of hospital admissions were to private hospitals in 2021-2022.[146] Privatisation of health is a concern for health inequities because it creates the risk that timely access to health care relies on ability to pay, and the potential for a two tiered system, where only wealthier people in the population can access private health care. The dental system in Australia has long been highlighted as an example of a two-tiered system, where those who cannot afford to access private dental services have very low access to dental care. The likelihood of visiting a dentist in the last 12 months decreases with education and income.[147]

Out of pocket costs for health care have increased by 50% over the last decade in real terms, driven by increases in out of pocket costs for specialists, allied health, diagnostic imaging, radiotherapy, optometry,

general practice visits, and other MBS services.[148] This creates inequities in access to health care, as people on lower incomes avoid seeking care due to the cost, while those who can afford the costs enjoy more frequent access to care.[149]

Private health insurance

Private health insurance creates inequities in access to care, particularly hospital care and allied health, based on people's capacities to afford paying health insurance premiums. In particular, private health insurance can influence timeliness of care, with private health insurance holders able to avoid public system waiting lists and access treatment sooner through private systems.[150]

Over the time period of interest, private health insurance coverage in Australia has fluctuated. The proportion of the Australian population covered by private health insurance fell from just over half the population when Medicare was introduced in 1984 to less than a third by 1998. The Medicare Levy Surcharge, lifetime health cover, and rebate policies were introduced in subsequent years, which saw the rate of coverage increase to approximately 45 per cent for the next decade and a half to 2017.[151] These private health insurance payments for hospital cover then form three quarters of the income of private hospitals,[152] and so are a key determinant of this two tiered system. Furthermore, a considerable proportion of this is public funding, as the government subsidises private health insurance $6 billion a year through rebates.[152] Private health insurance premiums have risen at a much higher rate than wages over 2010-2019, making private health insurance more and more unaffordable for lower income households.[151, 152]

Primary health care

Over recent decades, there have been funding reductions and changes to primary health care that are likely to have undermined equity.[153] Section 4.5 covered the loss of community health and education services since the 1970s, which have reduced the space in the health system to tackle health inequities. There have also been drivers of greater health inequities in general practice. In 2015, the Federal government froze the indexation of Medicare rebates to general practitioners, resulting in rates of bulk billing (providing services to people free of user fees) declining. The drop in bulk billing led to reductions in people visiting general practitioners, particularly in low socioeconomic and regional and rural areas.[154] In November 2023, the Federal government funded indexation of Medicare rebates and increased the incentives for bulk billing, and future research will be needed to examine whether this succeeds in reversing the decline in bulk billing. In addition, general practice in Australia has become more corporatised. While in the 1990s general practice largely comprised small independent practices,[155] over time these smaller practices have been merged into larger businesses.[156] Ownership has become concentrated, such that now over 400 medical centres are operated by the three largest corporate groups (Sonic Healthcare, Primary Health Care Limited and HealthScope).[155, 156] This corporatisation risks the prioritisation of revenue over good quality care and equity. More corporatised practices have been found to be associated with less patient satisfaction, higher out of pocket costs, and poorer continuity of care with the loss of a 'usual GP'.[155]

6.3 Education

> *I would abolish private schools. I think they are regrettable, very regrettable. They segregate society on religious grounds, on ethnic grounds and in terms of socioeconomic status. And when they offer scholarships to poor children, they just take the best and brightest children out of the public system.* (SA economist)

There has been a significant rise in private schools over recent decades. Commonwealth funding per capita for private schools has increased steadily from 1970 to the 2000s.[157] The proportion of students enrolled at private schools in Australia increased from just over 20 per cent in 1980 to over 35 per cent in 2022.[158] Private

schools disproportionately teach students from the top two socioeconomic quartiles.[159] There are large inequities in teacher shortages, educational resources, and educational attainment between schools in low socioeconomic areas and schools in high socioeconomic areas, and these educational inequities are more pronounced in Australia than countries like Canada, New Zealand, the UK, and the Netherlands.[160] As the continuing Gonksi reform failures highlight, addressing these inequities has been a challenge for governments. The needs-based funding model designed under the Gonski Review to support equity has been undermined by successive governments.

Australia has one of the most unequal education systems in the developed world, with a firm link between socio-economic position and education performance.[161] A growing gap exists between advantaged and disadvantaged schools, with commonwealth and state funding for private schools increasing almost five-fold compared with public-school funding over the last decade.[162] Between 2012 to 2021, per student funding to independent and Catholic schools rose by 34% and 31% respectively, while funding to public schools increased by just 17%.[163]

Privatisation has also had negative effects in the vocational education sector, revealing significant economic cost for taxpayers, with students left heavily indebted and bearing the major cost of privatisation.[164, 165] Early childhood education once mainly managed by the community sector also shifted towards for-profit providers holding a significant share, with claims that this had reduced operational standards, access to care, and a cost imposition to taxpayers.[164]

6.4 Job services

The Federal Howard Coalition government created the privatised Job Network in 1998, however, the previous Labor Keating government had already privatised two thirds of the CES.[166] This period was also characterised by the rise of a punitive and obligation-focused model of unemployment support. [166] Within this model, unemployed people aged 18 to 29 years were required to undertake a work experience program called 'Work for the Dole'.[167] Since then, there have been several revisions of the privatised employment service system; renamed Job Services Australia in 2009, and Jobactive in 2015.

Jobactive was the Australian Government employment service which operated between July 2015 and June 2022[168] when it was replaced by Workforce Australia on 4th July 2022.[169] The Senate Inquiry into Jobactive had released a report in February 2019 (*Jobactive: failing those it is intended to serve*)[170] and this, along with the considerable negative media coverage,[171, 172] highlights perverse incentives and fraudulent behaviour on the part of the private employment services.[173] Mutual obligations under Workforce Australia is still termed 'Work for the Dole', and ranges from 15 to 30 hours per fortnight to 30 to 50 hours per fortnight depending on age and level of obligation.[174]

More than two decades ago, an expert on privatisation highlighted negative and inequitable outcomes for clients under privatised employment services, arguing that tightening of incentives encourages service providers to abandon any aspects of their service provision not included in the goal specifications, such as counselling, or assistance for family-related problems. Under a competitive incentive-based system, such services could only be provided if they are cost-effective in meeting the goal of gaining employment, or if they are specifically included as part of the service specification.[175] He noted:

> *A second outcome of competitive incentive systems is 'cream-skimming' or 'cost-shifting'. Service providers face a strong incentive to seek out clients (the cream) whose needs can be met at relatively*

low cost compared to others in the same payment class. Meanwhile, high-cost clients are diverted to residual 'providers of last resort,' or, receive no service at all. (Document analysis[175])

Taken together, the findings for these sectors paint a picture of privatisation affecting a range of social determinants of health that drive a system less able to respond to health inequities and, is instead more likely to exacerbate these inequities in Australia.

7. Inequities in urban planning and the transition to zero carbon

Urban planning affects health and health equity profoundly, including through shaping social determinants of health and equity such as housing availability, affordability, and diversity; neighbourhood amenity, walkability, and safety; heat; air quality; and access to nature and green spaces.[176] Inequities in urban environments helped fuel the inequitable spread of COVID-19 in urban populations,[177, 178] resulting in higher death rates for people in lower socioeconomic areas.[179] Over the decades, urban planning has increasingly been informed by neoliberal principles[180] and car-centric approaches[181] that risk unhealthy and/or inequitable outcomes for residents. For example, in Australia less than 40% of suburbs meet criteria for being walkable and liveable (safe, inclusive, conducive to health), with walkability and liveability decreasing the further out from the central business district the suburb lies.[181] Analysis of suburbs in Adelaide found that the more recently a suburb was established, generally the less it was designed for liveability and walkability. For example, newer suburbs tended to have poorer pedestrian infrastructure, less street permeability (creating longer, less walkable routes), and fewer verges.[182] Lower socioeconomic suburbs had far poorer liveability and walkability, which will exacerbate health inequities.[182]

Climate change is already exacerbating urban health inequities, with critical ramifications for urban planning.[183] Inequities in exposure to severe weather events such as bushfires[184] and flooding[185] is evident, and climate change will continue to drive inequities in food insecurity, housing, and other social determinants of health, and increase the likelihood of future pandemics.[186] Urban planning can either contribute to or help mitigate climate action, and exacerbate or ameliorate urban health inequities, through transport systems and the physical built environment.[183]

There is some progress on reducing carbon emissions to lessen climate change, but the move to renewable energies itself holds the risk of exacerbating inequities.[187] The energy transition, needs to be a "Just Transition" that attends to equity.[188] Inequities are already evident in the transition in Australia. For example, as described in 5.4 Income stagnation and income and wealth inequalitywealthier households are more likely to install home solar panels, meaning the subsidies for adoption of solar power are flowing more to wealthier households, and these households are enjoying lower energy bills and revenue from feed in tariffs.[112] Renters, and households that can't afford to install solar are left locked into expensive energy from the power grid.

High energy prices are particularly of concern in relation to poor quality housing. Low income households also often lack the resources for low carbon household retrofits, leaving them with poorer indoor environments and higher energy bills.[189] They are more likely to be living in poorer quality, less insulated housing, and to be renting such housing, which reduces their control over improving the housing quality. Less insulated housing requires more heating and cooling, resulting in very high basic living costs:

> *People have often asked me what's the one policy thing you'd do to improve energy affordability and my response will always be have decent housing. I mean, the poorest people in this state are almost all renters and we're still seeing people spending two thirds of their income on housing plus electricity, so rent plus electricity. So, in terms of basic Maslow principles we've got two thirds of your income, add water and gas and you're probably up to 70 percent of income being spent just on level 1 of Maslow's needs hierarchy. Doesn't leave much for like food, health, exercise, holidays*. (NGO sector expert)

Interviewees noted that as well as the public housing stock dwindling, the quality of the stock that was left was decreasing, because they "*haven't been maintained properly*".

Likewise, electric vehicles are expensive to purchase, and lower income households are left to rely on costly to run internal combustion vehicles.[190] Inequitable distribution of electric vehicle infrastructure exacerbates this.[190] Thus, current decarbonisation policy efforts may be further entrenching inequities as the economy changes to more renewable energy.

8. Managerialism and the hollowing out of the public sector – its contribution to Australia's growing inequities

This section of the report focuses on changes to the public sector as a result of the adoption of New Public Management (NPM) and managerialism by both state and national public sectors. It describes how changes to the public sector have reduced Australia's capacity to respond to the economic and social challenges it has experienced since the 1980s and hence to the growing inequities. The NPM movement began in the late 1970s and early 1980s. It was the result of the historical changes to state ideology towards neoliberalism which rejects welfarism, opposes a large public sector, and emphasises competition and the primacy of the private sector. NPM first emerged in the United Kingdom and the USA, with New Zealand and Australia following soon after.[191]

8.1 Politicisation of the public service

Politicisation refers to the extent to which public servants are influenced by or aligned with the political interests of the government of the day, rather than acting impartially and professionally in the public interest. This includes by offering 'frank and fearless' advice. Politicisation involves manipulation or suppression of material that may embarrass or be unfavourable to governments.[192] New Public Management has resulted in an increasingly politicised public service in Australia, evident in the now common replacement of senior public servants following a change of government to facilitate the imposition of the new government's control of and authority over the public sector.[193, 194] This has been a significant move away from the Westminster model of an apolitical professional public service that provides impartial advice to the government of the day. Former PM Scott Morrison's 2019 speech on public service reforms provides a strong example of this change in attitude towards the public service:

> "*One of the worst criticisms politicians can make of each other is that a minister is a captive of their department…Only those who have put their name on a ballot can truly understand the significance of that accountability. I know you [public servants] might feel sometimes that you are absolutely right in what you are suggesting, but I can tell you when it is you that is facing the public and must look your constituents in the eye, it gives you a unique perspective*." [195]

In this section we draw on the in-progress research interviews we are conducting to examine the impact of changes in public servant management. One interviewee stated:

> *What's happened in recent years in Australia at a big scale and has really, particularly under the coalition government in Canberra, meant that you've had all these private firms who were the providers of choice for coalition ministers who wanted particular work done because they knew that many of the consultancies were willing to have regard to the preconceived views that some of the ministers might carry.* (Public sector administrator)

Another stated that a problem is:

> *…the gradual politicisation of the public sector and the creation of the external experts to do work that would be considered to be core. I think at the national and the state level the ability to actually think about, and plan for and execute major initiatives across a population I think is really doubtful…They don't have the engine room anymore to do it.* (Public sector worker)

This worker highlighted that politicisation of the public sector extended to demanding the use of private consultancy firms in place of public sector staff:

> *I remember one [instance] in particular that we were wanting to have a piece of work done about [stated requirement] to be modelled for a particular policy to include in a budget bid, and were basically told unless it's done by these people, it's not going to be considered accurate, even though, in my view, the people who we would have got to do it understood the nuance of the work much more than a firm who I didn't know the people and the expertise that they offered.*

Politicisation should be understood within the broader context of a decline in integrity, transparency, and accountability in Australian governments. It is also associated with forms of 'soft' corruption in policymaking.[192] The policy implications due to the politicisation of the public sector are discussed below.

8.2 Undermining the role of policy

The undervaluing of public sector policy roles and the narrowing of policy processes to responding to specific requests for advice from senior public servants and the minister has meant that policy actors necessarily have become reactive. Combined with the significant staffing cuts to the Australian public sector that have continued to be imposed from the 1980s, and most rigorously in the last decade, the limiting of the policy process has meant that policy actors have less capacity to build the expert knowledge base that is required to respond to new and emerging policy issues. An audit of the Australian Public Service workforce found that in the 2021-2022 financial year AU$20.8billion was spent on hiring tens of thousands of external contractors and global consultants which is reported to be 54,000 full time-equivalent public sector roles.[196]

The more that governments outsource, the less they know how to do, with public sector workers becoming overlooked and 'infantilised'.[197] However, as one respondent argued, the loss of capacity by public sector workers does not guarantee that private sector firms are a suitable alternative:

> *Usually those firms are involved in analysing the problem and proposing solutions, but they also do not necessarily have that on-the-ground operational experience, or relationships. Much of our work is complex and it requires an understanding, not just an understanding, but connections to the system to be able to shift it, and when that is outside, that's really tricky.* (Public sector worker)

This worker suggested that politicisation of the public service can be linked to a decline in the capacity of the public sector to develop and implement sound evidence-based policy:

> *At the moment, we almost regulate the number of public servants that people perceive as feasible, and I don't get why. If there's an additional job to be done, there are additional people that are required to do that job…We're a reduced public service already. We have outsourced all the [named sector] people who used to be public servants, and so when there were things like bushfires, they were the people… who we called up. We no longer have access to them. They're just not there.* (Public sector worker)

The effect of outsourcing becomes self-reinforcing as public sector workers lose opportunities to acquire valuable skills and experience. This further entrenches arguments that it is necessary to look beyond government departments because that is where the skills now exist.[198] Even when a government has a capability advantage over the private sector, consultants are often still engaged as they are often seen to provide legitimacy for controversial decisions.[197]

It is important to note that Australian Public Sector (APS) staff must comply with the requirements of a Code of Conduct established through the Public Service Act 1999. However, the same compliance is not required of private consultants.[199] With increasing outsourcing of policy-related roles by government this has implications for policy integrity.

8.3 Intersectoral collaboration essential but not enough

All government sectors have an impact on health, and this has long been recognised through calls for healthy public policy. Much of the work in sectors such as education and housing are in and of themselves good for health. Their health and especially their equity impacts can be enhanced through intersectoral collaboration. It is for this reason that a number of Australian jurisdictions have adopted programs to encourage such co-operation. Examples are the Healthy Cities program focussed on local government[200], Health in All Policies[201] and various other programs and structures designed to break down silos between Departments. In doing this Australia is adopting the type of programs which the World Organization has long advocated for.[202, 203] South Australia provides examples of such programs. South Australia's Strategic Plan (first launched in 2004, final version in 2011) was intended to drive intersectoral collaboration to break down 'silos' and improve work across government agencies and with other stakeholder organisations to address the most intransigent and complex policy problems. There were also administrative reforms such as the introduction of Cabinet impact statements as a required Cabinet submission process to drive intersectoral collaboration. In 2008 the state adopted a Health in All Polices approach which had some successes[204] but didn't focus on health equity.[205] and in 2021 established a government agency Wellbeing SA which was designed to continue this work. Since the 1990s and early 2000s NSW Health Department and its Local Health Networks have had health equity strategies. For example, the Sydney Local Health District produced a framework for improving health equity which speaks of working with a range of agencies to address inequities. Similarly the framework for South-West Sydney[206] speaks of "addressing the determinants of health equity". Tasmania has established the Premier's Health and Wellbeing Advisory Council which aims to provide "advice on cross-sector and collaborative approaches to improving the health and wellbeing of Tasmanians".[207] Queensland has established Health and Wellbeing Queensland [208] which has a focus on achieving health equity. Despite these types of initiatives, we have seen that health inequities have increased in the past three decades. Consequently, we need better understanding of how these initiatives and structures could be more effective.

The call for intersectoral collaboration to address the social determinants of health and improve population outcomes continues to be common, particularly among health promotion advocates. While it is suggested that the public sector operates in silos, one interviewee noted:

> *I think for a long time people in public health thought that if we could only get intersectoral actions happening to improve health outcomes, it would all be good. But the fact of the matter is intersectoral action happens very, very well in Australia, but it just so happens that it's in the interests of a conservative economic agenda and not in the interests of health. I mean, ministers and cabinets and senior bureaucrats know very well how to get coordinated intersectoral action, it's just that health's not the priority, full stop.* (SA health policy expert)

This perspective supports research which shows that action on health equity requires political will to be fully implemented.[209] Evidence on Health in All Policies shows it requires support and leadership from the head of the government to be impactful.

Further cases of how governments at all levels have encouraged sectors to work for health equity are required and this project will compile these.

9. Summary of causes across Australia

This report shows the consequences of challenging global, national, and state factors in Australia for the past four decades. While it has been a period of economic growth, the benefits of that growth have not been evenly spread. The result has been that while life expectancy has been improving for all groups, the rate of improvement has been greater at the upper ends of the health gradient. Unless there are changes to the way that the state and national governments respond with deliberate measures to reduce health inequities, we predict that health inequity is likely to worsen and the small decline of 0.1 year in average Australian life expectancy will deepen, as has been witnessed in the US and parts of the UK.[14]

The issues discussed in this report are complex and demonstrate that many reflect international and national trends and policies are driving increasing health inequities. However, state and federal governments can show leadership to reverse some of the impact of these trends through policies that ensure the state is able to weather the impact of these international and national forces more effectively.

In May 2024 the World Health Organization will publish the annual World Health Report on the Social Determinants of Health Equity and note the drivers of increasing inequities globally. The Lancet University of Oslo's Commission on Global Governance for Health: 'The Political Origins of Health Inequity'[210] asserted that what is required to motivate change is an explicitly political and moral perspective on health and equity. The report states:

> Justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death. We watch in wonder as life expectancy and good health continue to increase in parts of the world and in alarm as they fail to improve in others. (p.30)

The report also quotes the Durham Health Summit: '*Leaders need to be value-based but also evidence-informed*'. This interplay between the two themes of evidence-informed and value-based policies was strongly represented in the interviewees' and workshop participants' views on how to create healthy public policy. We align with the Lancet University of Oslo Commission report in arguing for a moral assertion concerning the importance of justice to improve health inequities.

11. Explanatory notes

Index of Relative Socio-Economic Disadvantage

Rate ratios, or inequality ratios, are calculated by using the Index of Relative Socio-Economic Disadvantage (IRSD), which is based on the ABS Socio-Economic Indexes for Areas (SEIFA). The IRSD is defined in terms of people's access to material and social resources, and their ability to participate in society.[211] SEIFA is one of the most commonly used indicators of socioeconomic status. One limitation of SEIFA is that the relationship between socioeconomic status of an area and socioeconomic status of a household (or individual) within that area is far from perfect. It is acknowledged that there can be high socioeconomic status households living within low socioeconomic status areas, and conversely low socioeconomic households living within high socioeconomic areas.[212] Use of SEIFA-based measures of disadvantage are justified by the influence of area characteristics on status, and the likelihood of availability of services and environmental and economic conditions within an area affecting socioeconomic status of individuals living within that area.

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APPENDIX 1

This Appendix presents social epidemiology analyses for Australia and for each jurisdiction. The social epidemiology analyses provide a detailed assessment of patterns of inequities in Australia. Data sources used for analyses include publicly available data and published reports with a focus on inequities in the past four decades, prior to and during the COVID-19 pandemic.

The analysis builds on our previous work on trends in health inequities. This previous work included a pilot study on why health inequities have increased in South Australia which was conducted in partnership with the South Australian Council of Social Services,[1, 2] a small project examining health inequalities in Australia and the contribution of income, wealth, and employment,[3] and a small study on regional inequalities in health and social determinants of health.[4] These studies provided evidence of increasing inequities in one jurisdiction (South Australia), evidence of increasing inequities in Australia overall, and evidence of increasing inequities in metropolitan and non-metropolitan Australia for a subset of key health indicators and for social determinants of health.

This Appendix is divided into subsections. First, a comprehensive health profile of the nature of health inequities in Australia. The comprehensive health profile is followed by analyses of inequities in key social determinants of health: income, wealth, housing, education, employment, and social exclusion. Each of the sections of the social epidemiology analysis synthesises findings from currently available PHIDU social health atlas data, the team's own analysis, and analysis from publicly available sources such as the AIHW, ABS, published reports and published journal articles, including statistics that are available relevant to the COVID-19 pandemic.

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Contents of Appendix

Detailed Social Epidemiology

Trends in Health Inequities in Australia

This health profile and the analysis and statistics reported within it has been compiled at a time where COVID-19 has not only highlighted inequities within Australia and globally but has also exposed how marginalisation of groups undermined health, with marginalised groups hardest hit by COVID-19. Our previous work provided evidence of increasing health inequities in South Australia, Australia overall, metropolitan Australia and non-metropolitan Australia.[2-4] The Restoring the Fair Go analysis provides a much more comprehensive profile of health in Australia, analysing the nature of health inequities by drawing on a wide range of indicators, published reports, and findings from articles.

PHIDU Social Health Atlas data were a key source for our analysis of health inequities, while the 2022 AIHW Burden of Disease study provided information on leading causes of morbidity and mortality in Australia. This health profile also analysed the nature of health inequities during the COVID-19 pandemic by drawing on findings from recently published reports from the AIHW and ABS.

Data are released with a lag therefore there are limited publicly available data as yet from during the first years of COVID-19, but we report on data from this period where it is available, particularly data published by the ABS. We also acknowledge the limitations of currently available data as described in our paper on the need for improved data on social determinants of health inequities.[5] Australia has good area-based data on health and social determinants, and we have incorporated these data into this social epidemiology analysis.

Other current publicly available data collected on health focuses on illness and disease rather than social determinants, many health data collections do not include socio-economic indicators or only include insufficient information, and differing forms of measurement of variables limits comparability of data over time. Most publicly available data other than that provided by PHIDU can provide national insights, but lack the granularity required to analyse the nature of health and social inequities by state and territories and in different regions.[5]

This health profile draws on PHIDU data for analyses of inequities as the best available data on health indicators by socio-economic status. While these data do not allow for identifying causal relationships, they are very useful for highlighting the distribution of health and social determinants and for studies of geographic areas where sufficient individual data are not available or are limited (e.g. by state and territory).

Median age at death and life expectancy

Measures of overall progress in longevity, particularly life expectancy, are often reported as a key indicator of health and health achievement. While overall longevity has increased over time, this does not take into account socioeconomic inequities in longevity.

Two measures of longevity are discussed in this appendix. The first is median age at death, which is the measure of longevity used by the Public Health Information Development Unit (PHIDU). Median age at death is the age at which 50% of people die before reaching and 50% of people live past. By using the median measure, PHIDU statistics on longevity are not influenced by people who live very long lives (which result in higher average measures).[6]

Figure A1 presents median age at death in Australia by quintile of socio-economic disadvantage produced from PHIDU data. Median age at death rose overall between 2003 to 2007 and 2016 to 2020 for every quintile for males, females, and persons. However, the gap in median age at death between the least disadvantaged quintile and most disadvantaged quintile grew from 3 years to 4 for males, from 2 years to 3

for females, and from 3 years to 4 overall. The growth in this gap represents a trend of increasing inequality in median age at death.

Life expectancy is the measure of longevity used by the Australian Institute of Health and Welfare (AIHW). Life expectancy measures how long on average a person is expected to live based on current age specific death rates and sex specific death rates.[7] Life expectancy at birth is the commonly reported measure, but the AIHW also reports life expectancy at age 65 and Health Adjusted Life Expectancy (HALE) which measures how many years a person is expected to live in good health.

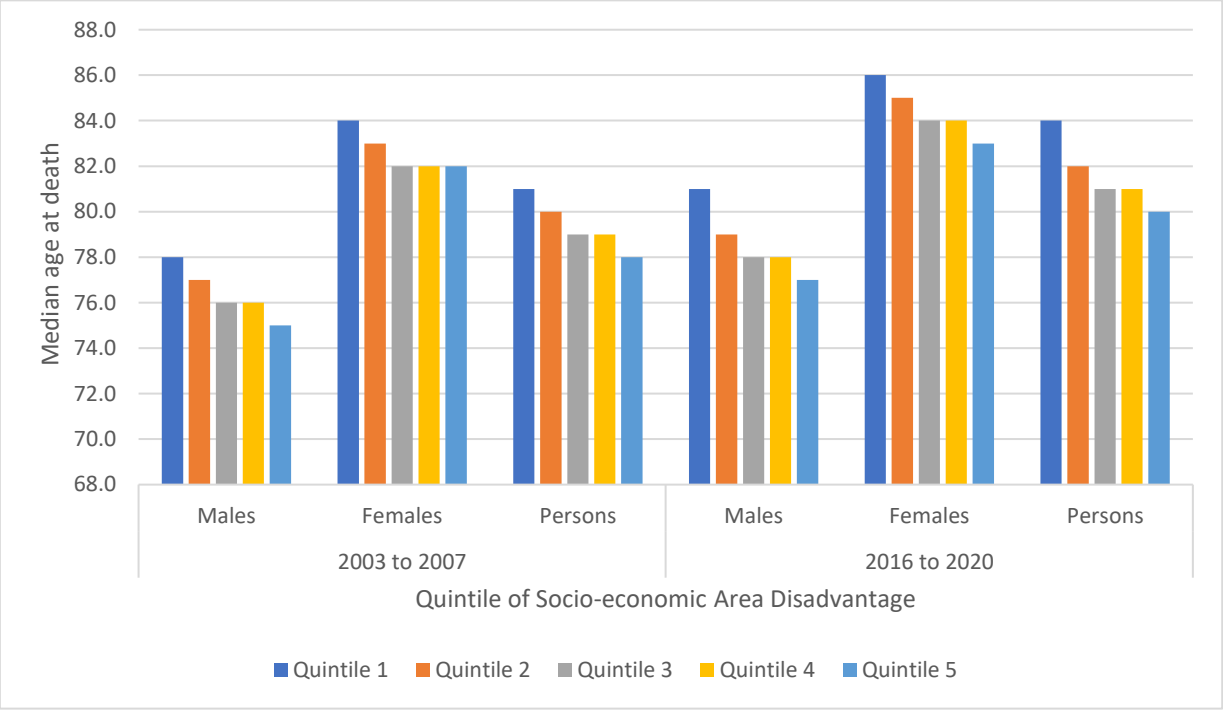


Figure A1: Median age at death of males, females, and persons in Australia, by socioeconomic quintile of disadvantage, 2003 to 2007 and 2016 to 2020 (Data source: Social Health Atlas, PHIDU, 2022)

Overall life expectancy at birth continually improved up to and including the latest available AIHW data for 2019-2021.[7] Average life expectancy at birth for a boy born in 2019-21 was 81.3 years, and for a girl born in 2019-21 was 85.4 years. Men aged 65 in 2019-21 could expect to live another 20.3 years (an expected age of death of 85.3 years) and women aged 65 in 2019-21 could expect to live for another 23 years (an expected age of death of 88 years). There are inequities in life expectancy just as there are with median age at death. For example, Aboriginal and Torres Strait Islander people have lower life expectancy compared to the general population due to historical and ongoing impacts of colonisation. Life expectancy at birth was 71.6 years for males born in 2015-2017, and 75.6 years for females, 8.6 years lower than non-Indigenous males and 7.8 years lower than non-Indigenous females born in 2015-2017.[7, 8]

These inequities are even more stark when examining PHIDU data on median age at death by socioeconomic status for Aboriginal and Torres Strait Islander people compared with non-Indigenous people (see **Figure A2**). The gap in median age at death between the least disadvantaged and most disadvantaged quintile for Aboriginal and Torres Strait Islander people was 4 years in 2016 to 2020, the same as the gap for non-Indigenous people. However, median age at death for the least disadvantaged quintile was 62 years, a gap of 22 years compared with the non-Indigenous median age at death of 84 years. Median age at death for the most disadvantaged quintile was 58 years, again 22 years below the median age of 80 years for non-Indigenous people living in the most disadvantaged areas.

Australia has one of the highest overall life expectancies in the world, but this headline measure overall masks differences in longevity by socio-economic status, and for groups such as Aboriginal and Torres Strait Islander people. Life expectancy changes over time due to changes in the pattern and burden of disease. In 1891-1900, life expectancy at birth was 51.1 years for males and 54.8 years for females.[7] In the early 20th century, 15% of all deaths in Australia were from infectious diseases and the average age of death from infectious diseases was 27. In 2021, less than 2% of deaths were from infectious diseases and average age of death from these diseases was 80.[7]

Life expectancy is expected to have fallen in Australia in 2020-2022 due to the impact of COVID-19.[9]

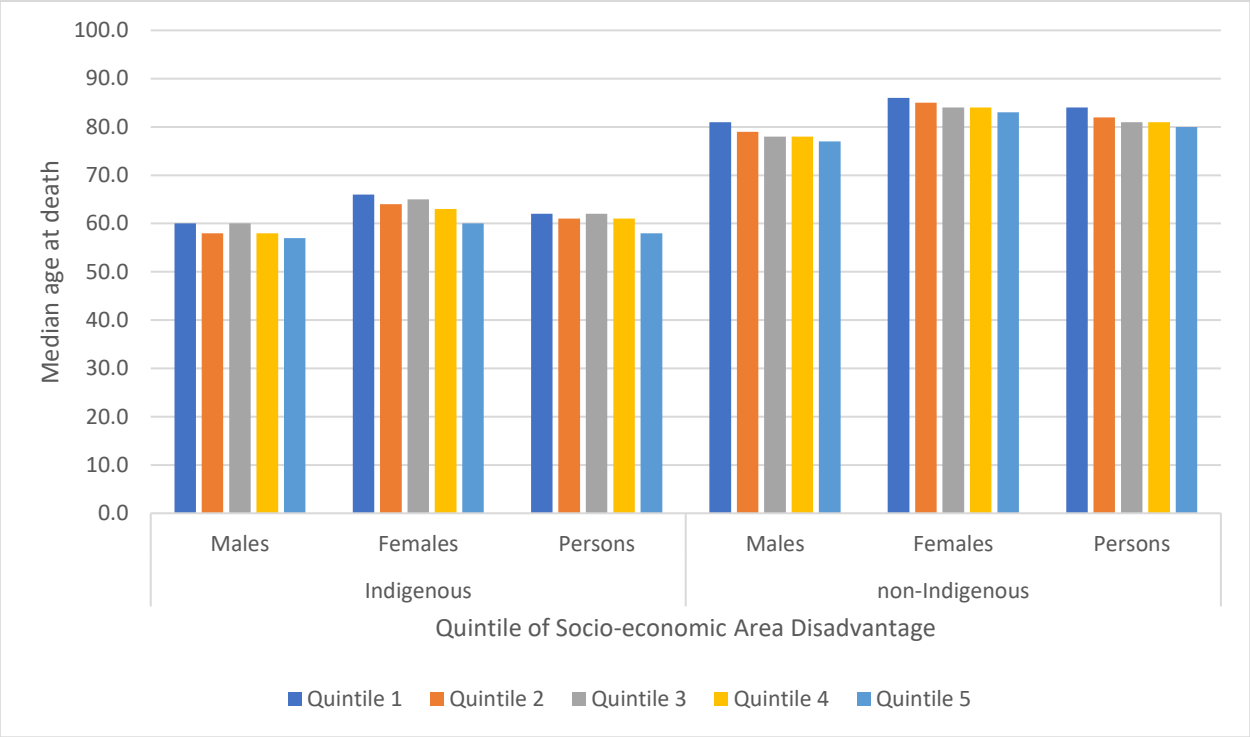


Figure A2: Median age at death at death of Indigenous and non-Indigenous males, females, and persons in Australia, by socioeconomic quintile of disadvantage, 2016 to 2020 (Data source: Social Health Atlas, PHIDU, 2022)

Mortality from COVID-19

The AIHW expected a "small decline" in life expectancy for 2020-2022 compared with 2019-2021, basing this on the age profile of COVID-19 mortality.[9] New ABS estimates of life expectancy found that life expectancy did decrease in 2020-2022 by 0.1 years for both men and women, the first decrease in life expectancy since the mid-1990s.[10] Age-specific death rates from COVID-19 are by far the highest among people aged 75 and over but emphasising the advanced age of most deaths from COVID-19 masks inequities within the mortality statistics.

Table A2 presents ABS statistics on age-specific COVID-19 death rates per 100,000 for Aboriginal and Torres Strait Islander people compared with non-Indigenous people for deaths up to end of February 2023. The death rates are lowest for those aged 0 to 44 and increase with age, but Aboriginal and Torres Strait Islander people have higher COVID-19 death rates for every age bracket compared with non-Indigenous people. The rate ratios are highest overall for 45-54 year olds with Aboriginal and Torres Strait Islander people having an overall death rate that is 4.6 times higher than non-Indigenous people.

Table A2: Age-specific death rates per 100,000 people for Aboriginal and Torres Strait Islander people

Age at death	Aboriginal and Torres Strait Islander people			Non-Indigenous people			Rate ratios		
	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons
0-44	2.8	1.8	2.3	1.1	0.7	0.9	2.6	2.5	2.6
45-54	27.9	25.1	26.4	6.7	4.7	5.7	4.1	5.3	4.6
55-64	67.6	53.6	60.2	18.0	9.4	13.6	3.7	5.7	4.4
65-74	101.5	96.0	98.5	68.6	35.3	51.5	1.5	2.7	1.9
75+	526.0	657.3	601.4	485.5	347.5	409.7	1.1	1.9	1.5

Source: Australian Bureau of Statistics
Note: this includes deaths from COVID and deaths with COVID registered by 28 February 2023

There are also inequities in COVID-19 mortality by socioeconomic status. Table 1 presents ABS data on percentage of COVID-19 deaths by quintile of Index of Relative Socio-economic Disadvantage. There is a strong social gradient in COVID-19 mortality, the percentage of COVID-19 deaths rises with increasing disadvantage. The percentage of COVID-19 deaths was 2.6 times higher for most disadvantaged males compared with least disadvantaged, and 3.3 times higher for most disadvantaged females compared with least disadvantaged.

Socioeconomic patterns are also not specific to a certain age group. People in the most disadvantaged quintile had a higher likelihood of dying from COVID-19 in each age group.[11]

Table A3: SEIFA (IRSD) quintile of those who died from COVID-19

SEIFA Quintile	Male deaths	% COVID-19 deaths	Female deaths	% COVID-19 deaths
1 (most disadvantaged)	2,277	31.3	1,899	32.3
2	1.614	22.2	1,394	23.7
3	1,323	18.2	1,127	19.1
4	1,122	15.4	833	14.1
5 (least disadvantaged)	871	12.0	583	9.9
Total	7,207	99.1%	5,836	99.1%

Source: Australian Bureau of Statistics
Note: Index of Relative Social Disadvantage quintile of those who died from COVID-19, deaths registered to 28 February 2023. Only includes deaths from COVID-19 (not deaths with COVID-19). Does not total to 100% because not all deaths can be assigned to a SEIFA score.

The AIHW also collected data on COVID-19 mortality by socioeconomic status during the first year of COVID-19 (a shorter time frame than recent ABS statistics) and found that there were almost four times as many deaths from COVID-19 for those living in the lowest socioeconomic area compared with the highest socioeconomic area, and age-standardised mortality rates were 2.6 times higher for those living in the lowest socioeconomic group.[12]

Inequities in COVID-19 mortality are also evident by country of birth.

Table A4 presents ABS data on COVID-19 mortality for people born in Australia and for people born overseas by region of birth as of end of February 2023. Australian residents born overseas had a higher age-standardised death rate than people born in Australia (16.4 per 100,000 persons compared with 11.2 per 100,000 persons). Death rates varies widely by region of birth. People born in the Middle East had the highest age-standardised death rate, and those born in Sub-Saharan Africa had the lowest. In Europe, people born in North-West Europe had the lowest age-standardised death rate, and there was wide

variation within Southern and Eastern Europe that is masked by the average for this region. People born in Southern and Eastern Europe had age-standardised death rates of 19.2 and 21.6 respectively, compared with 27.3 for people born in South Eastern Europe.[13]

Table A4: Country of birth of those who have died from COVID-19

Country of birth	Number of deaths	Age-standardised death rate
Australia	6.879	11.2
Oceania and Antarctica	439	17.2
North-West Europe	1,573	10.6
Southern and Eastern Europe	2,416	23.3
North Africa and the Middle East	611	33.7
North Africa	104	22.2
Middle East	507	38.1
South-East Asia	395	13.8
North-East Asia	288	13.2
Southern and Central Asia	231	13.2
Americas	153	13.5
Sub-Saharan Africa	110	9.4
Overseas born (overall)	6,216	16.4

Source: Australian Bureau of Statistics

Note: Age-standardised death rate is per 100,000 people. Includes COVID-19 deaths that occurred and were registered by 28 February 2023. Includes deaths from COVID and deaths with COVID registered by 28 February 2023

Premature mortality and avoidable mortality

Premature mortality is classified as deaths from 0 to 74 years of age. **Figure** presents the average annual age-standardised rate of premature mortality per 100,000 people by quintile of socio-economic disadvantage obtained from PHIDU for 1987-1991 and 2016-2020. These data do not yet capture the impact of COVID-19 on premature mortality in Australia, however they do reveal that prior to COVID-19 premature mortality was decreasing in all quintiles of socio-economic disadvantage but inequality in premature mortality was worsening. The social gradient in premature mortality evident in the data for 1987-1991 is even steeper in 2016-2020.

The rate ratio for premature mortality in 2016-2020 was 2.03 compared with 1.98 in 2013-2017, 1.60 in 2003-2007, and 1.55 in 1987-1991.[3, 14] Age standardised rates of premature mortality in the most disadvantaged areas of Australia are now more than double that in the least disadvantaged areas. Given this trend, it is not surprising that inequality in median age at death is increasing. Age-standardised rates of premature mortality are higher for males than females, and inequality in premature mortality was higher for males than females in both periods.

Table A5 presents the proportional reduction in the age-standardised rate of premature mortality by quintile of socio-economic disadvantage. There is a social gradient in the proportional reduction in premature mortality by disadvantage as well which explains the trend of worsening inequality. The areas represented by the most disadvantaged quintile experienced the lowest proportional reduction in premature mortality, however, it was not just the most disadvantaged quintile that had lower proportional improvement. The second quintile had lower proportional reduction in premature mortality than the first, and the third quintile had a lower reduction than the second, and so on, reinforcing and steepening the social gradient in premature mortality.

The statistics on COVID-19 mortality revealed high death rates for people aged over 75, and deaths for this age group will not be counted in premature mortality statistics when data are available for the time period when COVID-19 mortality increased in Australia. COVID-19 mortality amongst people aged under 75 *will* reveal impacts on premature mortality and given the clear social gradient in COVID-19 mortality and unequal impacts on groups such as people born overseas and Aboriginal and Torres Strait Islander people the current trend of increasing inequality in premature mortality is likely to be revealed to be much worse in future data that includes higher COVID-19 mortality.

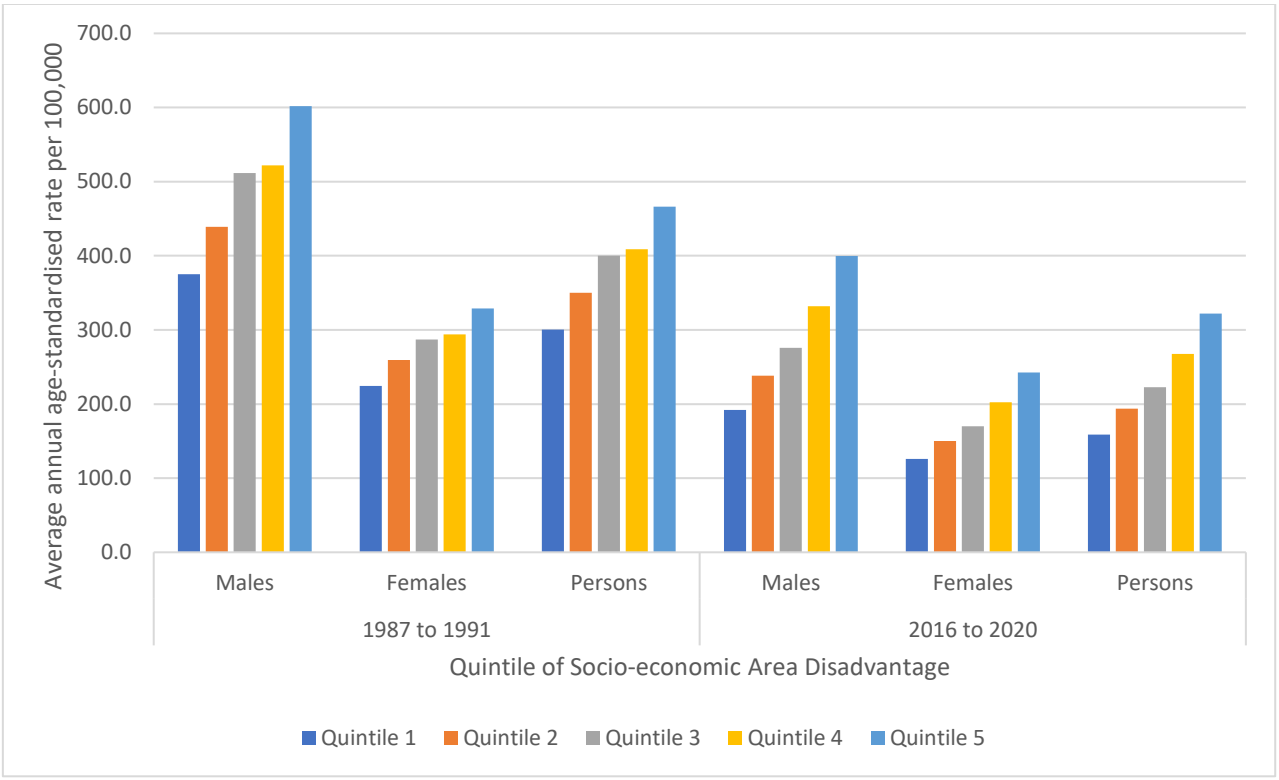


Figure A3: Average Annual Age-Standardised Rates of Premature Mortality per 100,000 in Australia, ages 0 to 74, by quintile of socioeconomic disadvantage, 1987-1991, and 2016 to 2020 (Data source: Social Health Atlas, PHIDU, 2022)

Table A5: Table of proportional reduction in age-standardised rates of premature mortality per 100,000 by quintile between 1987 to 1991 and 2016 to 2020

	Males	Females	Persons
Quintile 1	48.8%	78.4%	47.1%
Quintile 2	45.7%	72.8%	44.6%
Quintile 3	46.0%	69.0%	44.3%
Quintile 4	36.5%	45.2%	34.6%
Quintile 5	33.6%	35.6%	31.0%

Author's own calculations based on PHIDU data

PHIDU data on premature mortality by quintile of socio-economic disadvantage for Aboriginal and Torres Strait Islander people compared with non-Indigenous people shows inequities that provide some context for the gap in median age at death (see **Figure A4**). Rates of annual age-standardised premature mortality per 100,000 people for Aboriginal and Torres Strait Islander people in the least disadvantaged quintile are 1.4 times that of non-Indigenous people, and for the most disadvantaged quintile are 1.5 times that of non-

Indigenous people. There is a social gradient in premature mortality for Aboriginal and Torres Strait Islander people as with for non-Indigenous people. The rate ratio for premature mortality is also higher for Aboriginal and Torres Strait Islander people, with the most disadvantaged having a rate of premature mortality that is 2.17 times that of the least disadvantaged (compared with 2.03 for non-Indigenous people). Higher rates of premature mortality contribute to a lower median age at death (discussed further in the burden of disease section).

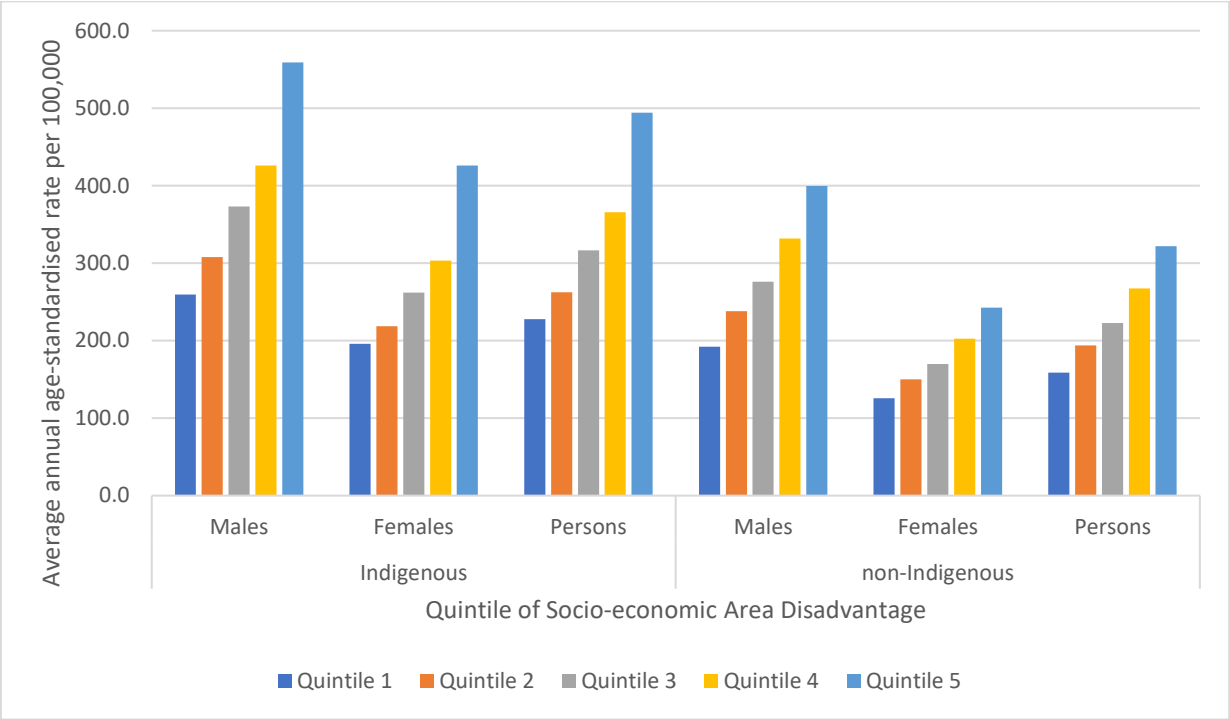


Figure A4: Average Annual Age-Standardised rates of Premature Mortality per 100,000 for Indigenous and non-Indigenous males, females, and persons in Australia, by socioeconomic quintile of disadvantage, 2016 to 2020 (Data source: Social Health Atlas, PHIDU, 2022)

PHIDU data on avoidable mortality (deaths for people aged 0 to 74 years from avoidable causes) also show a trend of increasing inequality. **Figure A5** presents the average annual age-standardised rate of avoidable mortality per 100,000 people for 1997 to 2000 and 2016 to 2020. Overall, avoidable mortality declined between 1997 to 2000 and 2016 to 2020 but as with premature mortality inequality in avoidable mortality was also increasing prior to COVID-19. The visual in the figure for males, females and persons and for both periods shows a clear social gradient in avoidable mortality. Age-standardised rates of avoidable inequality are higher for males and inequality in avoidable mortality for males is also slightly higher than inequality for females in both periods. The social gradient has steepened. The rate ratio of avoidable mortality in 2016-2020 was 2.20 compared with 2.13 in 2013-2017, 1.69 in 2003-2007 and 1.55 in 1997-2000.[3, 14] The increase in inequality in avoidable mortality is even higher than the increase in inequality for premature mortality.

Table A6 presents the proportional reduction in the age-standardised rate of avoidable mortality by quintile of socio-economic disadvantage. The relationship between proportional reduction in avoidable mortality and quintile of socio-economic disadvantage is the same as that observed in **Table A5** for premature mortality. The highest proportional reductions are for quintile 1 (the least disadvantaged) for males, females, persons. Each quintile then has a lower proportional reduction in avoidable mortality than the less disadvantaged quintile above it in the table, with the least disadvantaged quintile experiencing the lowest proportional reduction in avoidable mortality (only 17.8% overall for the most disadvantaged quintile compared with 42% in the least disadvantaged quintile).

PHIDU data on rates of avoidable mortality for Aboriginal and Torres Strait Islander people show a similar pattern to premature mortality with a clear social gradient for avoidable mortality as well. Rates of avoidable mortality were 1.7 times that of non-Indigenous people in the least disadvantaged quintile and 1.8 times higher for the most disadvantaged quintile (Figure not reported).

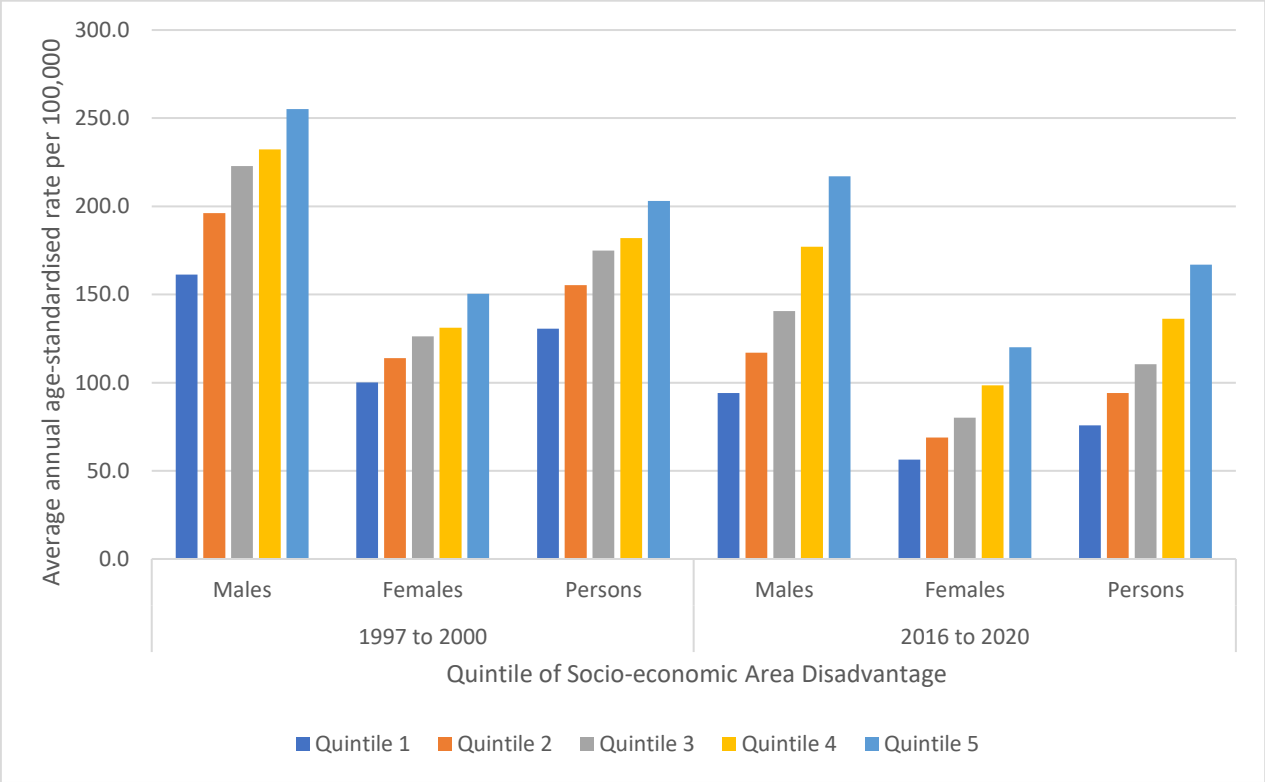


Figure A5: Average Annual Age-Standardised Rates of Death from Avoidable Causes per 100,000 people in Australia, ages 0 to 74, by quintile of socioeconomic disadvantage, 1997-2000, and 2016 to 2020 (Data source: Social Health Atlas, PHIDU, 2022)

Table A6: Table of proportional reduction in age-standardised rates of avoidable mortality per 100,000 by quintile between 1997 to 2000 and 2016 to 2020

	Males	Females	Persons
Quintile 1	41.7%	43.7%	42.0%
Quintile 2	40.4%	39.5%	39.3%
Quintile 3	36.9%	36.5%	36.9%
Quintile 4	23.7%	25.0%	25.1%
Quintile 5	14.9%	20.2%	17.8%

Author's own calculations based on PHIDU data

Avoidable mortality is mortality from avoidable causes for people aged 0 to 74, therefore COVID-19 mortality for people aged over 75 won't be included in future releases of data on avoidable mortality that include years where COVID-19 mortality was higher and likely to impact on avoidable mortality. COVID-19 mortality is avoidable through social distancing, better ventilation, wearing of face masks, and vaccination therefore COVID-19 mortality for people aged 0 to 74 is likely to have a larger impact on avoidable mortality than on premature mortality as age-standardised rates of avoidable mortality are lower than those for premature mortality due to being confined to avoidable mortality. The current trend of increasing inequality

in avoidable mortality is likely to be worsened in future data including COVID-19 mortality given the social gradient in COVID-19 mortality.

Infant Mortality

Infant mortality is measured by PHIDU as deaths that occurred before 12 months of age. **Figure A6** presents the average annual infant mortality rate per 1,000 live births for 2003-2007 and 2016-2020. As with premature and avoidable mortality, infant mortality rates have declined between 2003-2007 and 2016-2020. There is a social gradient in infant mortality as well, and the gap between most disadvantaged and least disadvantaged grew between 2003-2007 and 2016-2020. The rate ratio for infant mortality increased from 1.58 to 1.87. The 20% of the population living in the most disadvantaged areas had an infant mortality rate that was almost double that of the least disadvantaged in 2016-2020.

The proportional reduction in infant mortality rates was highest for the least disadvantaged between 2003-2007 and 2016-2020 but the trend in reduction in infant mortality did not follow the same clear trend by disadvantage as that observed for premature mortality and avoidable mortality (see **Table A7**). The fourth quintile experienced the second largest proportional reduction in infant mortality and the most disadvantaged had a slightly higher proportional reduction in infant mortality compared with the second quintile. This has reduced the differences between infant mortality rates for the second, third, and fourth quintiles in 2016-2020 which can be seen in **Figure A6**.

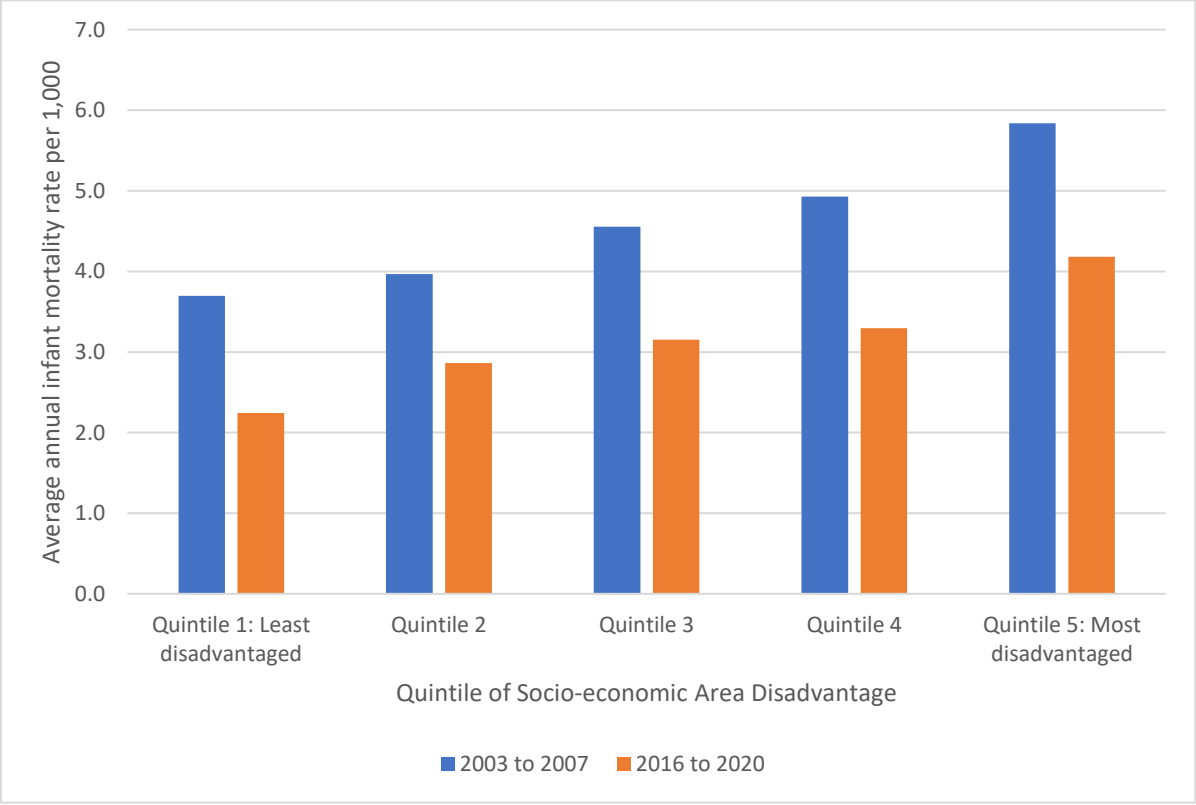


Figure A6: Average Annual Infant Mortality Rate per 1,000 Live Births in Australia, by quintile of socioeconomic disadvantage, 2003-2007 and 2016-2020 (Data source: Social Health Atlas, PHIDU, 2022)

COVID-19 mortality rates among infants are very low. The age-specific mortality rate for people aged 0 to 19 was 0.1 per 100,000 for COVID-19 deaths registered until the 28th of February 2023 therefore there will only be a low impact on infant mortality rates in future releases of data where COVID-19 mortality was higher in Australia.

Table A7: Table of proportional reduction in infant mortality rates per 1,000 live births by quintile between 2003 to 2007 and 2016 to 2020

Quintile 1	39.4%
Quintile 2	27.8%
Quintile 3	30.8%
Quintile 4	33.1%
Quintile 5	28.4%

Author's own calculations based on PHIDU data

Self-assessed Health

Self-assessed health has been found to be a strong predictor of morbidity and mortality.[15-18] **Figure A7** presents age-standardised rates of people reporting fair or poor self-assessed health in 2007-08 and 2017-18 by quintile of socio-economic area disadvantage. The social gradient that was observed for premature mortality and avoidable mortality is also evident for rates of self-assessed health by socioeconomic disadvantage in 2007-08 and 2017-18, with higher rates as disadvantage increases. There is a large gap between the age-standardised rate of poor or fair self-assessed health in the least disadvantaged areas (around 10%) compared with the most disadvantaged (more than 22%). These data do not capture the longer term trend but there was little change in the age-standardised-rates of fair or poor self-assessed health for each quintile between 2007-08 and 2017-18.

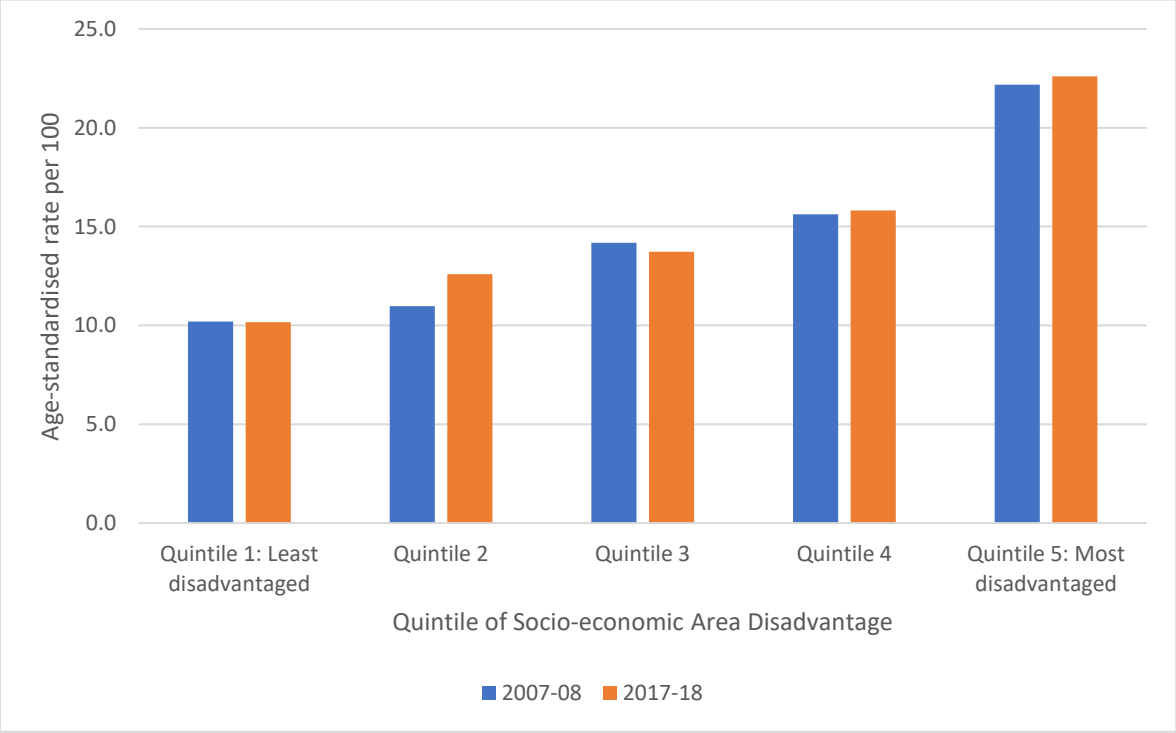


Figure A7: Age-Standardised Rates per 100 of fair or poor self-assessed health in Australia, people aged 15 years and over, by socioeconomic quintile of disadvantage 2007-08 and 2017-18 (Data source: Social Health Atlas, PHIDU, 2022)

Burden of Disease

The AIHW's 2022 Burden of Disease Study reported that Australians experienced more burden from living with illness (52% of total burden) than from premature mortality (48% of total burden). There was an 11% decline in the age-standardised rate of total burden between 2003 and 2022, driven by a 23% decrease in

the rate of fatal burden of disease. Non-fatal burden of disease rates rose slightly over this period. Rates of total, fatal, and non-fatal disease burden were higher in 2022 than in 2018, with diseases emerging since 2018 accounting for this increase (i.e. COVID-19).[9]

The 5 disease groups that caused the most burden were cancer (17%), musculoskeletal conditions (13%), cardiovascular diseases (12%), mental health conditions and substance use disorders (12%) and neurological conditions (8%). The leading 5 individual diseases causing burden in 2022 were coronary heart disease (5.5%), dementia (4.4%), back pain (4.2%), chronic obstructive pulmonary disease (3.7%), and anxiety disorders (2.9%). The total burden from COVID-19 ranked 8th among specific diseases in 2022, with the burden predominantly fatal (73%) and higher in males. COVID-19 was the 5th leading cause of fatal burden of disease in 2022.[9]

The AIHW's Burden of Disease study does not report on differences in morbidity or mortality by socioeconomic status. PHIDU includes estimates of age-standardised rates of chronic conditions by quintile of socio-economic disadvantage and age-standardised rates of premature and avoidable mortality for some of the leading disease groups and leading individual diseases that caused the most burden in 2022. PHIDU data use the National Health Survey for 2017-18 for the most recent estimates of morbidity from chronic conditions which provide information on the socio-economic pattern of these conditions for a time point preceding the most recent AIHW burden of Disease Study.

Figure A8 presents the age-standardised rate of musculoskeletal system diseases per 100 among people aged 15 and over by quintile of socio-economic area disadvantage for 2007-08 to 2017-18. Estimated rates of musculoskeletal system diseases were lower in 2017-18 for quintile 1 (least disadvantaged) and for quintile 3 than in 2007-08 but were little changed for quintile 4 and increased for quintile 2 and quintile 5 (most disadvantaged). In 2017-18, the rate of musculoskeletal system diseases for the most disadvantaged quintile was 1.34 times that of the least disadvantaged quintile. Rates of musculoskeletal diseases range from almost a quarter to almost a third, indicating a high prevalence of morbidity.

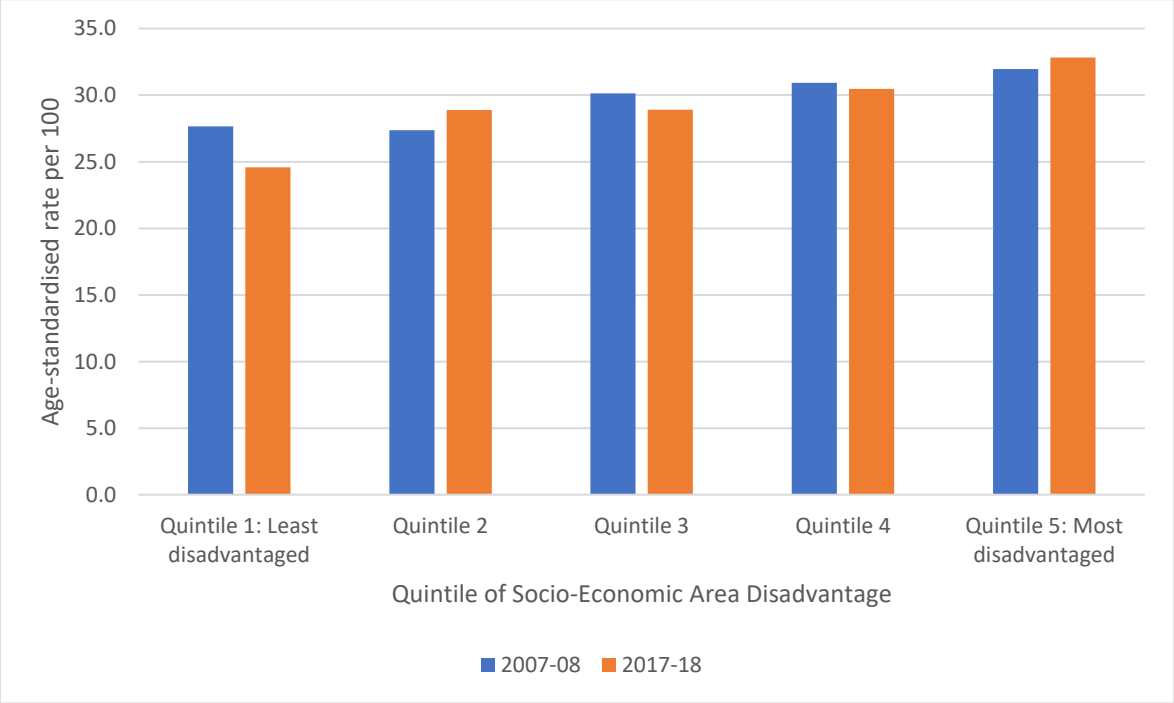


Figure A8: Estimated Age-Standardised Rate per 100 in Australia, aged 15 years and over, with musculoskeletal system diseases, by socioeconomic quintile of disadvantage 2007-08 and 2017-18 (Data source: Social Health Atlas, PHIDU, 2022)

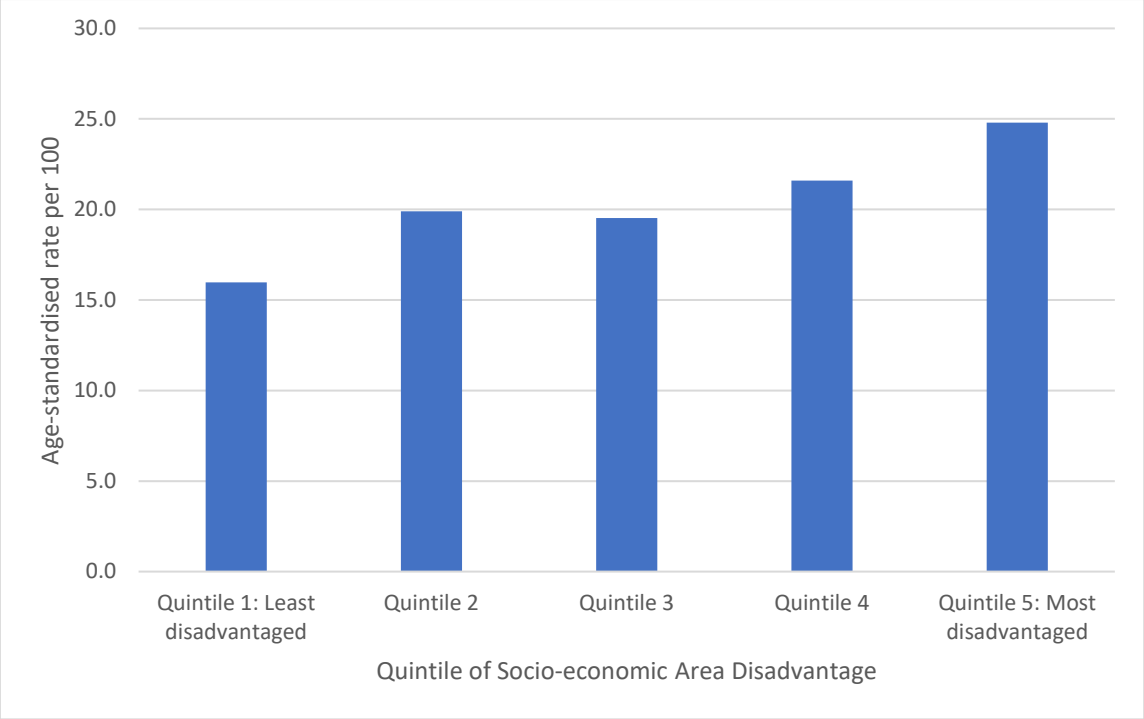


Figure A9: Estimated Age-Standardised Rate per 100 in Australia, aged 15 years and over, with mental and behavioural problems, by socioeconomic quintile of disadvantage 2017-18 (Data source: Social Health Atlas, PHIDU, 2022)

The estimated prevalence of mental and behavioural problems differs more clearly by quintile of socio-economic area disadvantage (see **Figure A9**). PHIDU estimates for mental and behavioural problems was available for 2014-15 and 2017-18, too short a time period to determine trends, therefore **Figure A9** only presents data from 2017-18. Estimated prevalence of mental and behavioural problems ranged from 16% for the least disadvantaged to almost a quarter for the most disadvantaged. The rate of mental and behavioural problems for the most disadvantaged quintile was 1.55 times that of the least disadvantaged quintile.

Figure A10 presents estimates of the prevalence of chronic obstructive pulmonary disease (COPD) by socio-economic quintile of area disadvantage for 2007-08 and 2017-18. Estimated rates of COPD for the most disadvantaged rose from 2.4% in 2007-08 to 3.6% in 2017-18, a higher increase compared with all other quintiles of area disadvantage. The rate for the most disadvantaged was almost double that of the least disadvantaged in 2017-18. The social gradient in estimated prevalence of COPD corresponds with the social gradient in smoking.

The last of the figures drawn from PHIDU data on prevalence of chronic diseases shows the age-standardised rate of mood (affective) disorders in 2017-18 (see **Figure A11**). Prevalence of mood (affective) disorders for the most disadvantaged were estimated to be more than double that of the least disadvantaged in 2017-18, with a rate ratio of 2.11. Estimated age-standardised rates of mood (affective) disorders ranged from 7.2% for the least disadvantaged to 15.7% for the most disadvantaged.

For the four chronic diseases where PHIDU estimates were available for morbidity there is a higher prevalence for more disadvantaged quintiles, particularly for mental and behavioural problems, COPD, and mood (affective) disorders. While the PHIDU classification of two of these chronic diseases are an imperfect match to the classification of two leading diseases in the AIHW Burden of Disease Study (mental health conditions and substance use disorders and anxiety disorders), data on prevalence of chronic disease by

socio-economic quintile illustrates the inequities masked by the overall figures in the AIHW Burden of Disease Study.

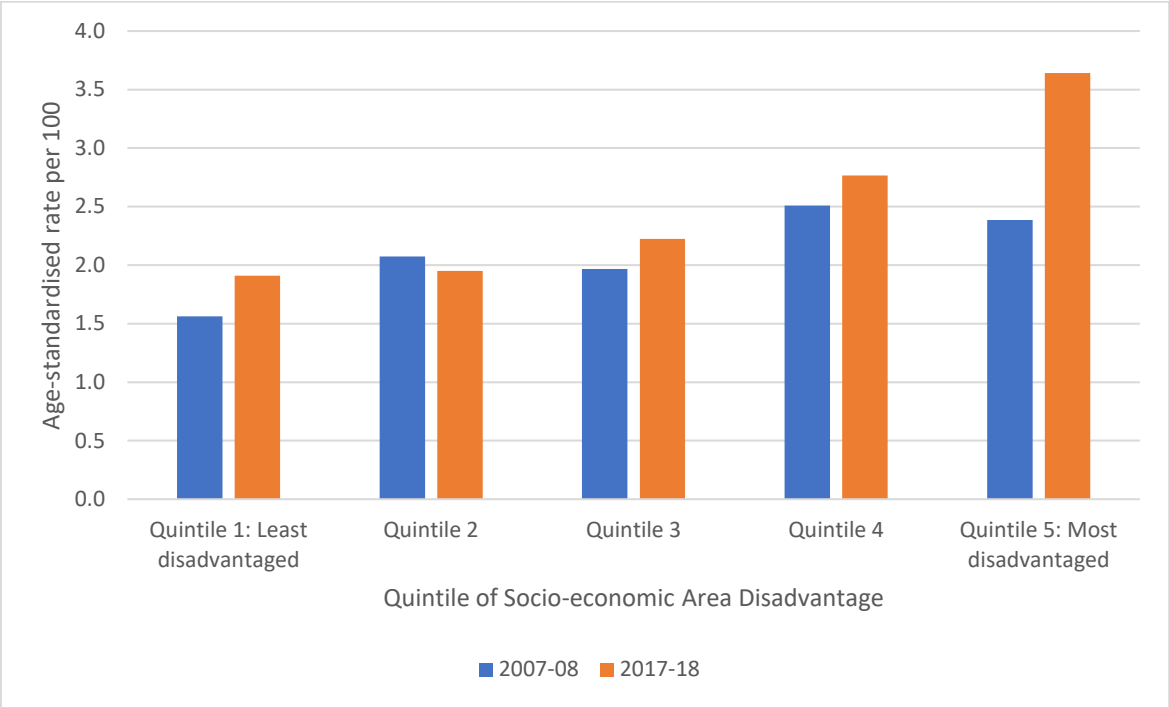


Figure A10: Estimated Age-Standardised Rate per 100 in Australia, aged 15 years and over, with chronic obstructive pulmonary disease, by socioeconomic quintile of disadvantage 2007-08 and 2017-18 (Data source: Social Health Atlas, PHIDU, 2022)

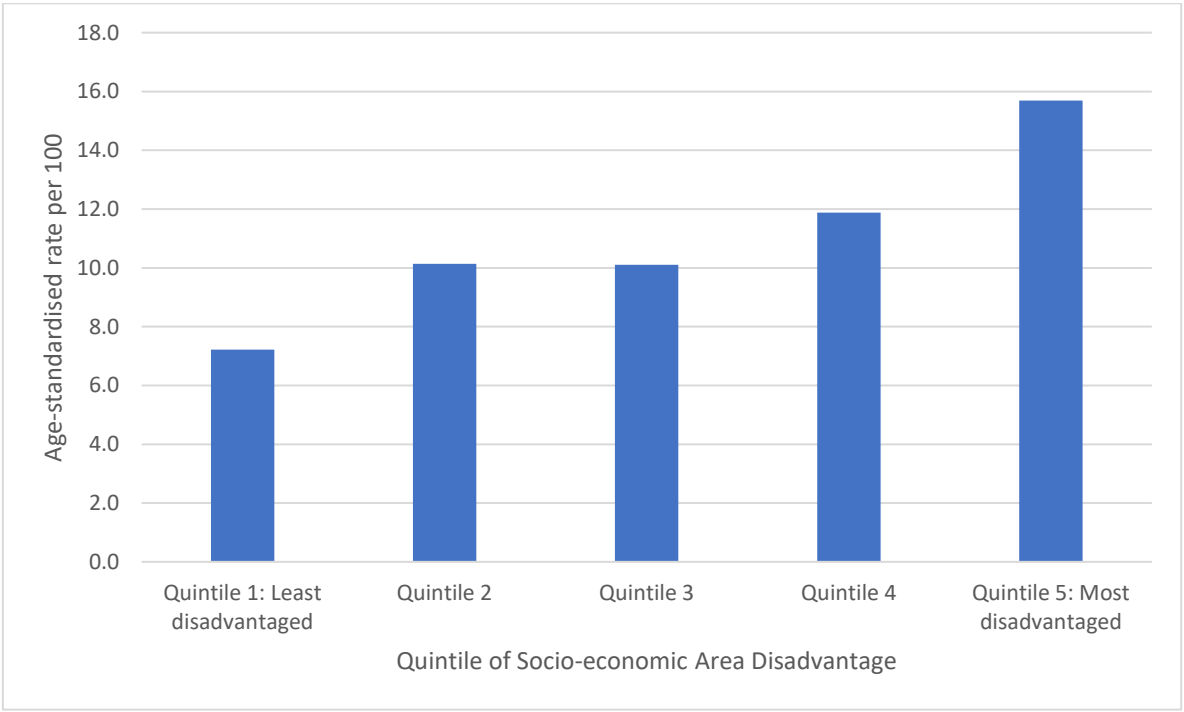


Figure A11: Estimated Age-Standardised Rate per 100 in Australia, aged 15 years and over, with mood (affective) disorders, by socioeconomic quintile of disadvantage 2017-18 (Data source: Social Health Atlas, PHIDU, 2022)

PHIDU data on premature mortality from some of the leading disease groups and individual diseases contributing to burden of disease are available as annual average age-standardised rates per 100,000 for 1987-1991 and 2016-2020. This includes a leading burden of disease grouping and an individual disease not included in the PHIDU estimates of chronic diseases: cancers, and coronary heart disease.

Age-standardised rates of premature mortality from cancer decreased between 1987-1991 and 2016-2020 as advances were made in treatment and early diagnosis (**Figure A12**). There were reductions in rates of premature mortality from cancer for each quintile of area disadvantage, but inequality increased over this period. The rate ratio increased from 1.25 to 1.64 due to much larger proportional reductions in premature mortality in less disadvantaged areas. Rates of premature mortality from cancer fell by 33% for quintile 1, 28% for quintile 2, 25% for quintile 3, 17% for quintile 4 and only 12% for quintile 5. The social gradient steepened as a result of this uneven improvement. The pattern of higher rates of premature mortality by disadvantage was visibly worse for 2016-2020.

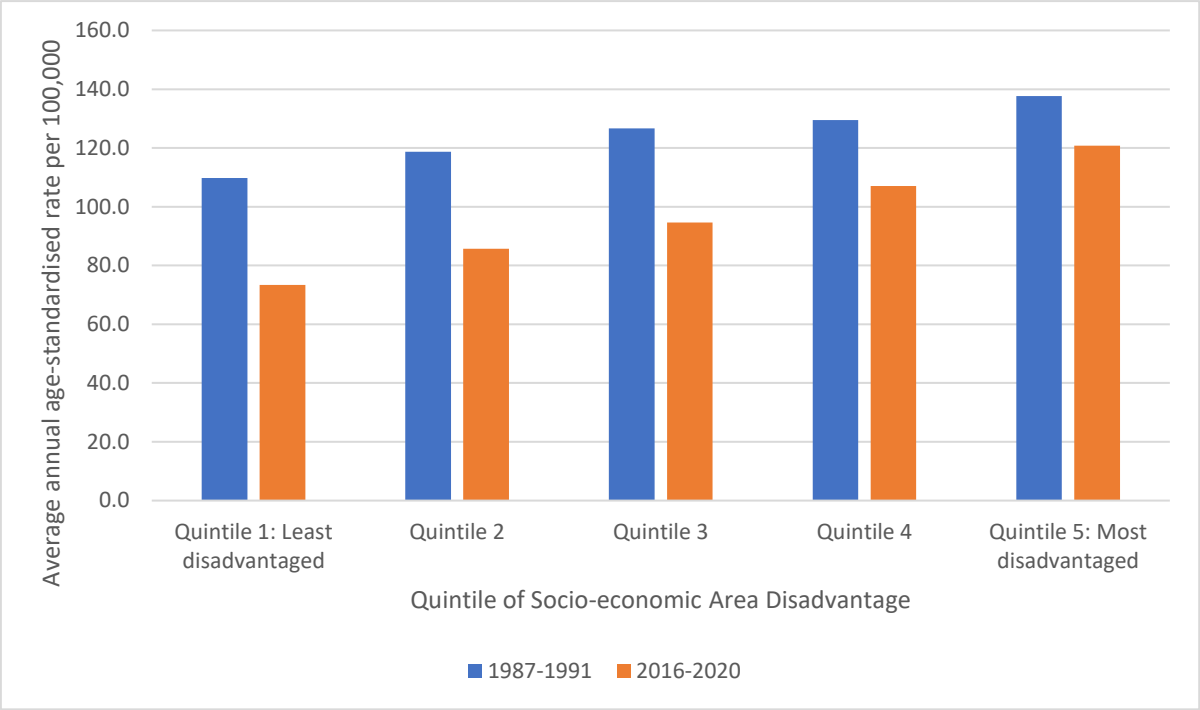


Figure A12: Average Annual Age-Standardised Rates of Premature Mortality from Cancer per 100,000 in Australia, ages 0 to 74, by quintile of socioeconomic disadvantage, 1987-1991, and 2016 to 2020 (Data source: Social Health Atlas, PHIDU, 2022)

There were very large reductions in premature mortality from coronary heart disease between 1987-1991 and 2016-2020 (**Figure A13**). Proportional reductions in rates of coronary heart disease by quintile of socio-economic disadvantage ranged from 82% for quintile 1 to 70% for quintile 5, reflecting major medical advances in diagnoses and treatment. However, inequality in rates of premature mortality from coronary heart disease still increased over this period. The reductions in premature mortality were larger for less disadvantaged and the rate ratio increased from 1.62 to 2.62 reflecting a much larger gap between the most disadvantaged and least disadvantaged.[14]

Rates of suicide and self-inflicted injuries are presented in **Figure A14** to represent rates of premature mortality from mental health problems. There is a clearer social gradient in rates of premature mortality from suicide and self-inflicted injuries in 2016-2020, and the rate ratio did rise between 1987-1991 and 2016-2020 from 1.52 to 1.82.[14] Rates did decrease over this period for all except quintile 4, but reductions followed the same trend as for other diseases discussed in this health profile with larger reductions for the

less disadvantaged. Rates of suicide and self-inflicted injuries decreased by 17% for quintile 1, 22% for quintile 2, and 15% for quintile 3, but were little changed for quintile 5 and rose by 2% for quintile 4.

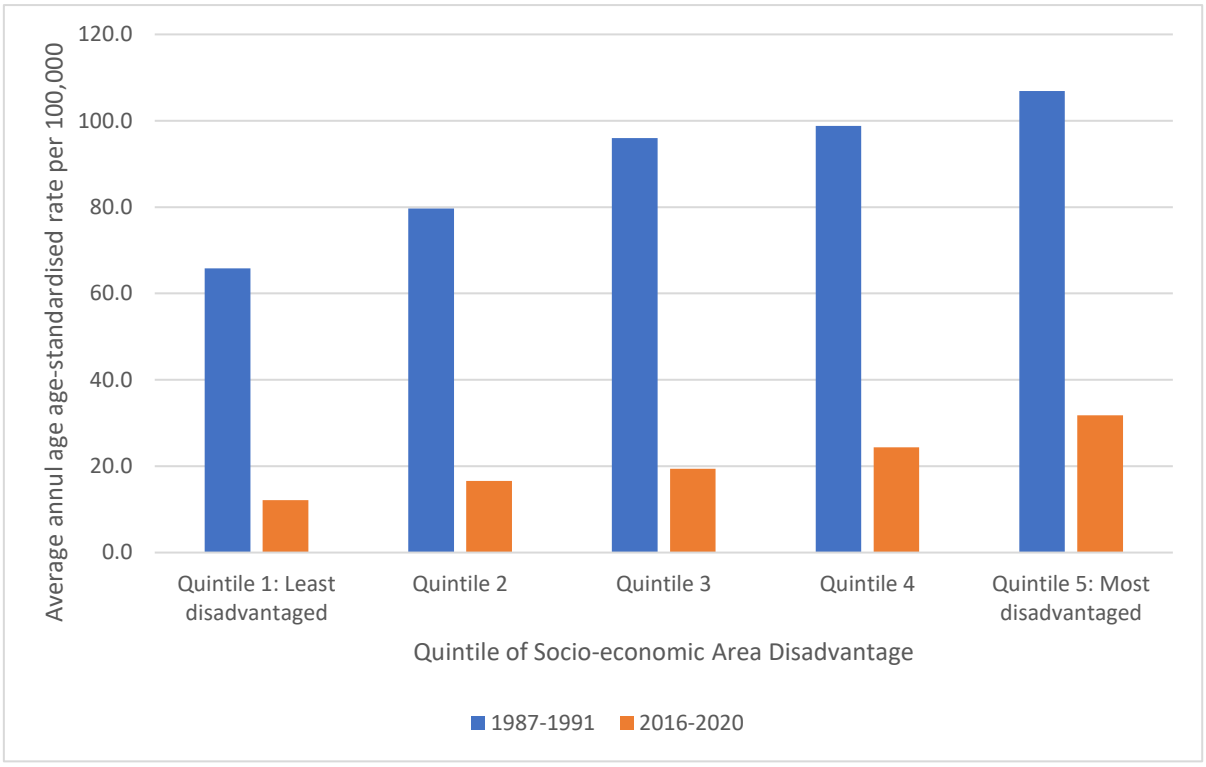


Figure A13: Average Annual Age-Standardised Rates of Premature Mortality from Coronary Heart Disease per 100,000 in Australia, ages 0 to 74, by quintile of socioeconomic disadvantage, 1987-1991, and 2016 to 2020 (Data source: Social Health Atlas, PHIDU, 2022)

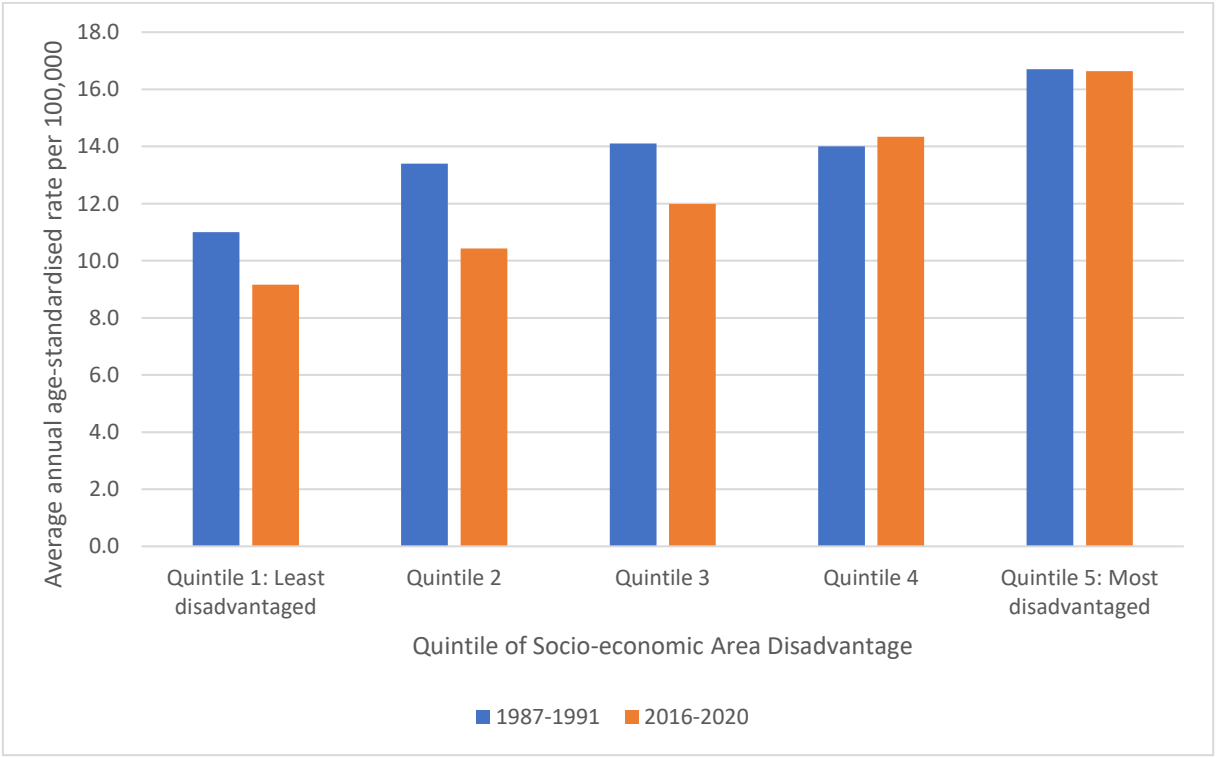


Figure A14: Average Annual Age-Standardised Rates of Premature Mortality from Suicide and Self-inflicted Injuries per 100,000 in Australia, ages 0 to 74, by quintile of socioeconomic disadvantage, 1987-1991, and 2016 to 2020 (Data source: Social Health Atlas, PHIDU, 2022)

Average annual age-standardised rates of premature mortality from COPD show an even steeper social gradient than that observed for morbidity from COPD. **Figure A15** presents PHIDU data on premature mortality from COPD. Reductions in rates of premature mortality from COPD between 1987-1991 and 2016-2020 ranged from 63% for quintile 1 to only 18% for quintile 5, and the rate ratio increased from 1.96 in 1987-1991 to 4.36 in 2016-2020. Rates of premature mortality from COPD for the most disadvantaged were more than 4 times that of the least disadvantaged. The social gradient in premature mortality from COPD steepened, corresponding with differences in smoking rates by socio-economic status.

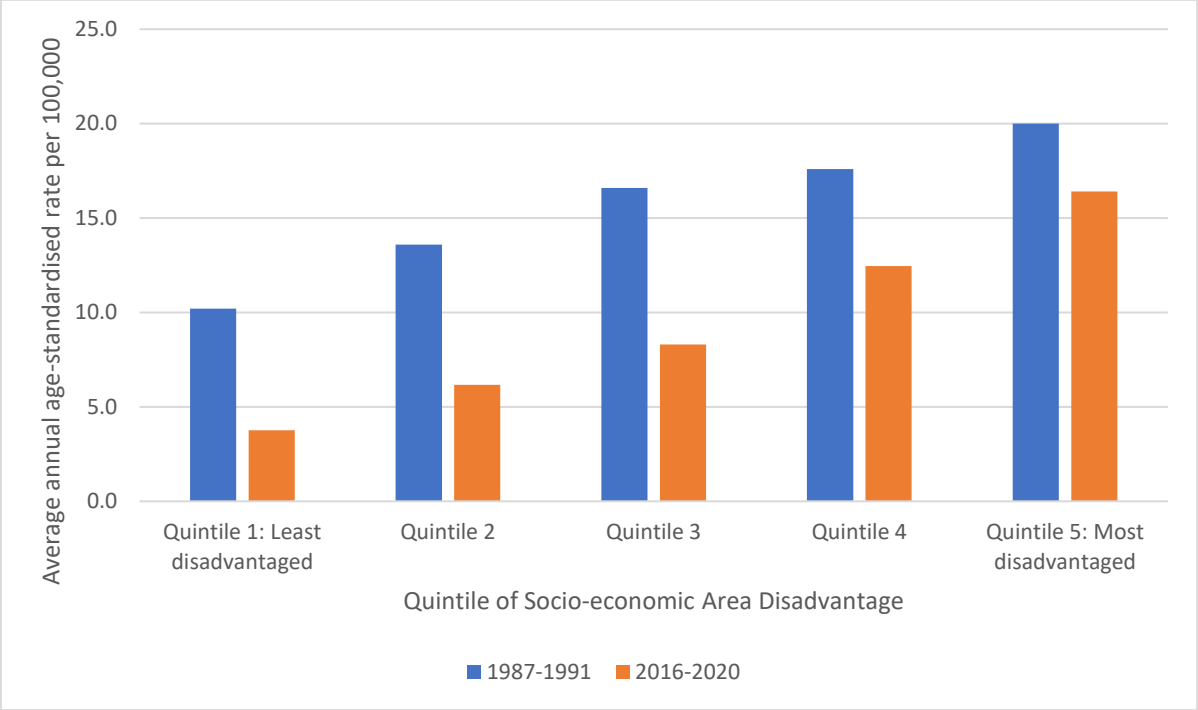


Figure A15: Average Annual Age-Standardised Rates of Premature Mortality from Chronic Obstructive Pulmonary Disease per 100,000 in Australia, ages 0 to 74, by quintile of socioeconomic disadvantage, 1987-1991, and 2016 to 2020 (Data source: Social Health Atlas, PHIDU, 2022)

This section has highlighted that there are socioeconomic inequities in rates of leading causes of burden of disease in Australia. The evidence presented has also identified increasing inequality in premature mortality from leading disease groups and individual diseases. Inequality in premature mortality is indicative of inequality in morbidity from these diseases. Some of the diseases discussed are also risk factors for COVID-19 mortality: coronary heart disease, COPD, and cancer.[13] The earlier section on COVID-19 mortality presented evidence of socio-economic inequality in COVID-19 mortality.

The total disease burden from COVID-19 was ranked 8th in 2022 but is likely to climb in future years as more evidence emerges on the extent, nature, and duration of Long COVID. Studies on COVID-19 infection in early stages in Australia have found that infection is associated with socio-economic status[19] and it is likely that prevalence of Long COVID will also be higher among lower socio-economic groups.[20]

Jurisdictional analysis

Jurisdictions: Median age at death

Median age at death within most jurisdictions in Australia followed the same trend as the National figures: median age at death increased between 2003-07 and 2016-2020. Figure A16 presents median age at death for each jurisdiction and for Australia for the least disadvantaged quintile (Q1) and the most disadvantaged quintile (Q5) for both data points. In WA, median age at death decreased slightly over this period. There are some other differences between the jurisdictions. The gap between most disadvantaged and least disadvantaged median age at death was 4 years nationally. The gap is 6 years for South Australia and Tasmania. The ACT does not have a clear social gradient in median age at death, but there is a social gradient in median age at death for all other jurisdictions. The Northern Territory has a much larger gap of 16 years between most disadvantaged and least disadvantaged, increasing from the 11 year gap in 2003-07.

Inequality increased nationally, with the gap between most disadvantaged and least disadvantaged increasing from 3 years in 2003-07 to 4 years in 2016-2020. Inequality in median age at death also increased in all jurisdictions except the ACT, and NSW. In NSW, median age at death for the least disadvantaged increased by 2 years and median age at death for the most disadvantaged quintile also increased by 2 years. In WA, median age at death for quintile 1 fell by 1 year but fell by 2 years for quintile 5. In Queensland and Tasmania, median age at death increased by 2 years and 3 years respectively for the least disadvantaged quintile but did not increase at all for the most disadvantaged quintile. In SA, median age at death for quintile 1 increased by 3 years, but only increased by 1year for quintile 5. In the NT, there was an increase in median age at death of 9 years for the least disadvantaged, but the increase was only 4 years for the most disadvantaged.

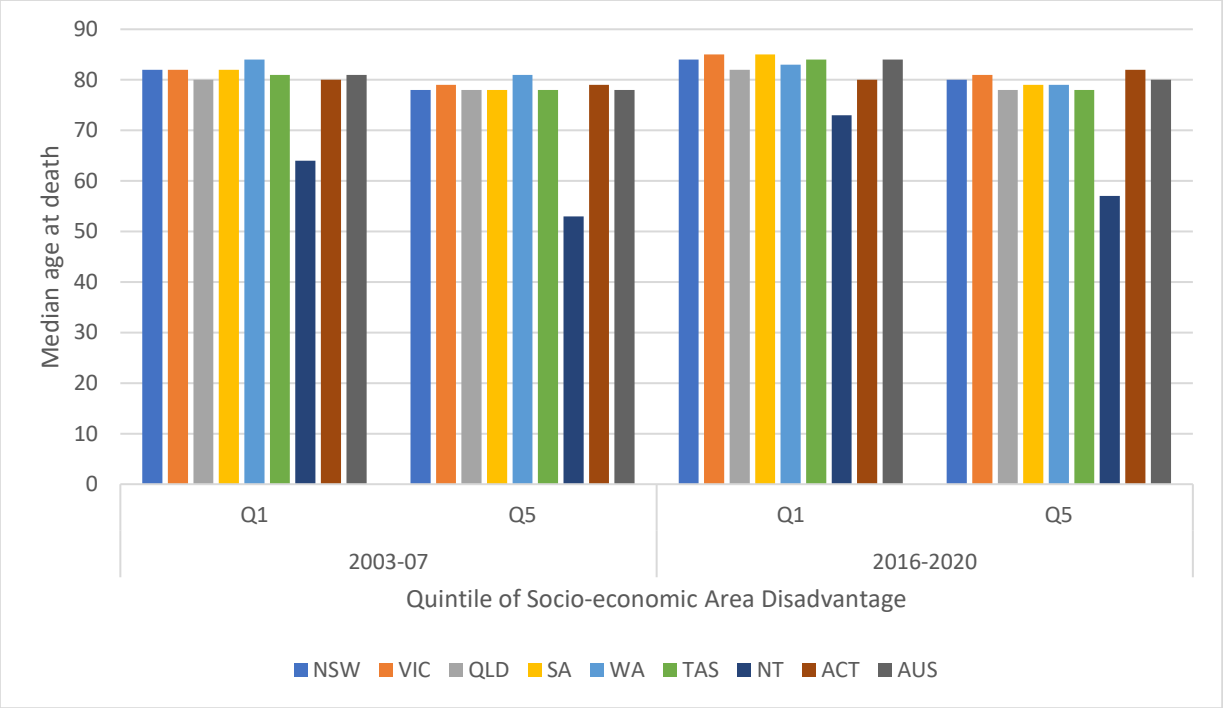


Figure A16: Median age at death at death of persons in each State and Territory in Australia, by quintile 1 (Q1, least disadvantaged) and quintile 5 (Q5, most disadvantaged), 2003 to 2007 and 2016 to 2020 (Data source: Social Health Atlas, PHIDU, 2022)

Jurisdictions: Premature Mortality

Age-standardised rates of premature mortality have decreased in all quintiles of area disadvantage for all jurisdictions between 1987-1991 and 2016-2020. **Figure A17** presents average annual age-standardised rates of premature mortality for each state and territory and for Australia for quintile 1 (least disadvantaged) and quintile 5 (most disadvantaged). The reductions in rates of premature mortality are large over this period, but the proportional change differs by quintile. In five jurisdictions the reduction in rates of premature mortality for quintile 1 was either close to or exceeded 50% (NSW, WA, ACT, Tasmania). In the other jurisdictions the reduction for quintile 1 was 43% in Queensland and SA, and 35% in the NT.

The reduction in rates of premature mortality by quintile followed the same national trend of lower reduction with more disadvantage that was shown in **Table A5** in all jurisdictions except the NT and the ACT. In the NT, the proportional reduction in premature mortality was higher for quintile 5 than for quintile 1, a 46% reduction. The largest reductions by quintile in the NT were for quintiles 2 and 3 (56% and 54% respectively). The reduction for quintile 5 in the ACT was the next highest after the NT, a 41% reduction. Reductions in rates of premature mortality for quintile 5 were around 32% for NSW and Victoria, around 26% for WA and Queensland, 22% for SA, and only 16% for Tasmania.

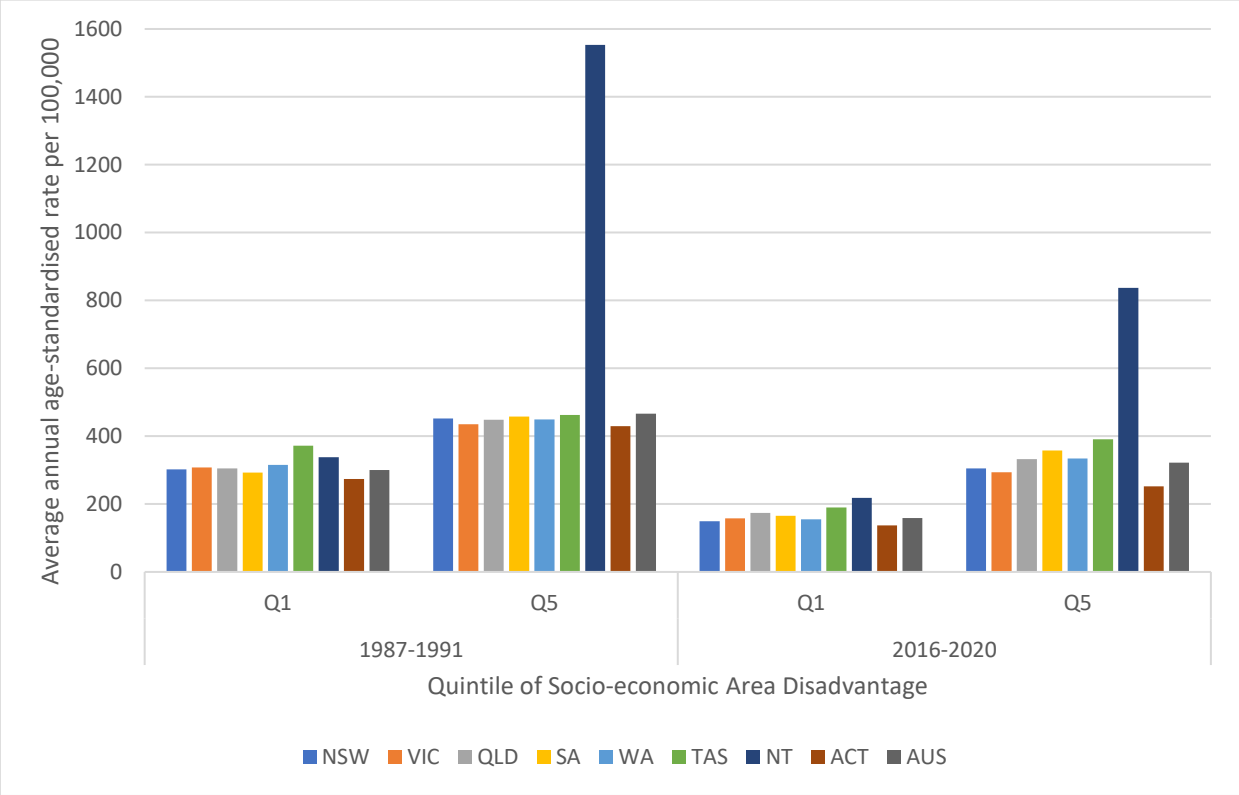


Figure A17: Average Annual Age-Standardised Rates of Premature Mortality per 100,000 in each State and Territory in Australia, by quintile 1 (Q1, least disadvantaged) and quintile 5 (Q5, most disadvantaged), 1987 to 1991 and 2016 to 2020 (Data source: Social Health Atlas, PHIDU, 2022)

Inequality in rates of premature mortality grew in all jurisdictions where the reduction in rates of premature mortality was higher for less disadvantaged than for more disadvantaged quintiles. **Figure A18** presents the rate ratios for rates of premature mortality by jurisdiction and for Australia for 1987-1991 and 2016-2020. Although rates of premature mortality are still much higher in the NT compared with other jurisdictions, and inequality is higher in the NT than other jurisdictions in 2016-2020, the rate ratio decreased for the NT because premature mortality declined more in the quintile representing the most disadvantaged areas than in the least disadvantaged. Inequality in rates of premature mortality declined in the NT. The rate ratio for

rates of premature mortality increased for every other jurisdiction. The largest increases in inequality were in SA and Tasmania, followed by WA.

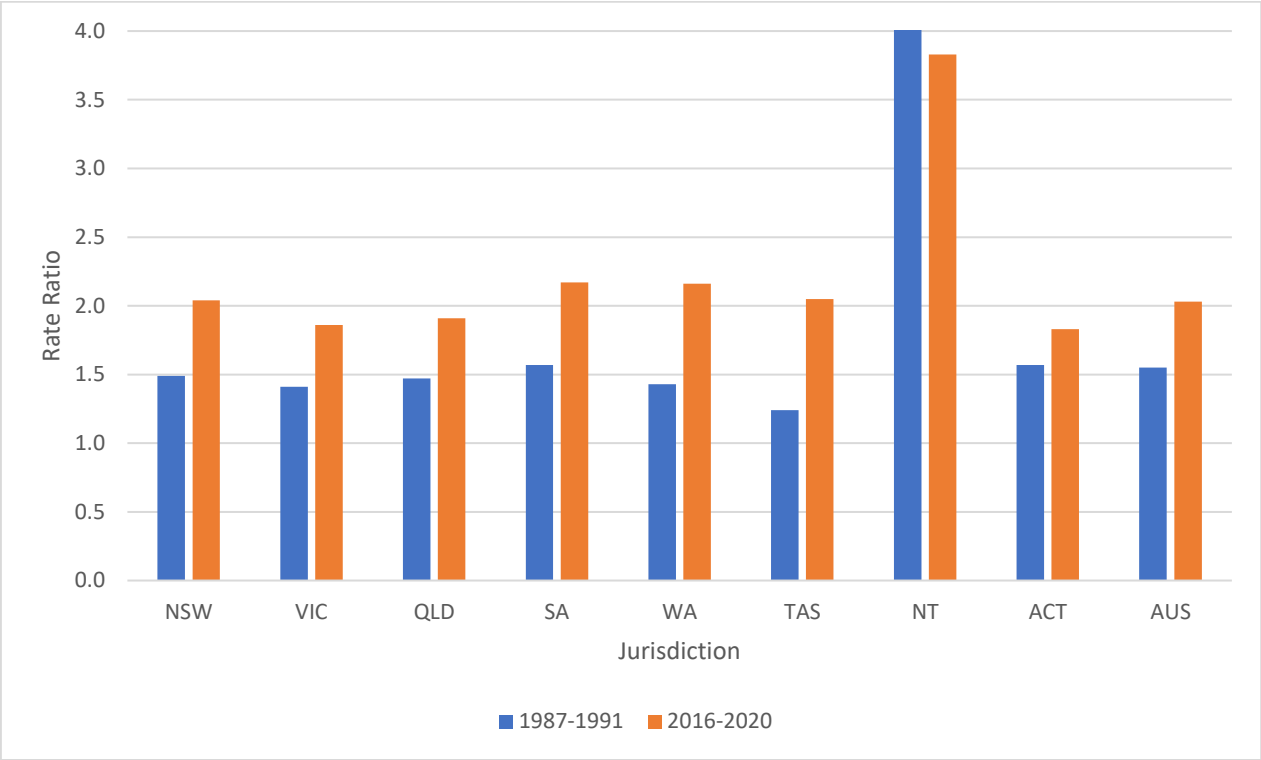


Figure A18: Rate Ratios for Age-Standardised Rates of Premature Mortality per 100,000 in each State and Territory in Australia, 1987 to 1991 and 2016 to 2020 (Data source: Social Health Atlas, PHIDU, 2022)

Jurisdictions: Avoidable Mortality

Figure A19 presents average annual age-standardised rates of avoidable mortality for each state and territory and for Australia for quintile 1 (least disadvantaged) and quintile 5 (most disadvantaged) for 1997-2000 and 2016-2020. Rates of avoidable mortality decreased in all jurisdictions, but inequality increased in all jurisdictions. The reduction in rates of avoidable mortality for quintile 1 (least disadvantaged) was 46% in SA and the ACT, 44% in NSW, 43% in the NT and Victoria, around 40% for Queensland and WA, and 37% for Tasmania. Reductions in rates of avoidable mortality by quintile were generally lower as disadvantage increased, with lowest proportional reductions for the most disadvantaged quintile in each jurisdiction. Reductions in rates of avoidable mortality for quintile 5 (most disadvantaged) were 27% for the NT, 23% for the ACT, 22% for Queensland, 21% for NSW, 17% for SA, 15% for Victoria, 8% for WA, and only 4% for Tasmania.

The much lower reduction in rates of avoidable mortality for the quintile representing the most disadvantaged areas led to increasing inequality for all jurisdictions. **Figure A20** presents the rate ratios for rates of avoidable mortality by jurisdiction and for Australia for 1997-2000 and 2016-2020. The largest increases in inequality between 1997-2000 and 2016-2020 were in Tasmania, WA, SA, then Victoria and NSW. The NT had the highest inequality in avoidable mortality in 2016-2020, followed by WA, then SA, then NSW. There is no jurisdiction that could be described as doing well in terms of inequality in rates of avoidable mortality. Inequality increased everywhere.

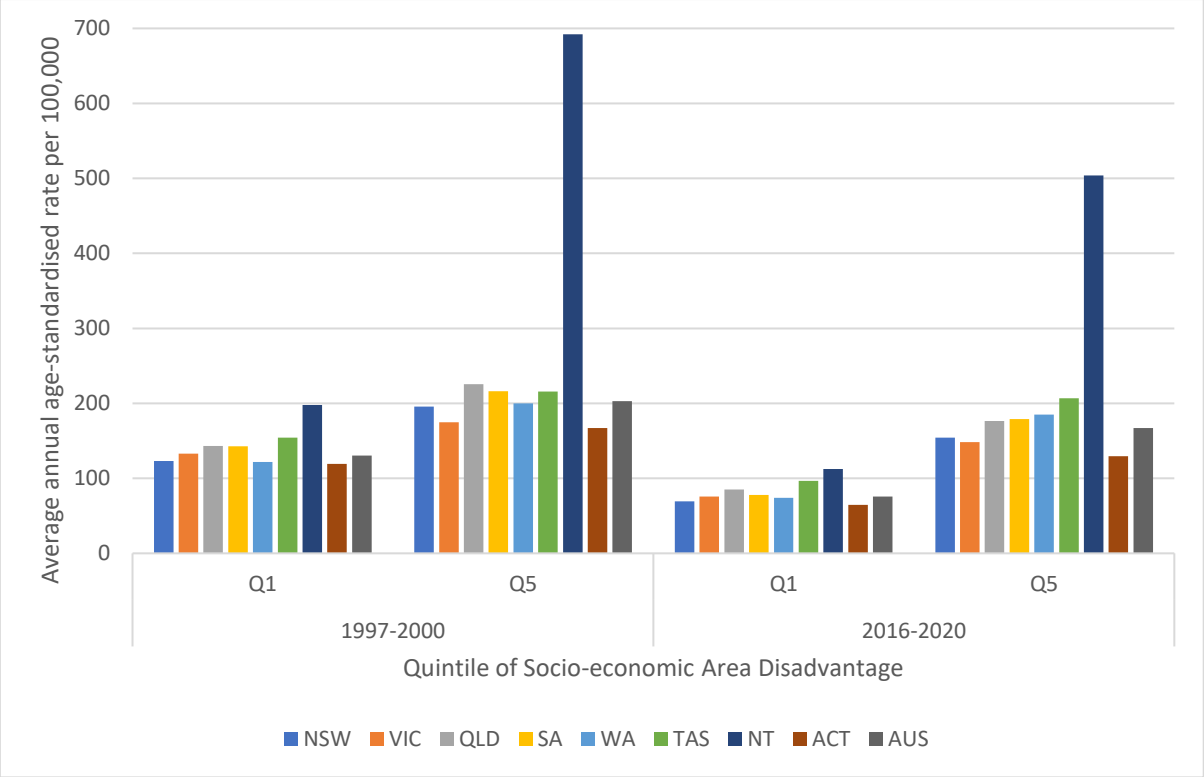


Figure A19: Average Annual Age-Standardised Rate of Avoidable Mortality per 100,000 people in each State and Territory in Australia, by quintile 1 (Q1, least disadvantaged) and quintile 5 (Q5, most disadvantaged, 1987 to 1991 and 2016 to 2020 (Data source: Social Health Atlas, PHIDU, 2022)

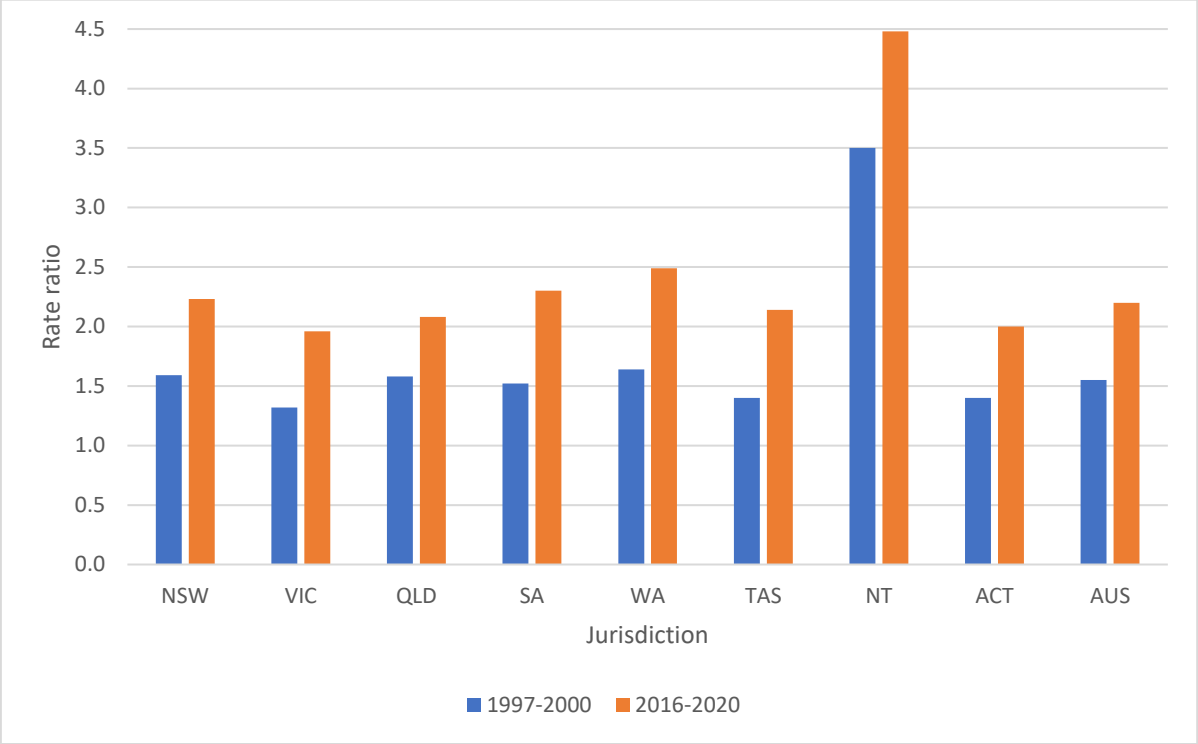


Figure A20: Rate Ratios for Age-Standardised Rates of Avoidable Mortality per 100,000 in each State and Territory in Australia, 1997 to 2000 and 2016 to 2020 (Data source: Social Health Atlas, PHIDU, 2022)

Jurisdictions: Infant Mortality

Figure A21 presents average annual age-standardised rates of infant mortality per 1,000 live births for each state and territory and for Australia for quintile 1 (least disadvantaged) and quintile 5 (most disadvantaged) for 2003-2007 and 2016-2020. Rates of infant mortality decreased over the period in all jurisdictions and generally for all quintiles in each jurisdiction. While inequality in infant mortality did increase nationally, there were some differences in the trends in infant mortality between jurisdictions. The proportional reductions in rates of infant mortality were higher for quintile 5 than for quintile 1 in the ACT, and slightly higher for quintile 5 than quintile 1 for SA and Victoria. This resulted in decreasing inequality in rates of infant mortality in the ACT and SA, and no increase in inequality in Victoria. There was not a clear social gradient in reduction in rates of infant mortality as there was avoidable mortality and for premature mortality in most jurisdictions, and this followed the national trend in rates of infant mortality by quintile of socio-economic disadvantage.

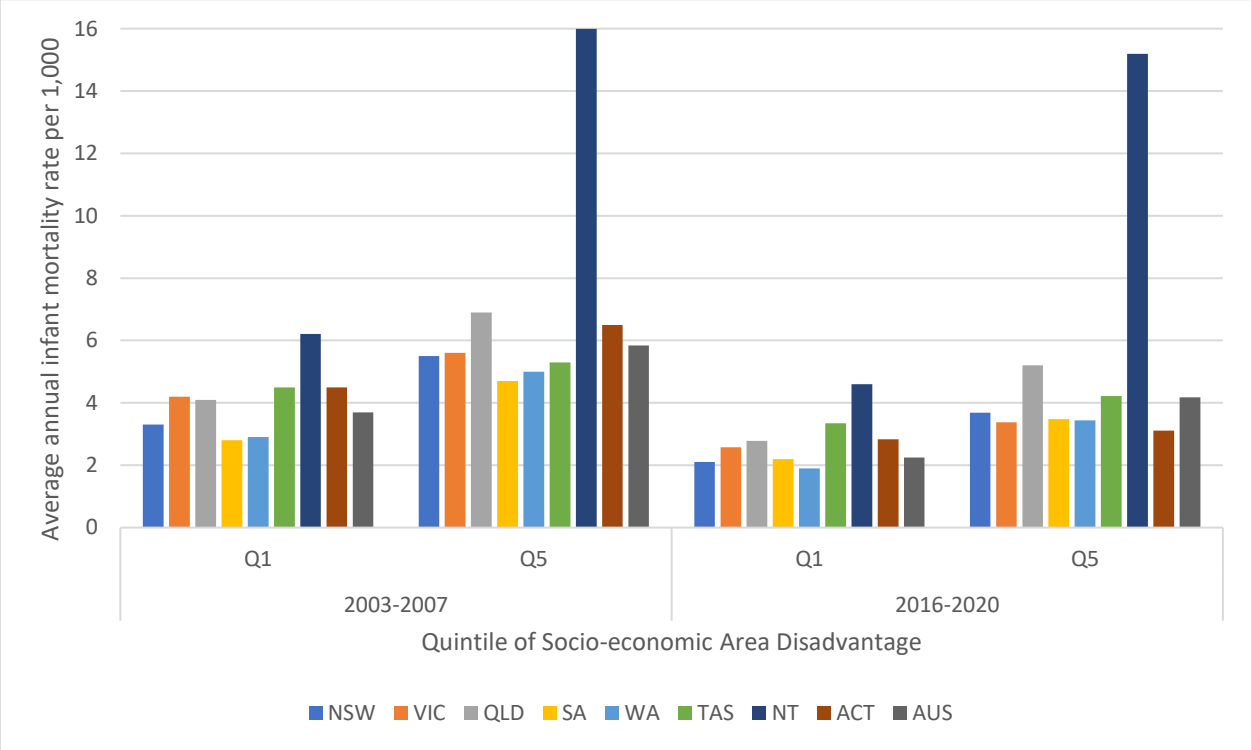


Figure A21: Average Annual Age-Standardised Rate of Infant Mortality per 1,000 Live Births in each State and Territory in Australia, by quintile 1 (Q1, least disadvantaged) and quintile 5 (Q5, most disadvantaged), 2003 to 2007 and 2016 to 2020 (Data source: Social Health Atlas, PHIDU, 2022)

The rate ratios for rates of infant mortality in each state and territory are presented in **Figure A22**. Inequality increased in NSW, Qld, WA, Tasmania, and the NT. The highest increases in inequality were in the NT, followed by Queensland, then NSW. The jurisdictions with the highest inequality in 2016-2020 were the NT, then Queensland, WA, and NSW.

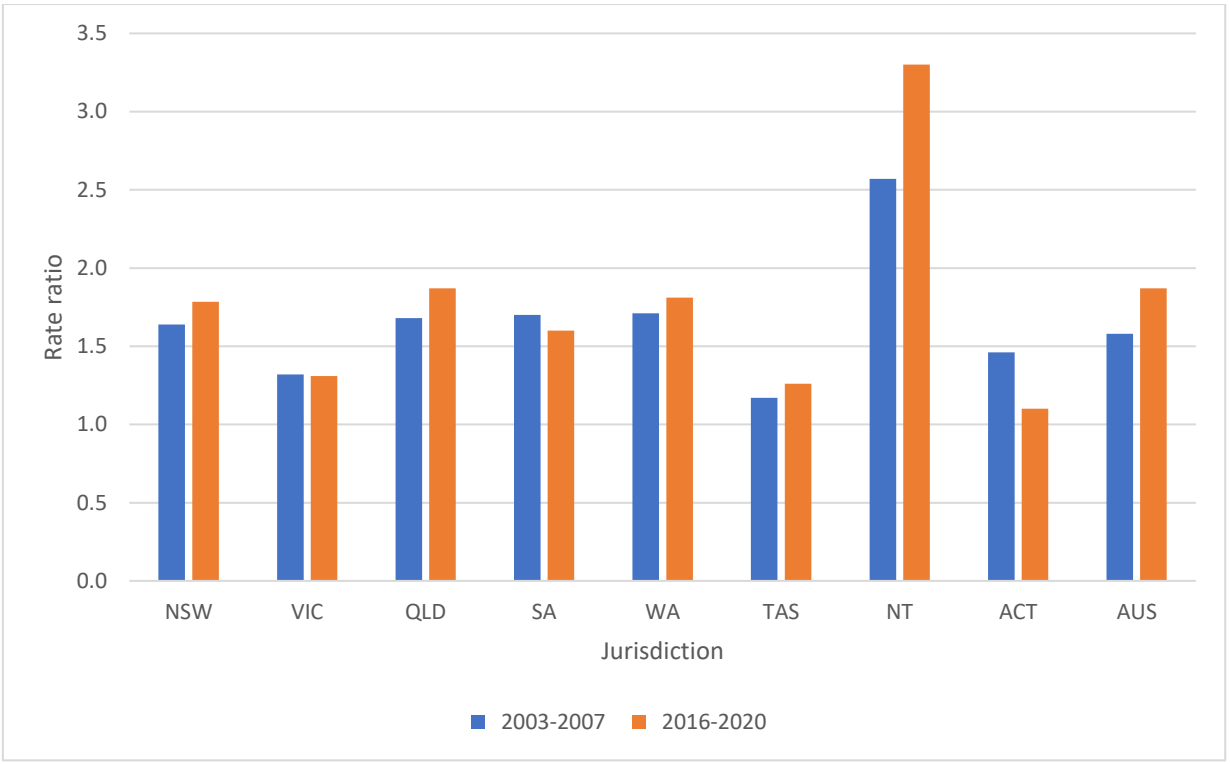


Figure A22: Rate Ratios for Age-Standardised Rates of Infant Mortality per 1,000 Live Births in each State and Territory in Australia, 2003 to 2007 and 2016 to 2020 (Data source: Social Health Atlas, PHIDU, 2022)

Jurisdictions: Self-assessed Health

PHIDU data for age-standardised rates of fair or poor self-assessed health per 100 were only available for the six states for 2007-08 and 2017-18 (see **Figure A23**). Data were available for the NT and ACT but for 2011-12 instead of 2007-08 which prevented comparability of the short term trend. There is a strong social gradient in rates of fair or poor self-assessed health in each jurisdiction that has persisted over the two available time points. The rate ratio for rate of fair or poor self-assessed health increased in all states except NSW, where the rate for fair or poor self-assessed health was slightly higher for quintile 1 in 2017-18 than in 2007-08, and the rate for quintile 5 decreased from 23.6% to 20%. The highest increases in inequality were in Queensland and Victoria. Inequality increased in all states except for NSW.

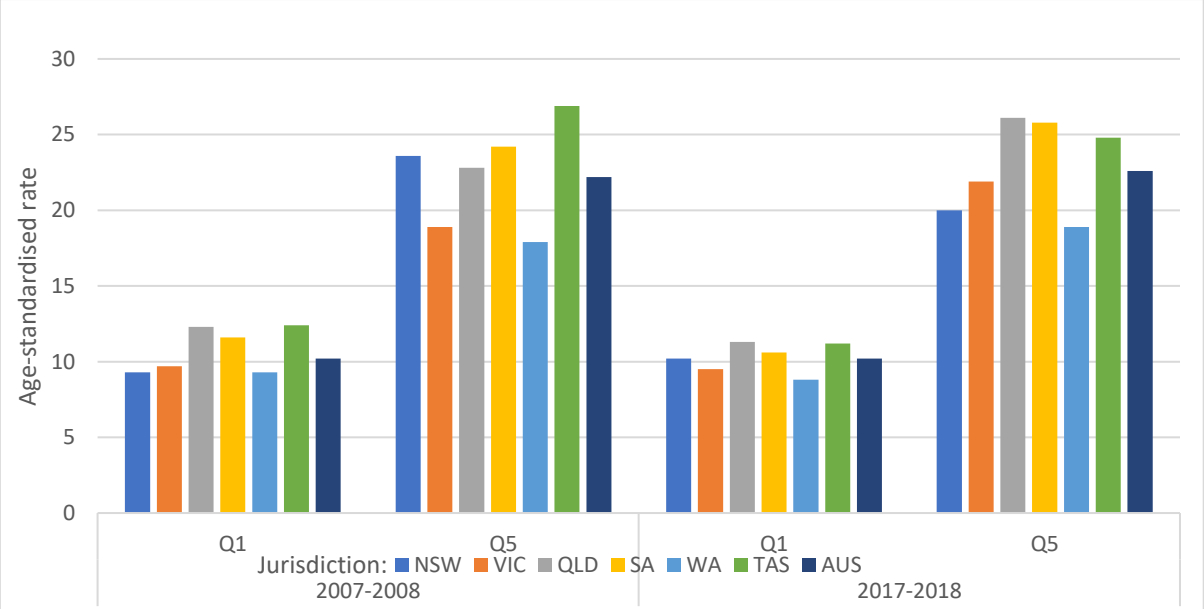


Figure A23: Age-Standardised Rates per 100 of fair or poor self-assessed health in each State in Australia, people aged 15 years and over, by quintile 1 (Q1, least disadvantaged) and quintile 5 (Q5, most disadvantaged) 2007-08 and 2017-18 (Data source: Social Health Atlas, PHIDU, 2022)

Multidimensionality of health inequities

Much of the analysis in this profile of health inequities examines inequities overall either nationally or by jurisdiction. There are groups that experience higher health inequities than the general population: people with disability, LGBTIQ+ people, refugees and asylum seekers and Aboriginal and Torres Strait Islander people. There can also be multiple of these factors compounding the inequities experienced by individuals. The multidimensional nature of inequities is acknowledged in each of the key social determinants of health sections in this appendix.

Summary

This profile of health and trends in health inequities in Australia has provided statistics on inequities in longevity, mortality, and morbidity. The social gradient in self-assessed corresponds with a social gradient in morbidity, which is reflected in people's lived experiences and leads to the social gradient in premature mortality and avoidable mortality. Inequities in longevity and mortality are worsening. The available evidence on the distribution of infections[19] and mortality from COVID-19 also reveals a social gradient which is troubling given the likelihood that this has resulted in a social gradient in Long COVID.

The National Preventive Health Strategy has targets to reduce inequities.[21] These targets include: 1) Australians in the 2 lowest socioeconomic groups will have at least an additional 3 years of life lived in full health by 2030; 2) Australians in regional and remote areas will have at least an additional 3 years of life lived in full health by 2030; and 3) Aboriginal and Torres Strait Islander people will have at least an additional 3 years of life lived in full health by 2030.[21] Action must be taken to reverse current trends if these targets are to be met.

The WHO Commission on Social Determinants of Health attributed the social gradient in health within countries to the unequal distribution of power and of social determinants of health such as income, wealth, housing, education, and employment.[22] The remainder of this appendix contains analyses of the distribution of each of these social determinants of health in Australia, finishing with another key social determinant of health: social exclusion.

Trends in Social Determinants of Health in Australia

Income

Income is a key determinant of health and has been found to be strongly related to morbidity and mortality.[23, 24] **Figure A24** presents the percentage of individuals reporting fair or poor self-assessed health by quintile of household equivalised income in 2019-2020. The percentage reporting fair or poor self-assessed health ranges from 7.1% for the highest income quintile to 26.8% for the lowest income quintile and there is a steep social gradient. The rate ratio of fair or poor self-assessed health is 3.8, and the percentage reporting fair or poor self-assessed health is much higher than the overall rate of 15% and is over 20% for quintiles 4 and 5.

The social gradient in self-assessed health is steeper in Figure A24 compared with Figure A7 which used PHIDU data. Data used to produce Figure A24 were not age-standardised which explains some of the difference between this figure and the figure on self-assessed health in the health profile, however analyses using area-based data (such as PHIDU data) have been found to underestimate income, education and health inequality[25] and this is evident in Figure A24 where inequality in self-assessed health by income quintile is higher than inequality in self-assessed health in PHIDU data.

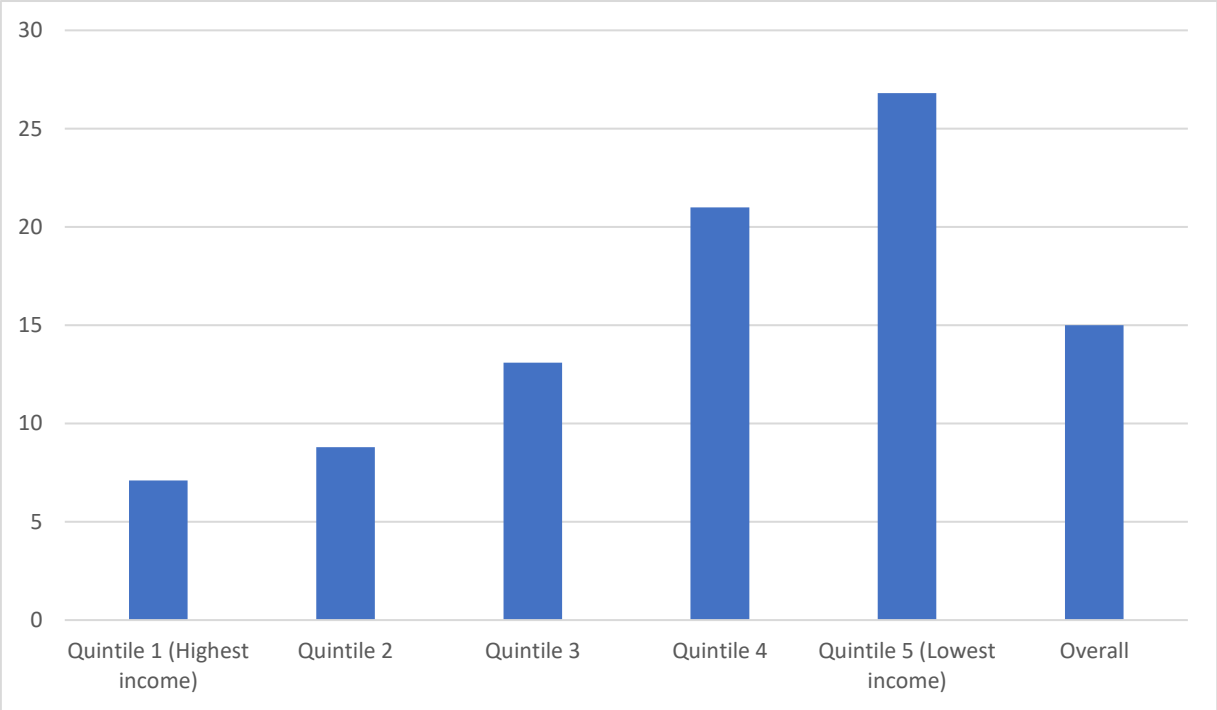


Figure A24: Percentage of Individuals Reporting Fair or Poor Self-Assessed Health in Australia, people aged 15 years and over, by Quintile of Household Equivalised Income 2019-20 (Data source: Survey of Income and Housing, ABS, 2022)[26]

Note: uses population weights provided by the ABS

Estimates of the trend in income inequality

There are different estimates of the trend in income inequality from different sources. The Actuaries Institute noted that income inequality is much higher than it was in the early 1980s but income inequality has not increased in the past decade.[27] ACOSS reported that income inequality increased during the boom from 2000 to 2008.[28] The Actuaries Institute estimate that the top 20% had six times the average annual household income of the bottom 20% in 2021 (after adjusting for tax, benefits, and household size) (See **Figure A24**). The Actuaries Institute argue that the trend of income inequality not increasing during the last

decade is unlikely to continue. There are warning signs of higher inequality: a falling share of labour income as a fraction of the total economy, and changes to the labour market such as gig work and increasing casualisation.[27]

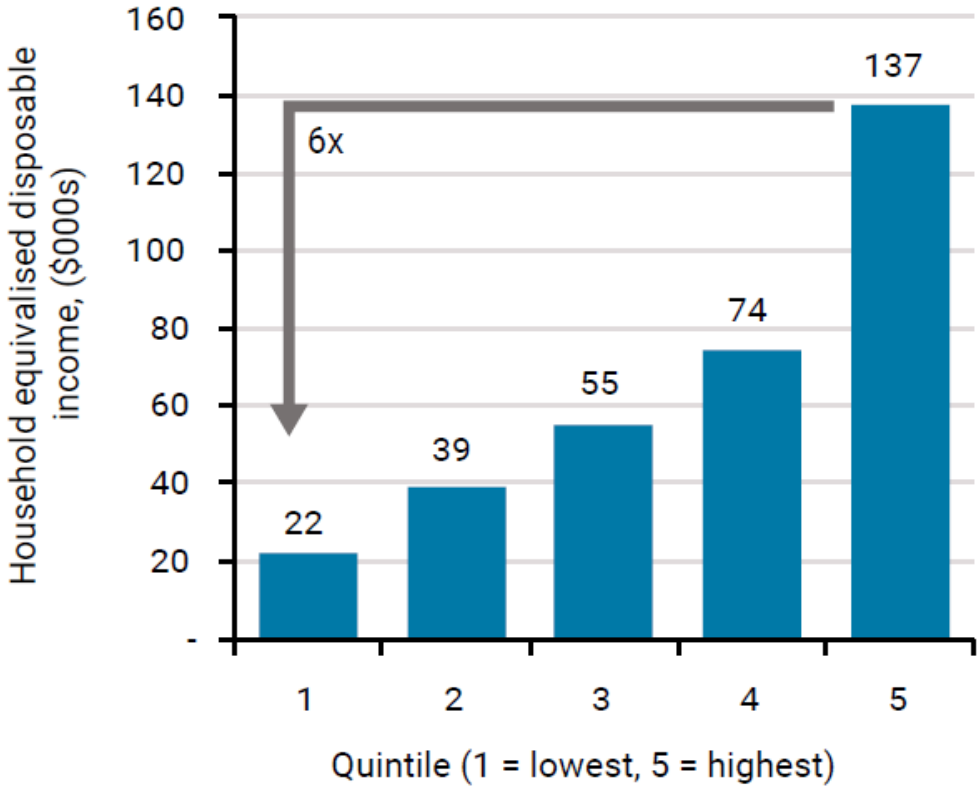


Figure A245: Household income distribution, all ages, household equivalised disposable income, 2021 (Data source: Actuaries Institute)[27]

Figure A26 presents the change in the share of wages and the share of profits over 45 years from 1974 to 2019. The wages share has declined over this period and is currently at a near all-time low while the share of income going to profits has reached an all-time high.[29] This trend has coincided with a period of growing income inequality, particularly since the 1980s.[27]

The Australia Institute measured how growth in national income has been distributed since 1950, combining changes in real national income per adult with the share of national income going to the top 10%.[30] **Figure** presents estimates of the percentage share of growth going to the top 10% and the bottom 90% in five periods where the economy was expanding and real national income was growing. Inequality increased in any period where the share of growth for the bottom 90% is less than 90% (the population share of the bottom 90%). From 1950-60, equality improved, with over 90% of growth going to the bottom 90%. From 1961-81, inequality slightly increased, with 84% going to the bottom 90%. Subsequent decades show increasingly worsening inequities. From 1982-1990, only just over half of the growth went to the bottom 90%. The period from 1991-2008 saw almost two thirds of growth go to the bottom 90%. Only 7% of growth went to the bottom 90% in the decade from 2009 to 2019. The trends in **Figure** of increasing inequality since the 1980s are similar to the increasing inequality in health since the 1980s with a lag between increasing social inequality and increasing health inequalities.

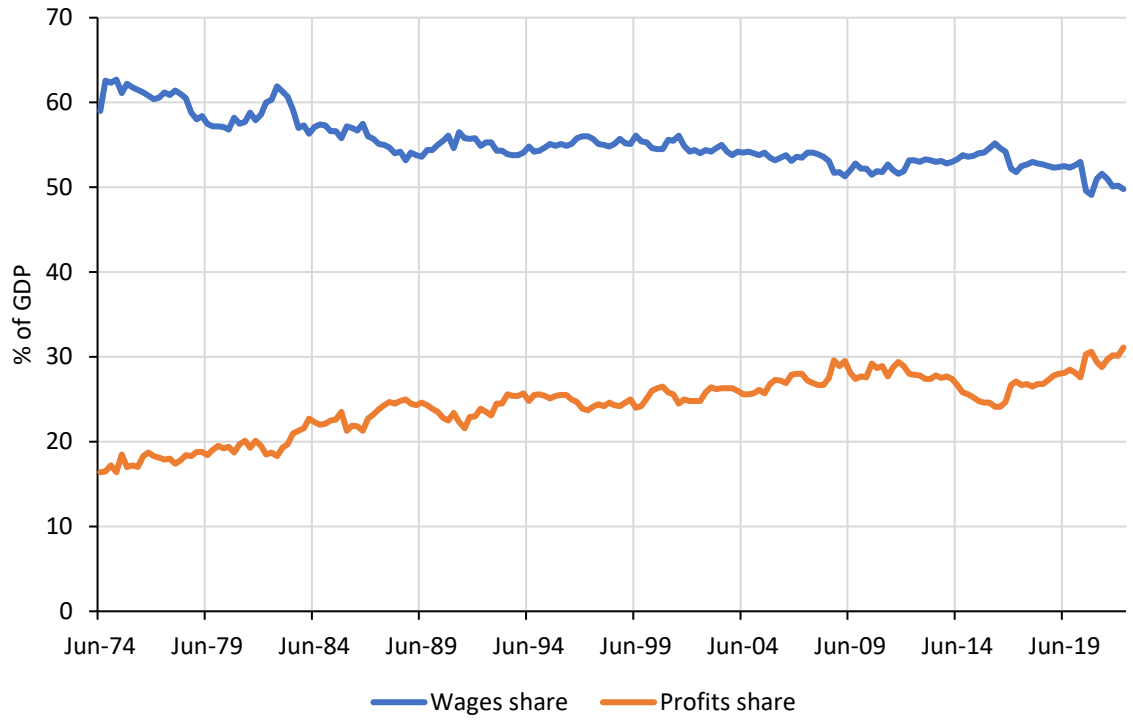


Figure A26: Changing share of wages and profits as a fraction of GDP (Data source: Actuaries Institute, ABS National Accounts)[27]

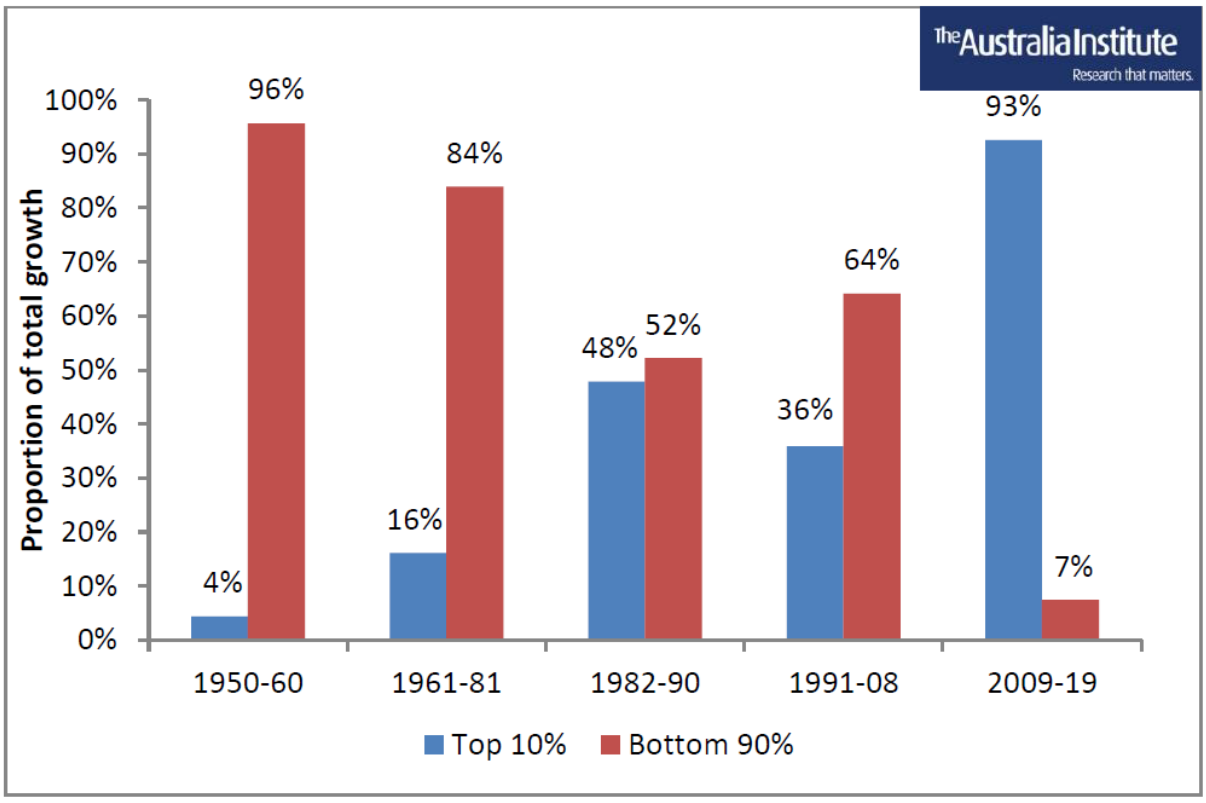


Figure A27: Per adult real economic growth: Share of growth (%) going to the top 10% and bottom 90% (Source: the Australia Institute)[30]

Trend in distribution of income

The trends in the Australia Institute analysis match the trend in the share of the top 1% and top 10% in statistics from the World Inequality Database (https:// https://wid.world) (which was the data source used by the Australia Institute). **Figure A28** presents the shares of national income held by the top 1%, top 10%, and bottom 50% from 1950 to 2021. The share of national income held by the top 10% declined through the 1960s and 1970s and then rose from the early 1980s through to the early 2010s. The share of the top 1% declined through the 1950s, 1960s and 1970s then rose in most years from the early 1980s through to 2009. The share for the bottom 50% fluctuated more than for the top 1% and top 10% but the overall trend was an increase in the share for the bottom 50% from around 16.5% in 1950 to almost 20% in 1978 then a decline from 1979 through to 2020 when the share for the bottom 50% was 17.2%. The top 10% held 32.9% of national income and the top 1% held 9.9% of national income in 2021.

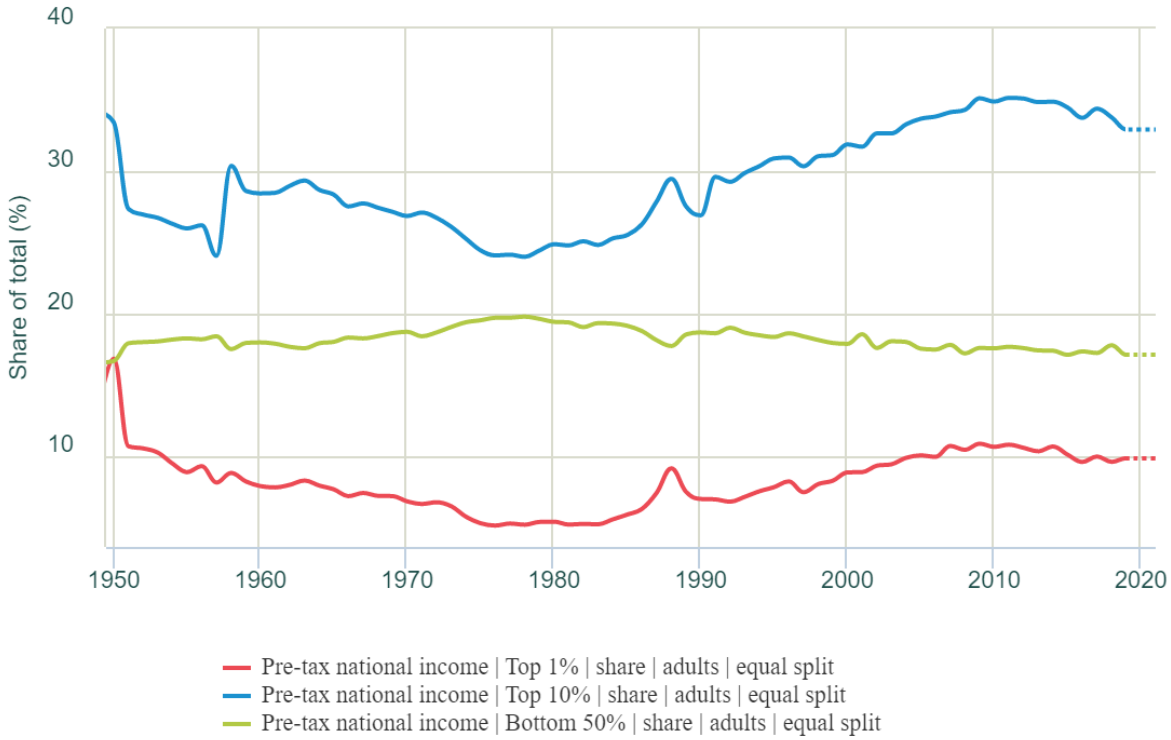


Figure A28: Income inequality, Australia, 1950-2021 (Data source: World Inequality Database, https://wid.world)

Statistics on the bottom 50% are informative, but they do mask differences in the distribution of income within this bottom 50%. **Figure A29** presents ABS data on shares of equivalised disposable household income by quintile for 2019-20. The lowest quintile held only 7.4%, and the second quintile only 12.6%. There is a social gradient in income by quintile whereby the less advantaged have lower shares of income. The highest quintile held 39.8% of income, more than 5 times the income share of the lowest quintile.

The Actuaries Institute report emphasises the multidimensional nature of inequality and estimates the contribution of demographic factors to income inequality. The income gap for Country of birth (people born in a country that is not a wealthier English speaking country) was estimated to be $13,000 per annum.[27] The income gap for gender was estimated to be $16,000 per annum, and the income gap for disability was estimated to be $8,000 per annum.[27] Aboriginal and Torres Strait Islander people were twice as likely to be in the lowest income quintile compared with non-Indigenous people.[27] These factors intersect and income gaps are much larger for people who are in multiples of these social groups.

Figure A30 presents ACOSS estimates of trends in average weekly disposable income by quintile and for the top 5% between 1999-2000 and 2017-18. Income inequality grew during the boom from 2000 to 2008. Overall, average incomes of the highest 5% grew 59% in the boom period between 1999 and 2007, compared with 40% for the highest 20%, 32% for the middle 20% (third quintile) and 31% for the lowest 20%.[31] After the Global Financial Crisis growth in household income was sluggish and ACOSS estimates indicate a slight moderation in income inequality between 2007 and 2019-20. After-tax incomes of the highest 20% increased by 4% between 2007 and 2019-20, by 7% for the middle 20%, by 12% for the bottom 20%, with after-tax income of the highest 5% declining 0.4% due to the effects of the pandemic.[31]

ACOSS estimates of income inequality found that the highest 20% of households by income had average after tax incomes that were five times that of the lowest 20% in 2019-20, and estimated that the highest 5% of households had eight times the income of the bottom 20%.[31] On average, the lowest 20% of households by income rely on social security for half of their income, which is not the case for higher income groups who obtain most income from wages.[31]

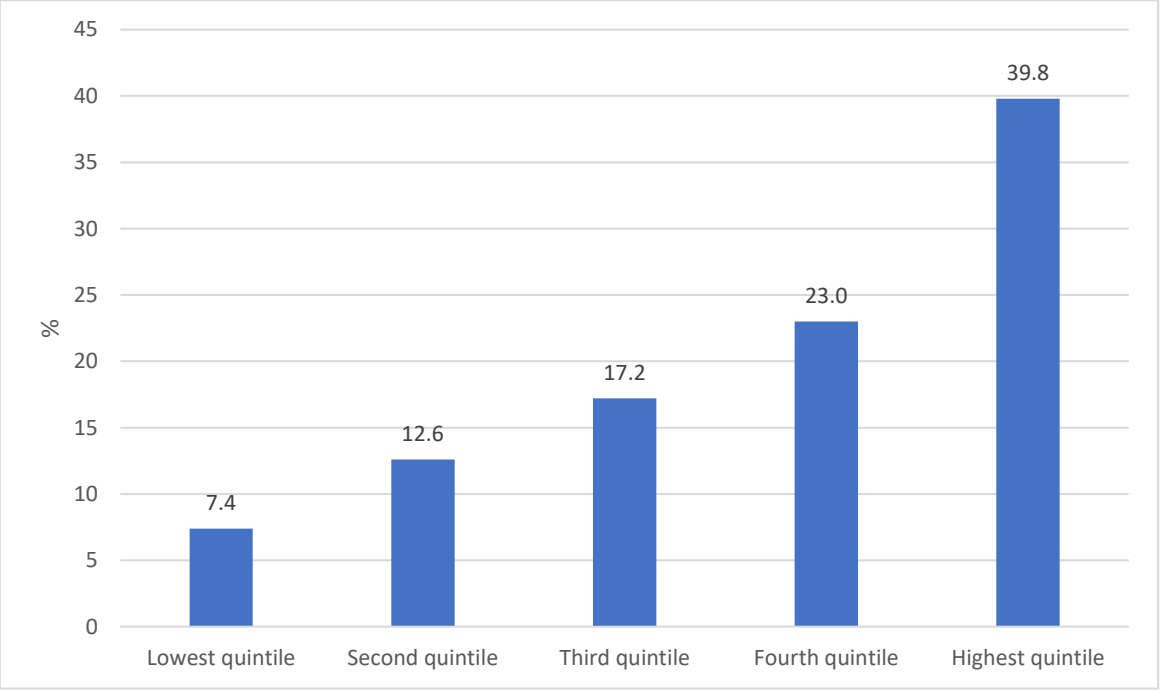


Figure A29: Share of Equivalised Disposable Household Income by quintile (Source: ABS Survey of Income and Housing 2019-2020)[32]

In 2020, the first year of the COVID-19 pandemic, income inequality fell to its lowest level since at least 2001 despite a recession and the effective unemployment rate reaching 17%.[33, 34] This fall in income inequality was primarily due to the Coronavirus income support supplement, but JobKeeper also contributed.[33] Between March and December 2020, the average income of the bottom 20% increased by 8%, the average income for the next 20% increased by 11%, for the middle 20% average income grew by 3%, and for the highest 20% average income fell by 4%. The decline in average income for the highest 20% can be attributed to the JobKeeper payment being worth less than their pre-pandemic wage income.[34]

Pandemic income supports were withdrawn in 2021 and income inequality increased above the pre-pandemic level.[34]

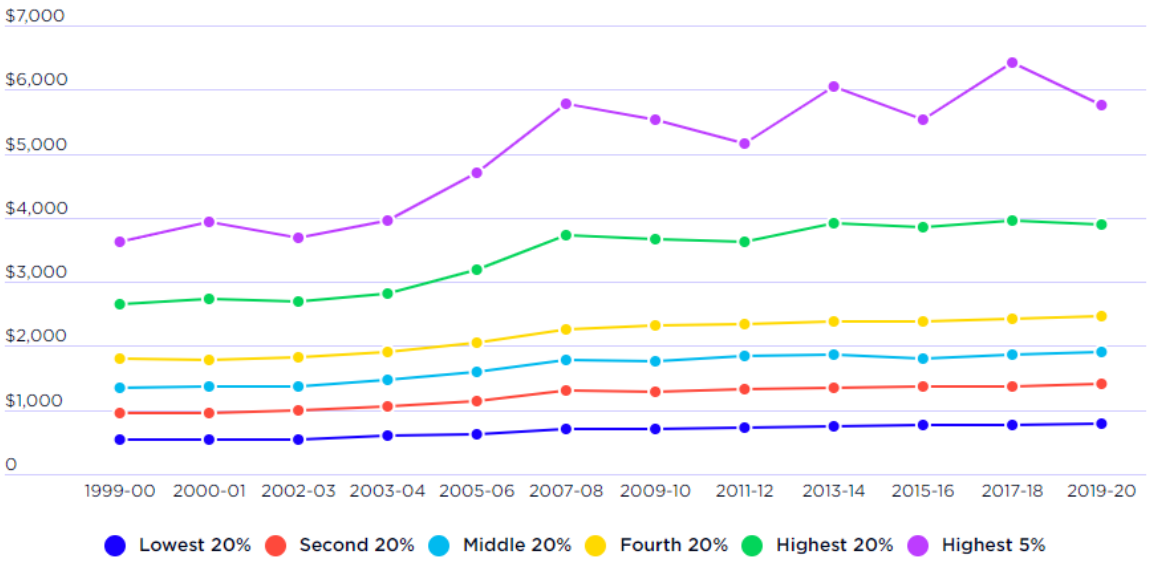


Figure A30: Trends in average weekly household disposable income by income group from 1999-2000 to 2019-20 in 2019 dollars (Data source: ACOSS calculations from ABS Survey of Income and Housing Microdata)[35]

Jurisdiction analysis: Income

There are interstate differences in the representation of people by state and territory in the national income quintiles. Figure presents the income distribution of people by state/territory in 2015/16. The top row is the national income groups with each colour in the bar representing 20% per quintile. New South Wales, Victoria and Queensland with their larger populations had a more even representation of people across the income distribution with the exception of New South Wales having a high (23.4%) share of people in the highest 20%. The ACT had higher shares of people in the highest 20% (30.6%) and Western Australia also had a high (23.3%) share of people in the highest 20%. South Australia and Tasmania had higher shares of people in the lowest 20% (24.7% and 25% respectively), which reflects the lower average incomes in these states. Jurisdictions with lower average incomes generally have lower average housing costs compared with jurisdictions which have higher average incomes. Data for the Northern Territory appear to have higher shares of people in the highest 20% however ABS data from the Survey of Income and Housing did not include households in very remote areas for the Northern Territory which explains the much lower than expected share of households in the lowest 20% and second lowest 20%.

Interstate differences in income distribution reflect differences in employment levels and differences in age profiles.[36]

Table A7 presents ABS data on mean weekly income by quintile and overall in 2019-20 for each state and territory in Australia and for Australia, and our calculation of the ratio of the income of the highest quintile to the lowest quintile. The ACT had the highest mean income per week in 2019-20, followed by the NSW, WA, and Victoria[2]. Tasmania had the lowest mean income per week, followed by SA. The ACT had the lowest income inequality in 2019-20 according to the ratio, with the highest quintile having 4.4 times the mean weekly income of the lowest quintile. NSW had the highest income inequality (ratio of 5.7), followed by WA and Victoria (both had ratios of 5.5).

[2] The exclusion of very remote households from NT data prevents an accurate assessment of income inequality.

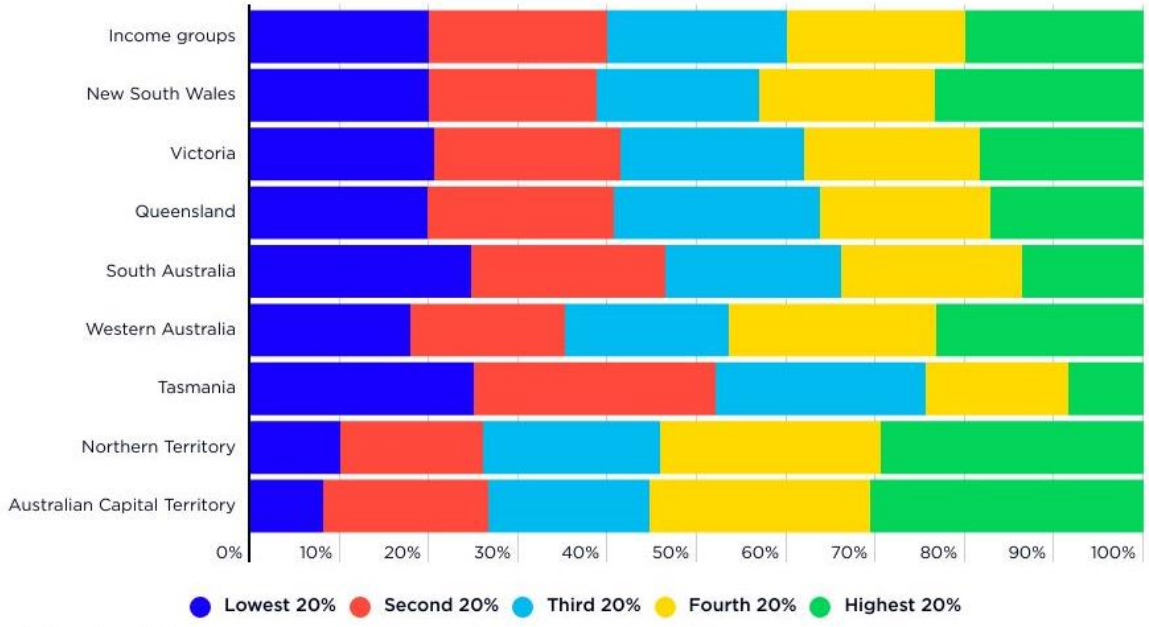


Figure A31: Income distribution of people by state/territory 2015/16 (Data source: ACOSS calculations using ABS Survey of Income and Housing Microdata)[36] Note: Data for NT excludes households in SA1s defined as very remote which represent 21% of the NT population.

Table A8 presents income share by quintile in 2019-20 for each state and territory and for Australia. According to this measure NSW had the highest income inequality, with only 7.1% of income held by the lowest quintile and 40% held by the highest quintile. WA had the next highest income inequality, with 7.5% held by the lowest quintile and 41.2% held by the highest quintile. The ACT had the lowest income inequality, with 8.2% of income held by the lowest quintile and 35.5% held by the highest quintile. Tasmania had the second lowest inequality.

The ABS also provides the Gini coefficient as a measure of income inequality in each state and territory, for capital cities, and for rest of states (see **Table A9**). The Gini coefficient ranges between 0 and 1 with 0 representing total equality and higher values representing higher inequality. A comparison of the Gini coefficient by state and territory indicates WA had the highest income inequality closely followed by NSW, then Victoria. The ACT has the lowest Gini coefficient, followed by Tasmania. For greater capital city areas, Greater Sydney had the highest inequality, followed by Greater Brisbane and Greater Perth, then Greater Melbourne. Greater Canberra has the lowest inequality. The Gini coefficient is higher in all greater capital city areas compared with rest of states with the exception of Greater Adelaide. With in rest of states, rest of WA had the highest income inequality followed by rest of SA. Rest of Tasmania had the lowest income inequality followed by rest of NSW and rest of Victoria.

Table A7: Mean equivalised disposable household income per week by quintile and overall, States and territories (Data source: ABS Household Income and Wealth, 2019-20)[32]

	NSW	Vic.	Qld	SA	WA	Tas.	NT[1]	ACT	Aust.
Lowest quintile	407	406	429	403	430	391	452	574	415
Second quintile	726	723	686	662	711	633	767	981	710
Third quintile	996	972	923	917	942	828	1,093	1,308	966
Fourth quintile	1,315	1,312	1,249	1,196	1,299	1,123	1,446	1,685	1,294
Highest quintile	2,306	2,237	2,150	2,015	2,349	1,839	2,176	2,501	2,234
All persons	***1,150***	***1,129***	***1,087***	***1,038***	***1,146***	***961***	***1,185***	***1,406***	***1,124***
Ratio highest to lowest	5.7	5.5	5.0	5.0	5.5	4.7	4.8	4.4	5.4

Notes: 1. Data for NT excludes households in SA1s defined as very remote which represent 21% of the NT population

Table A8 Income share by quintile of equivalised disposable household income, States and Territories (Data source: ABS Household Income and Wealth, 2019-20)[32]

	NSW	Vic.	Qld	SA	WA	Tas.	NT[1]	ACT	Aust.
Lowest quintile	7.1	7.2	7.9	7.7	7.5	8.1	7.5	8.2	7.4
Second quintile	12.6	12.8	12.6	12.8	12.4	13.4	13.1	14.0	12.6
Third quintile	17.4	17.2	17.1	17.8	16.4	17.0	18.6	18.5	17.2
Fourth quintile	22.9	23.1	22.8	23.2	22.6	23.6	24.7	23.8	23.0
Highest quintile	40.0	39.6	39.7	38.6	41.2	37.9	36.9	35.5	39.8

Notes: 1. Data for NT excludes households in SA1s defined as very remote which represent 21% of the NT population

Table A9: Gini coefficient of equivalised disposable household income by state and territory, greater capital city area, and rest of states 2019-20 (Data source: ABS income and Wealth, 2019-20)[32]

	NSW	Vic.	Qld	SA	WA	Tas.	ACT	Aust.
Gini coefficient	0.329	0.325	0.317	0.312	0.331	0.301	0.277	0.324
	Sydney	**Melbourne**	**Brisbane**	**Adelaide**	**Perth**	**Hobart**	**Canberra**	**Aust.**
Gini coefficient	0.340	0.330	0.333	0.309	0.333	0.308	0.277	0.332
	Rest of NSW	**Rest of Vic**	**Rest of Qld**	**Rest of SA**	**Rest of WA**	**Rest of Tas**		**Aust.**
Gini coefficient	0.290	0.291	0.295	0.315	0.321	0.275		0.296

Notes: 1. Data for NT excludes households in SA1s defined as very remote which represent 21% of the NT population

Fleming and Measham from the CSIRO calculated Gini coefficients for income inequality for regions in Australia for 2001 and 2011.[37,3] **Table A10** presents these Gini coefficients by state and territory for 2001 and 2011. While this does not provide the trend in income inequality over the whole period of interest in this analysis, it does allow an assessment of the trend in inequality by jurisdiction over the boom period when inequality was increasing for Australia as a whole. Gini coefficients for income inequality increased for every jurisdiction between 2001 and 2011. The largest increases were for the ACT and NT followed by WA. The lowest increase in income inequality was in Tasmania, followed by SA.

Table A10: Gini coefficient of income inequality by jurisdiction, Australia 2001 and 2011 (Data source: CSIRO)[37]

State/Territory	2001	2011
NSW	0.392662	0.419017
Vic	0.375029	0.400498
Qld	0.364046	0.388980
SA	0.365503	0.386706
WA	0.364499	0.398450
Tas	0.358422	0.377692
NT	0.361192	0.401609
ACT	0.348043	0.389861

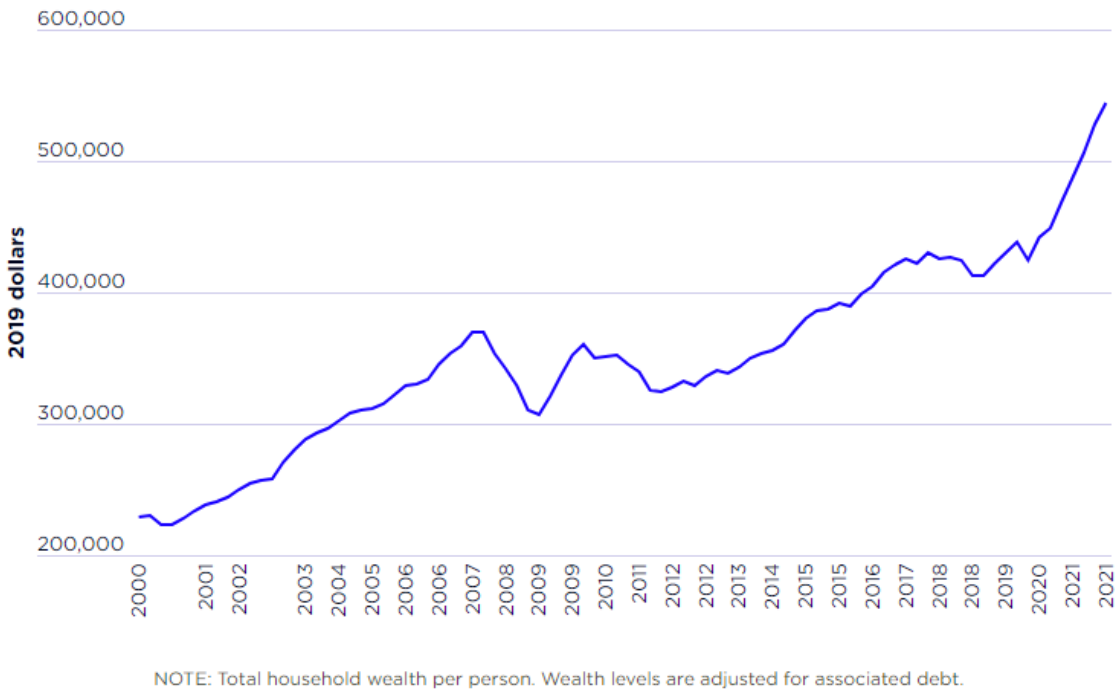
Publicly available data on the trend in income inequality by state and territory is limited and does not allow an assessment of the increase in income inequality over the period available for national data.

[3] Note that the Gini coefficients in **Table A10** were calculated using Census data and are not comparable with the Gini coefficients in **Table A9** which were calculated from the ABS Survey of Income and Housing

Wealth

Average household wealth

Total household wealth per person has grown in almost every year since the year 2000, the exceptions being the global financial crisis and the COVID-19 recession (**Error! Reference source not found.**). From 2000 until 2009 household wealth per person grew by 5% per year, from $257,000 to $353,000.[38] After the global financial crisis, household wealth per person grew more slowly up until 2018, rising an average of 2% per year to $413,000.[38] From 2018 to 2021 the increase averaged 11% per year despite the COVID-19 recession. Household wealth per person was estimated to be $544,000 in 2021.[38]



NOTE: Total household wealth per person. Wealth levels are adjusted for associated debt.

Figure A32: Household Wealth per Capita in Australia in 2019 Dollars (Data source: ACOSS estimates based on Reserve Bank of Australia Household Statistics and Business Balance Sheets adjusted for inflation to 2019-20 dollars using ABS data)[39]

Australia has high average wealth and was ranked fourth highest in the world in Credit Suisse's 2021 Global Wealth Report (behind only Switzerland, the US, and Hong Kong).[40] The OECD Framework for Measuring Wellbeing and Progress ranks Australia as above the OECD average for household wealth.[41] This average household wealth measure is flawed, particularly as a measure of wellbeing, for two reasons: 1) it does not take into account how much of Australia's average wealth is from rising house prices (58% of Australia's wealth is from non-financial assets (mainly housing) compared with the global average of 46%).[38] 2) the average measure tells us nothing about the distribution of wealth, and the extent of inequities.

Distribution of wealth

Measures of the distribution of wealth are publicly available from the World Inequality Database, ACOSS' 2022 Report on COVID and wealth inequality,[38] ACOSS' 2023 report providing an overview of inequality,[31] and the ABS. **Figure** presents World Inequality Database data on the share of net personal wealth in Australia of the top 1%, the top 10%, and the bottom 50% between 1995 and 2021. The share for the bottom 50% was only around 5% over this period, beginning at around 5.2%

in 1995 and declining slightly to just under 5% in 2021. The share for the top 1% increased from just under 22% in 1995 to almost 24% in 2021. The top 10% share also increased, from just over 55% to just over 57%.

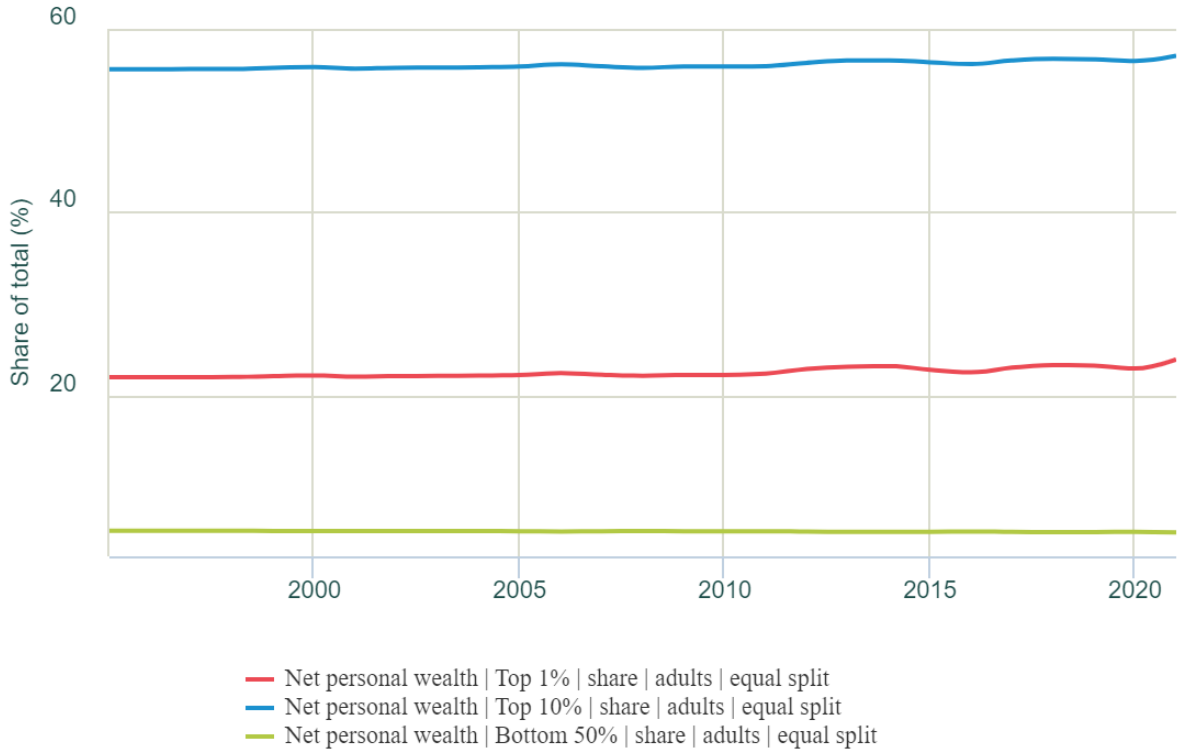


Figure A33: Wealth Inequality, Australia, 1995-2021 (Data source: World Inequality Database https://wid.world/country/australia/)

ACOSS reported data on the top 10%, the next 30%, and the bottom 60% calculated using the ABS Surveys of Income and Housing from 2003-04 to 2017-18 and projections to 2021 (see **Figure A25**).[38] The top 10% were estimated have 46% of all wealth in 2021 compared with 38% for the next 30% and only 17% for the bottom 60%.[38] Wealth inequality increased sharply during the period of economic growth between 2003-04 and 2018-19 due to much higher growth in wealth amongst the relatively wealthy. The wealth of the top 1% increased (after inflation) by an average of 84%, wealth of the top 10% increased by 65%, the wealth of the next 30% grew by 44%, while the wealth of the bottom 60% rose by only 20%.[38]

ACOSS estimated that there was a modest decline in wealth inequality during the pandemic. In 2019-20 and 2020-21, the wealth of the top 10% was estimated to have increased by 11%, the wealth of the next 30% rose by 13%, and the wealth of the bottom 60% rose by 16%. The modest decline in wealth inequality was attributed to rising home prices.[38] It is important to note that statistics for the bottom 50% (World Inequality Database) or the bottom 60% (ACOSS) masks differences in the distribution of wealth. For example, wealth is known to have declined during the pandemic for those who made withdrawals through the COVID-19 early release of superannuation for individuals adversely financially affected by COVID-19. There was much higher take up of the early release of superannuation by people with lower incomes and lower superannuation balances.[42]

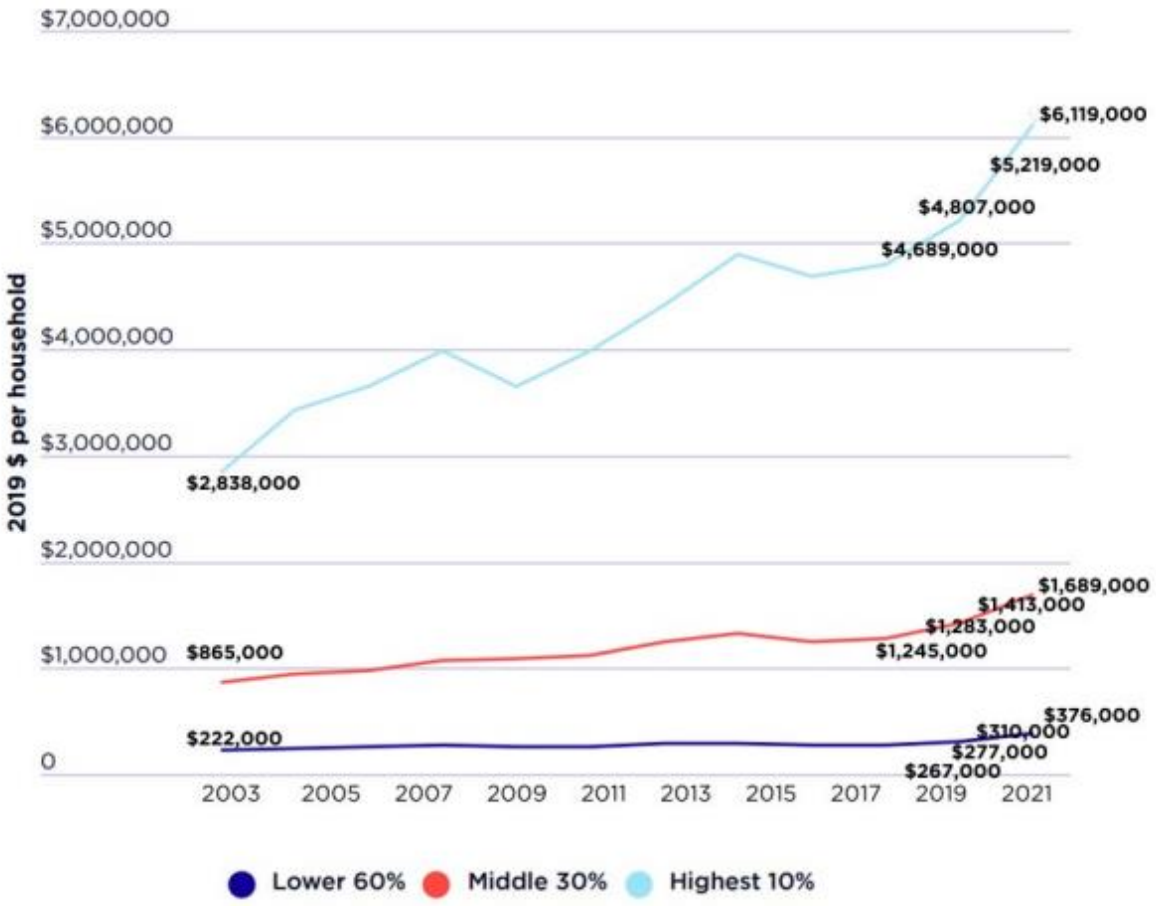


Figure A254: Average wealth by wealth group (2019 dollars per household) (Data source: ACOSS Build Back Fairer Report 4 2022)[38]

Notes: 1. Net wealth adjusted for inflation using 2019-20 values. 2. Wealth levels are adjusted for debt but are not adjusted for household size.

While Australia is ranked highly for average wealth, Australian households also rank very highly on indebtedness.

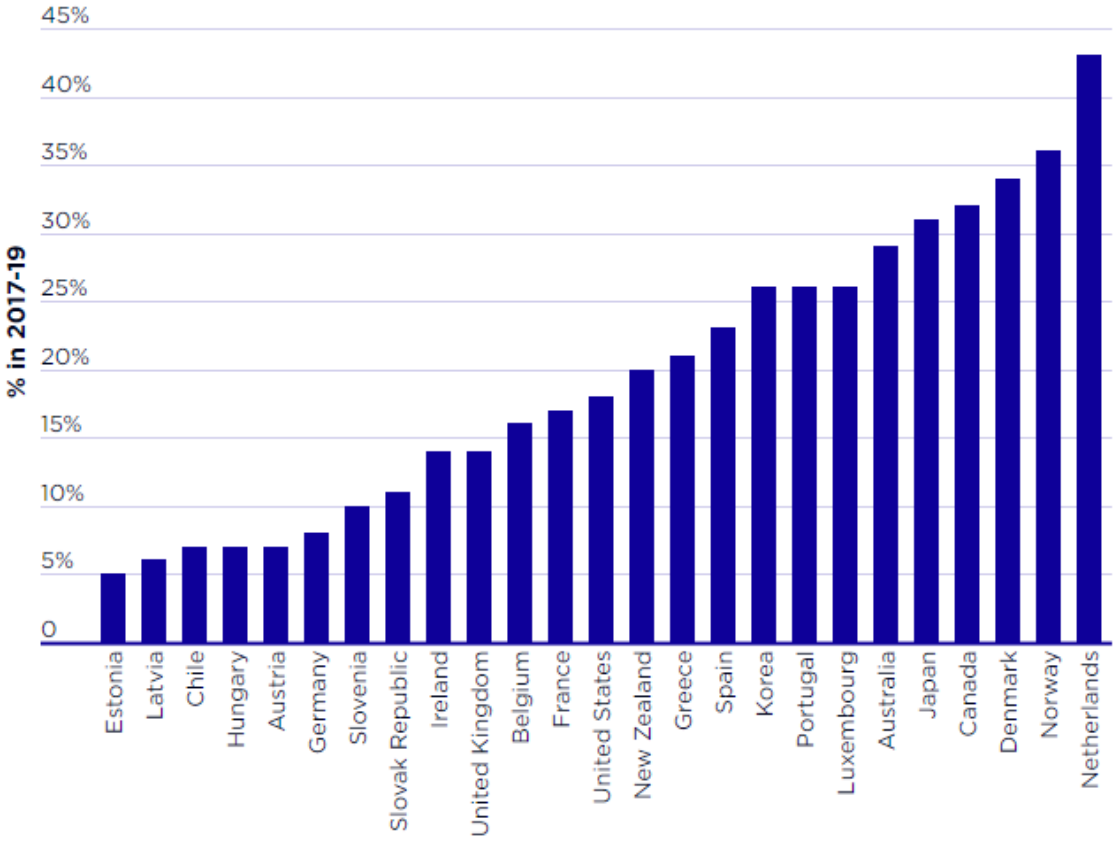


Figure A35 presents the percentage share of low-income households (in the lowest 40% by income) with debt at least 3 times their annual disposable income for 23 OECD countries. Australia ranks 6th highest among these 23 countries with 29% of low-income households over-indebted and at financial risk.[38] According to the ABS, 75% of households had debt in 2019-20.[32]

Wealth inequality

Wealth is distributed much more unequally than income. **Figure A36** presents ABS data on shares of household net worth by quintile in 2019-20. The lowest quintile held less than 1% of household wealth in 2019-20 and the highest quintile held 62.8%. The highest quintile had almost 90 times the household net worth of the lowest quintile. There is a marked social gradient in the distribution of wealth, even steeper than the gradient for income.

ACOSS' estimates of wealth inequality were similar to ABS estimates, finding the top 20% held average household wealth of $3.24 million in 2019-20, six times higher than the average household wealth of the middle 20% (the third quintile) and 90 times than the average household wealth held by the lowest 20% (an average of $36,000).[31] The top 5% were estimated to hold average wealth of $6.66 million.[31] ACOSS also found that the highest 20% by wealth held 82% of the overall value of all investment properties and 78% of all financial investments including shares.[31]

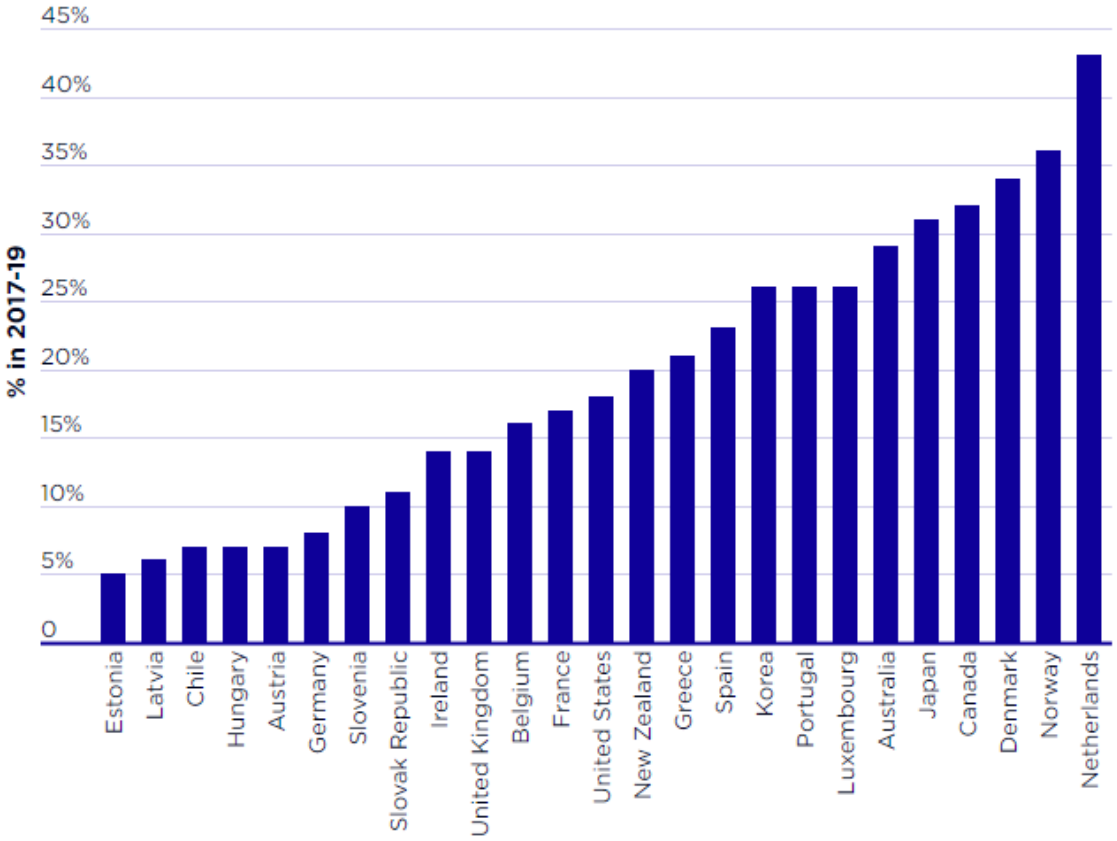


Figure A35: Share of low-income (bottom 40%) indebted households with debt-to-annual income ratio above 3 (% in 2017-2019) (Source: ACOSS Build Back Fairer Report 4 using OECD Wealth Distribution Statistics, 2022)[38]

Wealth compared across income quintiles is less unevenly distributed compared to wealth by quintile of wealth.[31] ACOSS estimated that the wealth of the highest 20% by income in 2019 was two and a half times the average wealth by income of the middle 20% (the third quintile) and three times the average wealth of the lowest 20%.[31] This lower inequality can be attributed to retirees with lower incomes having high levels of outright ownership of their homes which increases average wealth for the bottom 20% (younger people with low income in the bottom 20% would have much lower wealth).[31] Wealth from home ownership for low income retirees does not provide access to wealth that can be readily liquified when in need but outright home ownership does reduce housing costs.

Figure presents the distribution of household net worth in Australia in 2017-18 and 2019-20 (assets minus liabilities). This figure shows inequality in wealth using a visual of the whole distribution. The lowest 20% of households had a mean net worth of $35,100, much lower than the overall mean of just over $1 million. The mean net worth of the highest 20% of households was $3.27 million, more than 92 times the net worth of the lowest 20% of households.[32]

Wealth inequality is very high in Australia, and it has been getting worse. The average wealth of the top 20% grew ten times faster than the bottom 20% over the past 20 years.[27, p.23] A 2023 Actuaries Institute report found that just over half (53%) of Aboriginal and Torres Strait Islander people, 31% of people with a disability, 72% of the working age unemployed with dependent children and 52% of working aged unemployed with no dependent children were in the lowest household wealth quintile based in 2018 Household, Income and Labour Dynamics in Australia survey data.[27] The Australian

Financial Review reported on the Actuaries Institute report with the headline 'Australia's wealth gap on the rise with inequality worst since 1950'.[43]

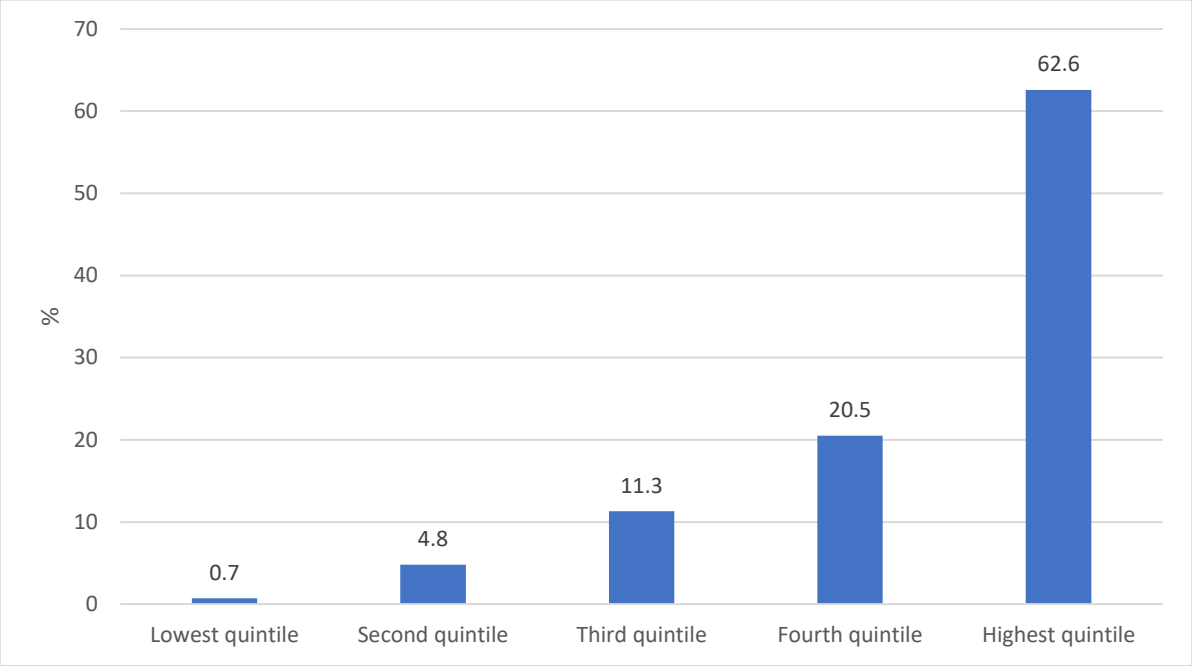


Figure A36: Share of household net worth by quintile (Source: ABS Survey of Income and Housing 2019-2020)[32]

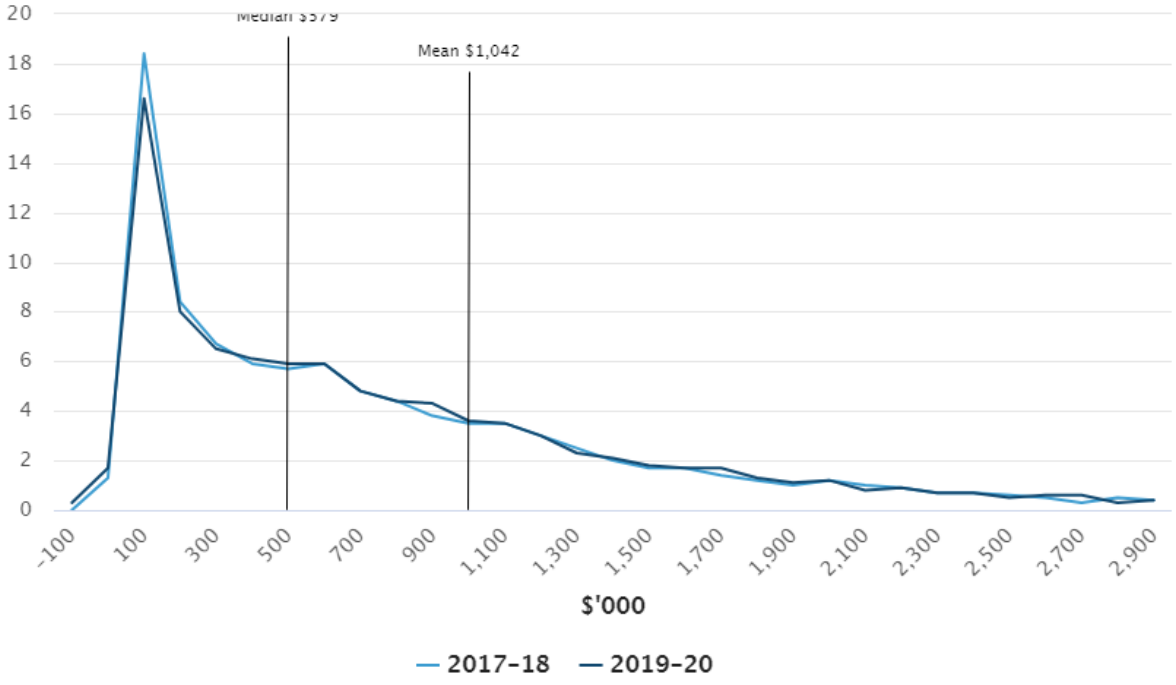


Figure A37: Distribution of household net worth, 2017-18 and 2019-20 adjusted to 2019-20 dollars (Source: ABS Survey of Income and Housing, 2019-20)[32]

Distribution of superannuation and benefits to minimise taxable income

A 2023 Anglicare report assessed the benefits Australians can use to minimise their taxable income, the total expenditure for each and the amount and percentage received by the bottom income quintile and the highest income quintile.[44] Table A11 shows the cost of forgone tax revenue and distribution of benefits. Expenditure on housing related tax reduction benefits (principle residence CGT exemption, CGT concession, and negative gearing) added up to $76.7 billion dollars in forgone tax revenue for 2022-23, with $42.8 billion (55.8%) benefitting the top quintile and only $3.9 billion (5.1%) benefitting the bottom quintile. Expenditure on superannuation benefits has no benefit for the bottom 20% and more than $25 billion in benefits for the top 20%. All of the benefits in Table A11 increase wealth inequality in Australia, with more than half of the benefits going to the top 20% for most benefits included in the table.

Table A11: Benefits and expenditures, recipients by income quintile, 2022-23 (Data source: Anglicare Australia A Costly Choice Report, 2023) [44]

Benefit	Total expenditure ($B)	Bottom 20% ($B)	Top 20% ($B)
Principle residence CGT exemption	$48	$3.36 (7%)	$20.64 (43%)
Superannuation - earnings	$21.5	$-0.06 (0%)	$12.47 (58%)
Superannuation - contributions	$23	$-0.07 (0%)	$13.34 (58%)
Capital gains tax concession	$23.7	$0.47 (2%)	$19.4 (82%)
Negative gearing	$5.06	$0.1 (2%)	$2.78 (55%)
Private health GST exemption	$5	$0.4 (8%)	$1.75 (35%)
Discretionary trusts	$2	$0 (0%)	$2 (100%)
Total	$128.26	$4.2 (3%)	$72.38 (56%)

Australia's 131 billionaires in 2021 comprised 0.001% of the population but held 2.9% of all household wealth in Australia, more than the 0.7% of wealth held by the lowest quintile of household wealth.[38] ACOSS estimates that Australia's billionaires held as much wealth between them as the 2.8 million households that represent the lowest 30% ranked by wealth.[38]

Wealth by Jurisdiction

ABS statistics on household income and wealth include measures of average (mean) household net worth and median household net worth. Table A12 presents data on these measures by jurisdiction for 2019-20. Victoria had the highest mean household net worth, followed by NSW and the ACT. Data for the NT is suggestive of lower relative mean household net worth. Tasmania had the next lowest mean household net worth, followed by Queensland.

Mean household net worth can overstate average wealth if it is skewed higher by a small number of extremely wealthy people. Median household net worth is not influenced by the very wealthy at the top of the distribution and provides an alternate measure of average wealth. The ACT had the highest median household net worth, much higher than all other jurisdictions. Victoria had the next highest median household net worth, followed by NSW. Data for the NT suggests relatively lower median household net worth. Tasmania had the next lowest median net worth, followed by Queensland, then SA.

Table A12: Mean and median household net worth by jurisdiction in 2019-20 ($'000s) (Data source: ABS Household Income and Wealth, 2019-20)[32]

	Mean household net worth	Median household net worth
NSW	1,187.1	674.2
Vic.	1,199.4	684.3
Qld	790.3	473.9
SA	917.8	475.8
WA	868.1	503.3
Tas.	779.0	470.5
NT[1]	735.5	425.4
ACT	1,116.2	817.2
Aus.	1,042.0	579.2

Notes: 1. Data for NT excludes households in SA1s defined as very remote which represent 21% of the NT population

As discussed in relation to national data, measures of average wealth mask inequities in the distribution of wealth. Data on the distribution are needed to assess which jurisdictions have relatively higher wealth inequality. Publicly available data on wealth by jurisdiction appears very limited. We have been unable to find publicly available data on the distribution of wealth by jurisdiction thus far.

Housing

Safe, secure, and affordable housing is protective for physical and mental health.[45] In Australia, government policy regarding generous tax breaks for property investors is playing a central role in contributing to income and wealth inequality.[46] The wealth section of this report highlighted the role of house prices in inflating wealth in Australia. Rising house prices in Australia have impacted on housing affordability and widen the income and wealth gap between those who own their home and those who are renting.

House prices and distribution of benefits from the capital gains tax discount

Figure A38 presents the average growth in house prices in Australia compared with average growth in wages from 1980 to 2020. Growth in house prices began to diverge from growth in wages in the late 1990s but increased sharply with the introduction of the capital gains tax (CGT) discount for sale of residential investment properties in 1999 and changes to increase the generosity of negative gearing.[47] Banking deregulation in the 1980-90s which included property investors being able to take interest-only loans also contributed to increasing house prices.[48] The average house price rose from 2.5 times annual household income in the 1990s to more than six times average annual household income in 2020.[47]

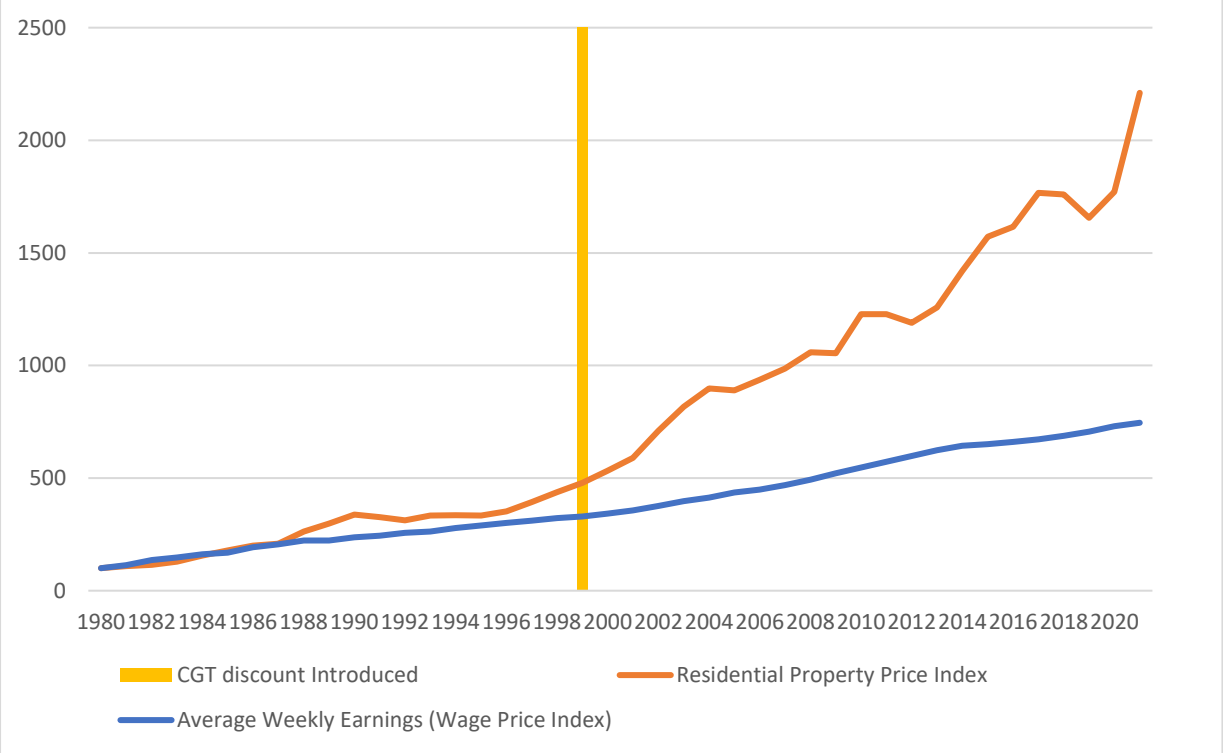


Figure A38: Changes in house prices and average weekly earnings, 1980 to 2021 (Data source: Centre for Equitable Housing National Housing and Homelessness Plan Submission, 2023[48])

The distribution of benefits from the capital gains tax (CGT) discount illustrates the role of this policy in contributing to housing inequality and perpetuating wealth inequality (**Figure A39**). The benefits from the CGT discount have largely gone to the highest household income decile, the wealthiest in Australia. At the time the CGT discount was introduced, a huge amount of money went into the property market and resulted in much higher house prices and land values.[47] The CGT discount was estimated in 2015-16 to cost around $6.2 billion per year in lost public revenue.[47] The effects of the distribution of the CGT discount and its impact on house prices has been a reduction in housing affordability and increase in wealth inequality.[47]

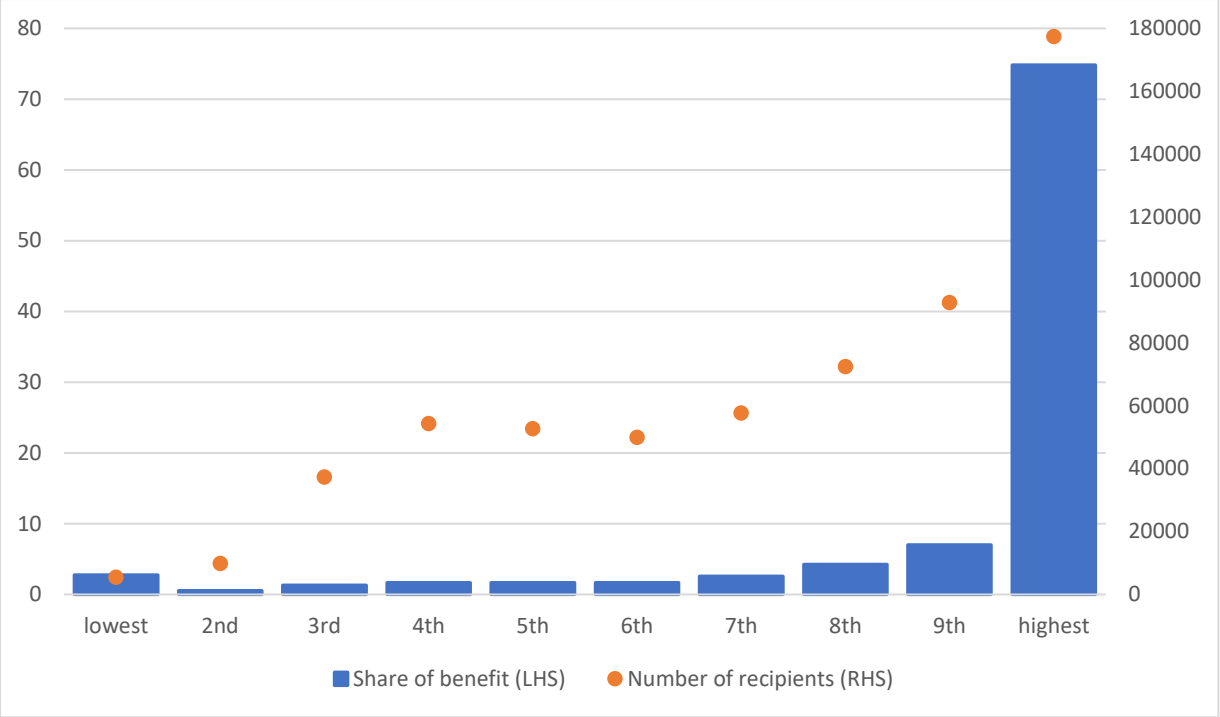


Figure A39: Distribution of capital gains tax discount effects and number of recipients by household income decile, 2019-20 (Data source: Centre for Equitable Housing National Housing and Homelessness Plan Submission, 2023[48])

Housing tenure

Figure presents the proportion of households by housing tenure type from 1994-95 to 2019-20. There was a steady decline in the percentage of households owning their home without a mortgage over this period, from 42.8% in 1995-96 to 29.5% in 2019-20. The percentage of households owning their home with a mortgage increased from 28.1% in 1995-96 to 36.8% in 2019-20 but the percentage of households renting from a private landlord also increased from 18.4% in 1994-95 to a high of 27.1% in 2017-18. The percentage of households renting public housing declined from 5.5% in 1994-95 to just 2.9% in 2019-20.

Private renters are a diverse group. The 2016 National Renters Survey jointly produced by National Shelter, Choice and the National Association of Tenant Organisations found that 48% of renters had a personal income of less than $35,000, 37% of renters were under the age of 35, and half of people aged 35-44 who were in private rental housing had been renting for more than 10 years (compared with 65% of people aged 45-64 and 58% of people aged 65 or over).[49] Just over half (51%) of renters were on a fixed-term one year lease.[49]

Social housing

The availability of public housing in Australia has declined since 1996. In 1996, 329,830 occupied dwellings in Australia were rented from the state or territory housing Authority (see

Table A83). In 2021, the number of occupied public housing dwellings had declined to 277,534. Public housing represents 72% of Australia's stock of social housing.[47] Base funding for social housing construction was cut by 24% from 1996 onwards, resulting in the rate of new social housing builds falling to 3% of total national residential construction.[47] This contrasts with the period from 1945 to 1970 when new social housing properties averaged 16% of total national residential construction.[47]

Between 1951 and 1996, there were between 8,000 and 14,000 social housing dwellings built per year.[50]

Growth in social housing has not kept pace with population growth. Social housing only grew by 4% from 1996 to 2016, while the total number of Australian households grew by 30%.[50] Lawson et al (2018) estimated in 2016 that there was a shortfall of 433,000 social housing dwellings in Australia, and after taking population growth into account by 2036 estimated that Australia will need 726,000 new social housing properties.[51] Lawson et al's (2018) prediction is supported by separate research from 2019 by the University of New South Wales's City Futures Research Centre, which calculated a very similar estimate of 728,600 new social housing properties needed by 2036.[52] Meeting these needs would require 36,000 new social housing dwellings per year every year.[47]

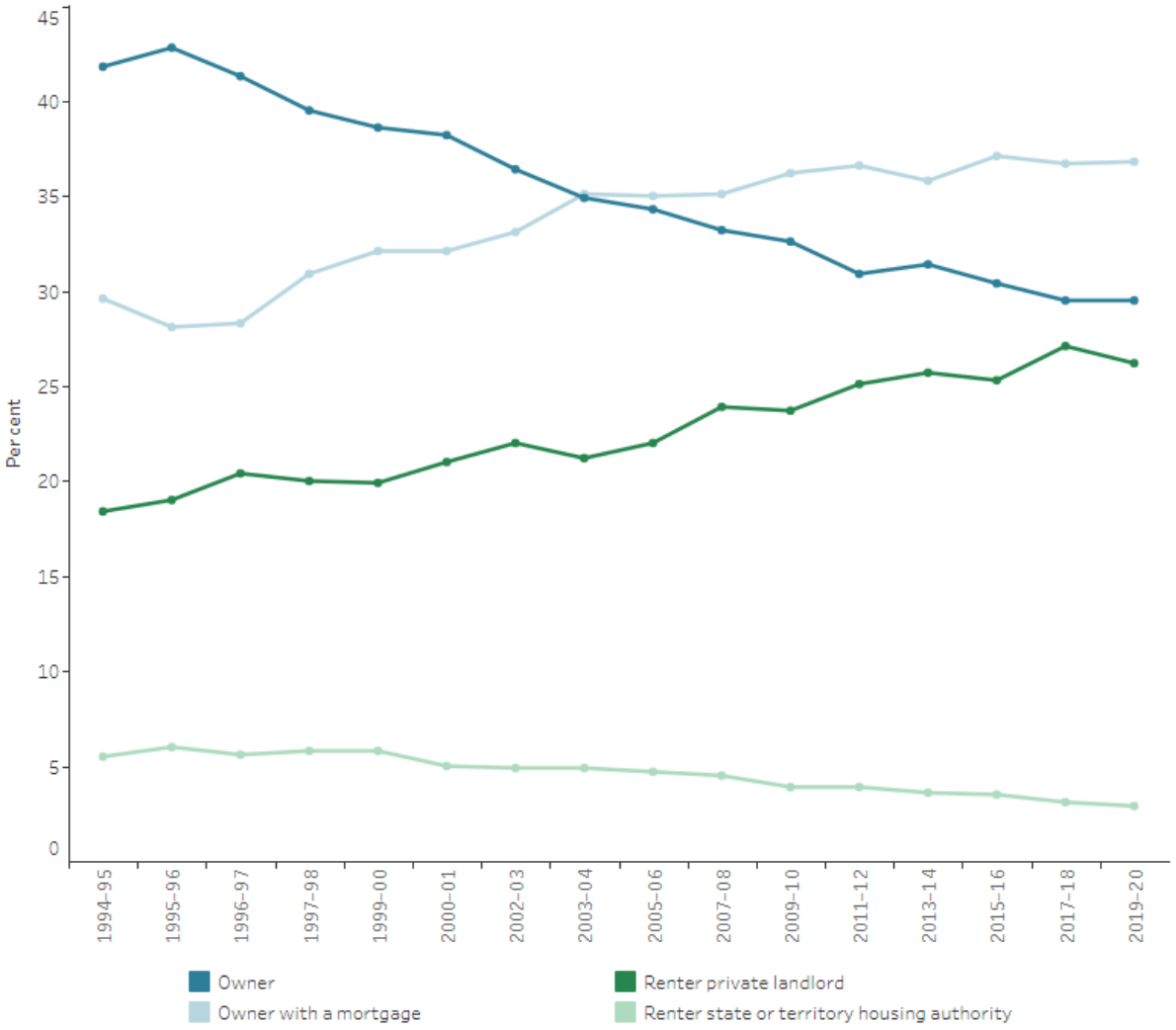


Figure A40: Proportion of households by housing tenure type, 1994-95 to 2019-20 (Data source: AIHW Home ownership and housing tenure[53] Figure A38, 2023)

Table A83: Count of Occupied Dwellings Rented from the State or Territory Housing Authority in Australia, 1996 to 2021 (Data source: Census of Population and Housing, Time Series Profile)[54]

	1996	2001	2006	2011	2016	2021
Australia	329,830	318,292	306,696	295,301	283,098	277,534

Australia's social housing stock was only 3.1% of total housing in 2017-18 compared with 5.8% in 1997-98.[47] Australia has a very low stock of social housing as a percentage of total housing stock compared with other OECD countries. In the UK, social housing represents 16% of total housing stock, and the comparable figure in Austria is 37.7%.[47]

Housing costs

Public housing rents depend on household income and composition and are 25 to 30% of the household's income. Community housing rents also depend on household income and composition and are 25 to 30% only for tenants with very low incomes. Social housing is provided for people on low incomes who are very unlikely to be able to afford private market rents in most areas, or who may have difficulty getting accepted for a private rental due to medical, age-related, or other forms of support needs.[55] The reduction in public housing dwellings and resulting shortfall of social housing has pushed many earning low incomes into the private rental market. The size of the private rental sector grew as shown in **Figure** , and the increase from 18.4% in 1994-95 to 26.2% in 2019-20 is large.

Figure A261 presents mean weekly housing costs in Australia from 1999-2000 until 2019-20 by tenure and landlord type. People who own their home without a mortgage have minimal housing costs. The difference in average housing costs for people renting public housing and people renting from a private landlord was large even in 1999-2000. The gap became even larger as average housing costs rose by more for those renting from private landlords than for people renting public housing. The lowest average housing costs were for people who owned their home without a mortgage.

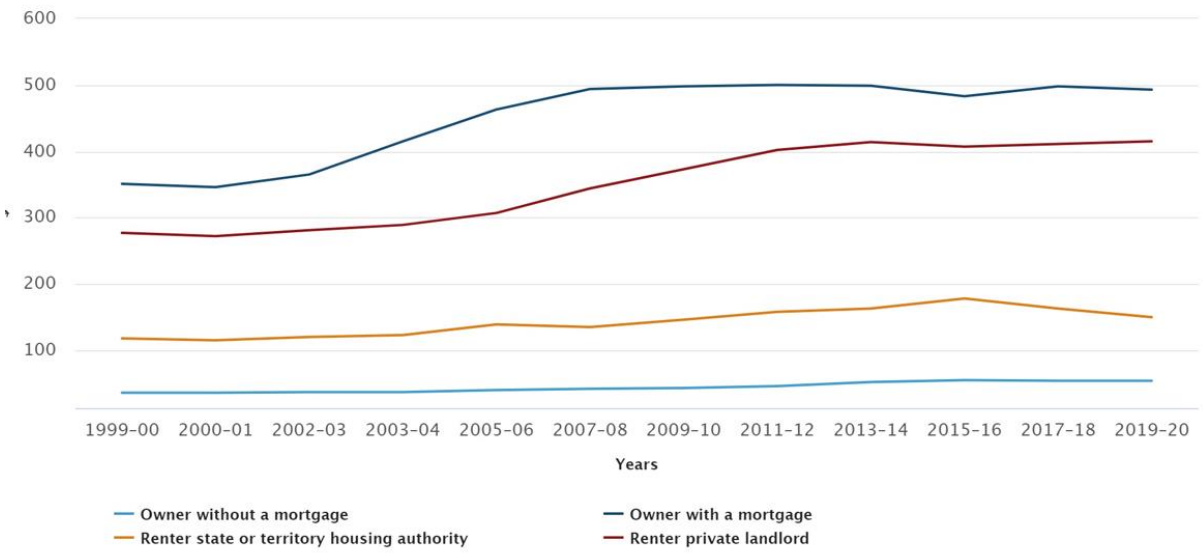


Figure A261: Mean weekly housing costs in 2019-20 dollars by tenure and landlord type, 1999-2000 to 2019-20 (Data source: ABS Housing Occupancy and Costs, 2019-20)[56]

Housing costs are a higher percentage of disposable household income for lower income quintiles (

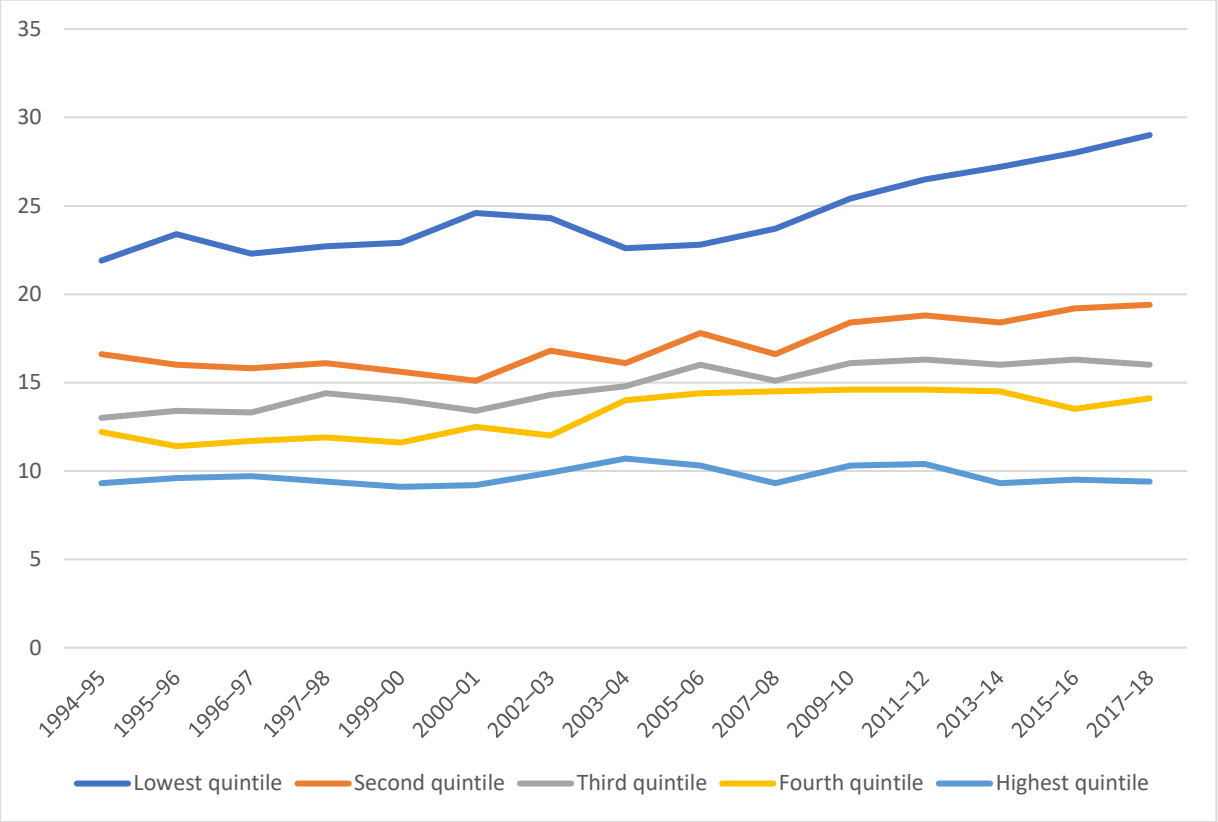


Figure A4). Housing costs as a percentage of disposable household income are lowest for the highest income quintile and remained around 10% from 1994-95 until 2017-18. Housing costs increased by around 2 to 3% for the fourth quintile, the third income quintile and second income quintile. Housing costs increased the most for the lowest income quintile, rising from 22% in 1994-95 to 29% in 2017-18. This increase in housing costs has coincided with the decrease in social housing (particularly public housing) and increase in the size of the private rental sector.

Estimates of housing costs as a percentage of income for the lowest 40% of households were higher in ABS data compiled for the Interim Economic Inclusion Advisory Committee 2023-24 report to the Australian Government.[57] The Interim Economic Inclusion Advisory committee reported that housing costs as a percentage of income were an average of 26% for the lowest income households in 1984, and were around 33% in the years prior to the pandemic.[48, 57] Households experience housing stress when housing costs are more than 30% of disposable household income. In recent years the average low income household was in housing stress.[57]

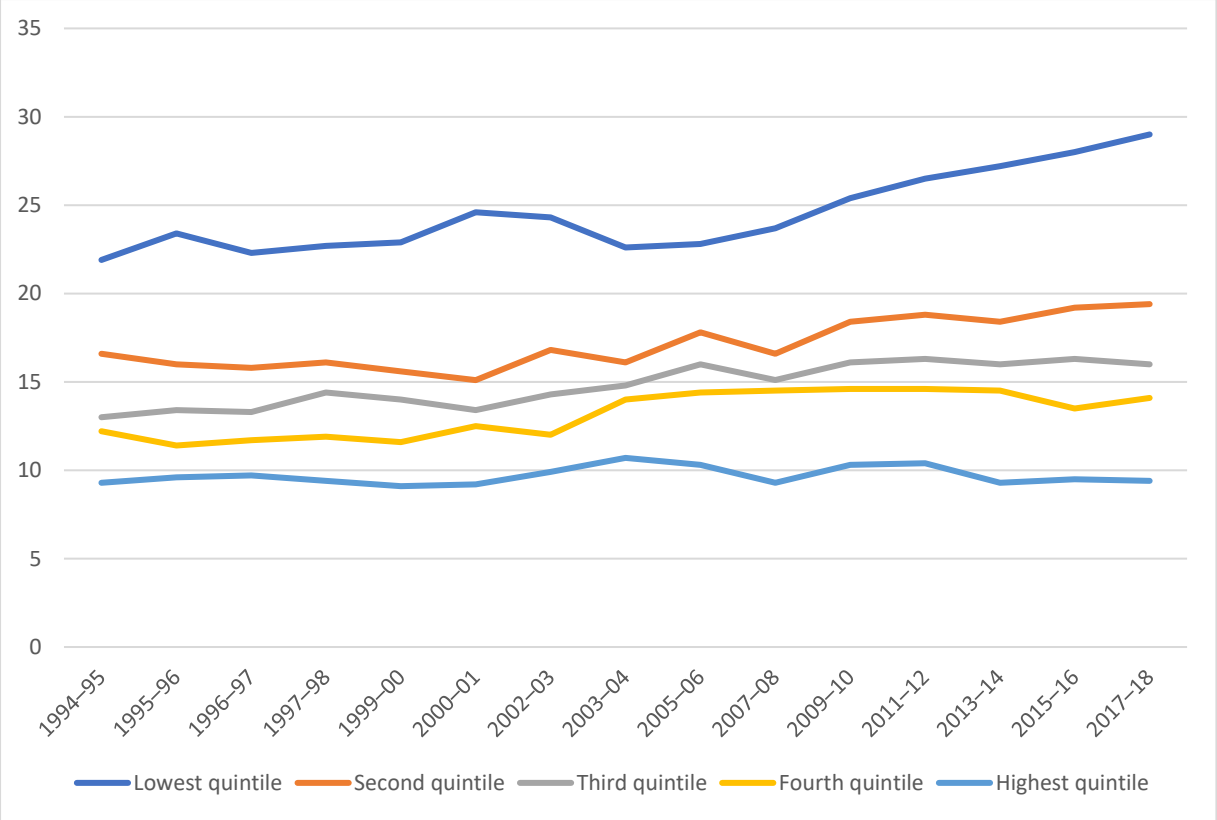


Figure A42: Housing costs as a percentage of disposable household income, 1994-95 to 2017-18 (Data source: Per Capita Housing Affordability in Australia report, 2022)[47]

Benefits of social housing

The National Social Housing Survey asks social housing tenants about the benefits of living in social housing, listing 10 nominated benefits that tenants can select yes, no, or not applicable as to whether tenants consider these to be a benefit. **Table** presents results from the 2018 and 2021 surveys. A very large majority of between 93.2% and 98.3% reported deriving a benefit from social housing. More than 95% reported improved wellbeing as a benefit of living in social housing in 2021, and the proportion was even higher for economic participation. The proportion reporting improved social connection was also more than 90%.[58]

Table A14: Proportion of social housing tenants self reporting that they experienced improved wellbeing, social connection and economic participation through living in social housing, Australia (Data source: Report on Government Services, 2022[58])

		% in 2018	% in 2021
Public housing	Wellbeing	95.6	95.7
	Social connection	92.5	93.2
	Economic participation	97.5	96.8
State Owned and Managed Indigenous Housing	Wellbeing	96.3	97.1
	Social connection	96.3	94.9
	Economic participation	97.3	98.3
Community Housing	Wellbeing	94.1	95.0
	Social connection	92.0	93.3
	Economic participation	95.9	95.7

Housing affordability

The Demographia International Housing Affordability report calculates international housing affordability based on a price-to-income ratio, national median house price divided by pre-tax median household income.[4] In 1990, housing in Australia was rated as affordable (a price-to-income ratio of 3.0 or less, see **Figure**). Demographia rates housing as moderately unaffordable if the price-to-income ratio is between 3.1 and 4.0, seriously unaffordable if price-to-income ratio is between 4.1 and 5.0, and severely unaffordable in price-to-income ratio is above 5.0. Housing in Australia has been rated as severely unaffordable since the early 2000s.[59] The ratio of median house price to median household income rose from 6.9 in 2019 to 8.2 in 2022.

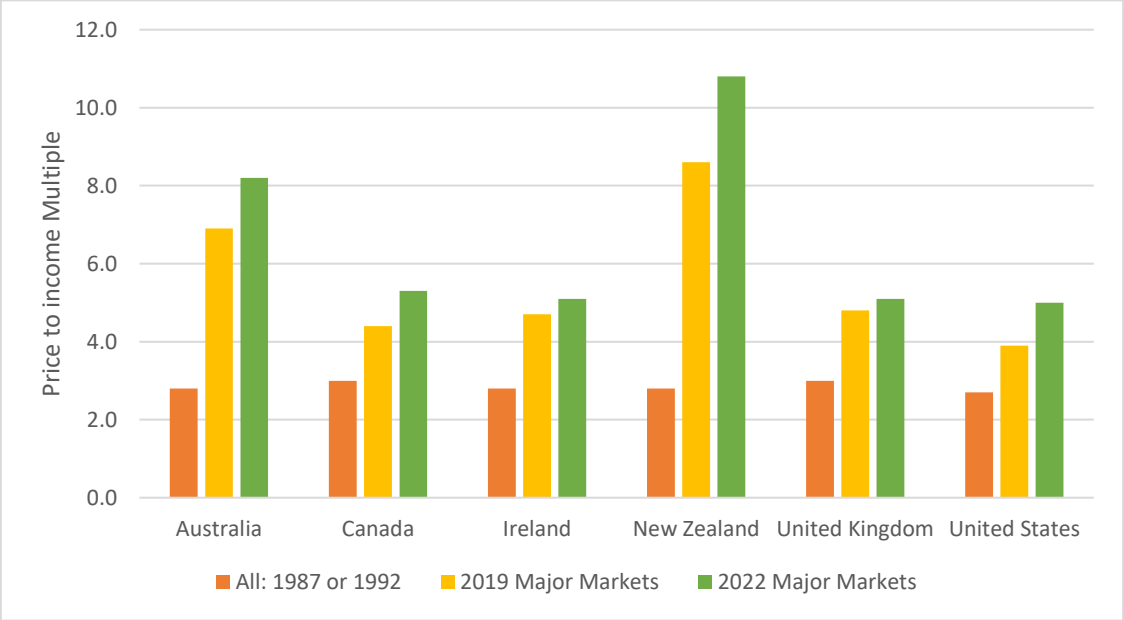


Figure A43: International House Price-to-Income Ratios 1987/1992 to 2022 (Data source: Demographia International Housing Affordability report, 2023[59])

The use of negative gearing (which allowed property investors to gain a tax deduction on housing loans) increased after the introduction of the CGT discount. The combination of negative gearing and the CGT discount provided an incentive for investors to move their cash into the property market in pursuit of capital gains with the negative gearing system acting as a subsidy on this investment.[47] Revenues forgone from all rental property tax deductions were $24.4 billion in 2022-23.[48]

[4] The Demographia price-to-income ratio differs from the Per Capita price-to-income ratio due to different data sources and difference measures used to calculated the ratio (e.g. Demographia uses the median and Per Capita used the mea n).

The benefits from negative gearing are concentrated among high income earners (

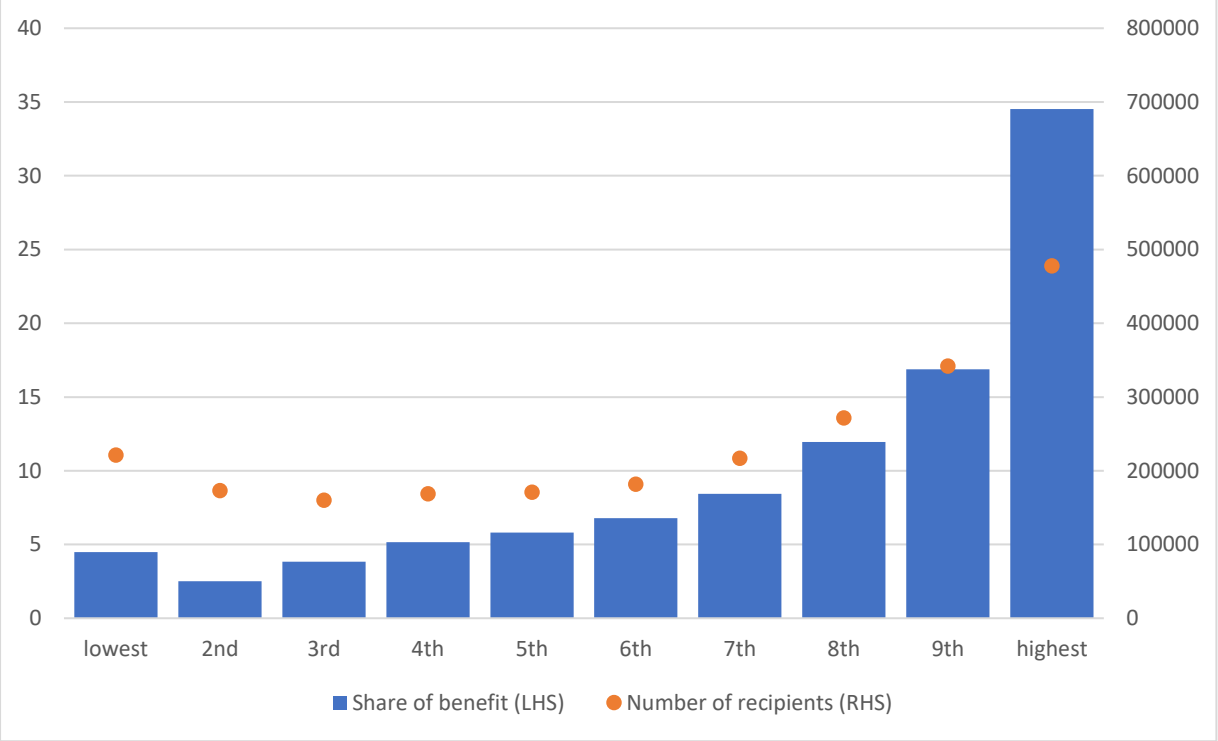


Figure). The top income quintile (income deciles 9 and 10) received 51.4% of the benefits of negative gearing in 2019-20. The bottom 50% of income earners received only 21.8% of the benefits. The combination of the CGT discount and negative gearing transfers wealth from the general population to the wealthiest households, and from young to old.[47] These tax concessions have not just pushed first home-buyers out of the property market, they have undermined security of tenure for renters. The CGT discount and negative gearing provide an incentive to pursue short-term capital gains instead of longer-term reliable income streams from rental properties.[47] Long term tenures are rarely available in the private rental market.

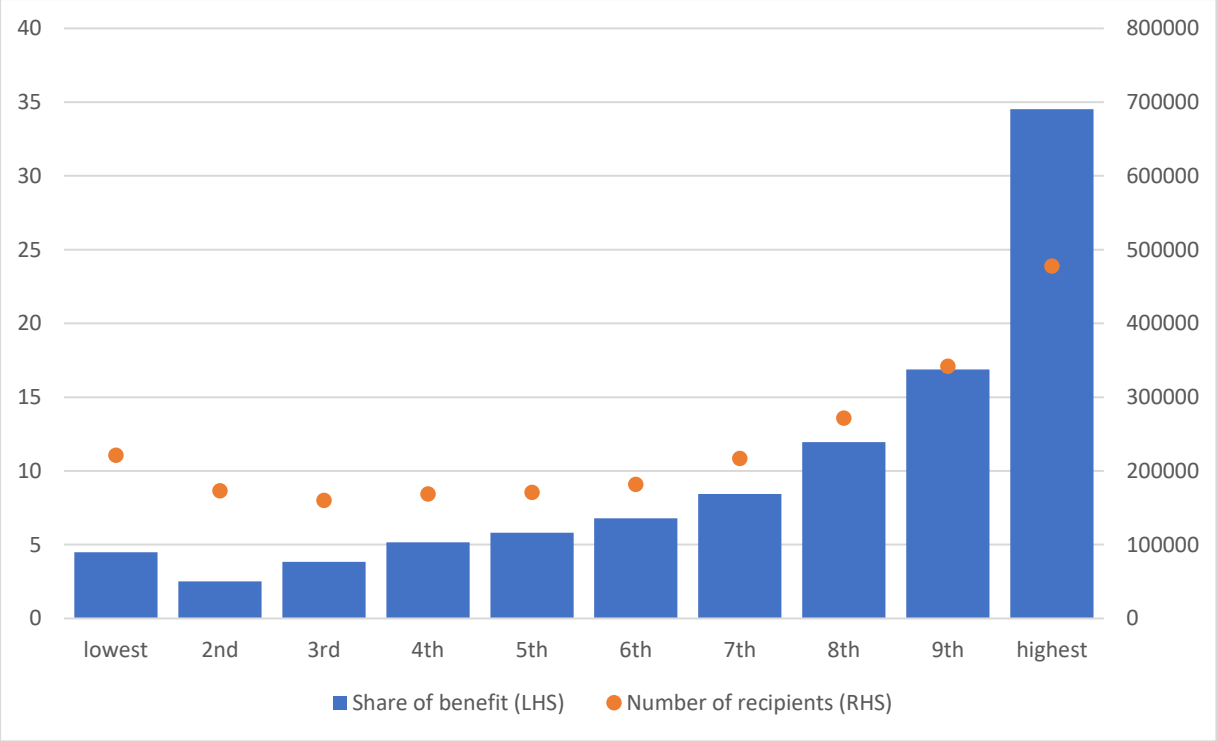


Figure A44: Distribution of negative gearing benefits and number of recipients by household income decile, 2019-20 (Data source: Centre for Equitable Housing National Housing and Homelessness Plan Submission, 2023[48])

Home ownership rates

The result of mechanisms such as the CGT discount and negative gearing and the impact of these on house prices is lower home ownership rates for successive birth cohorts (**Figure**). The home ownership rate for 30-34 year old's was 64% in 1971, and was 50% in 2021. The home ownership rate for 25-29 year old's was 50% in 1971 and was 36% in 2021. Home ownership rates for Australians born in 1947-1951 were 54% in 1976 (when they were 25-29) and rose to 82% in 2021 (when they were 70-74). Home ownership rates of people born in 1992-1996 was 36% in 2021, 18 percentage points lower than home ownership rates for the 1947-1951 cohort when they were the same age.[53]

The rate of home ownership for Aboriginal and Torres Strait Islander people was 42% in 2021 (the non-Indigenous rate of home ownership was 67% in 2021).[53] Home ownership rates for Aboriginal and Torres Strait Islander people have steadily increased from an estimated home ownership rate of 25% in 1981. Home ownership rates for Aboriginal and Torres Strait Islander people have increased for each successive birth cohort but remain consistently around 20 percentage points lower than home ownership rates for non-Indigenous people across age groups and birth cohorts.[53]

There are also gender gaps in home ownership rates (see

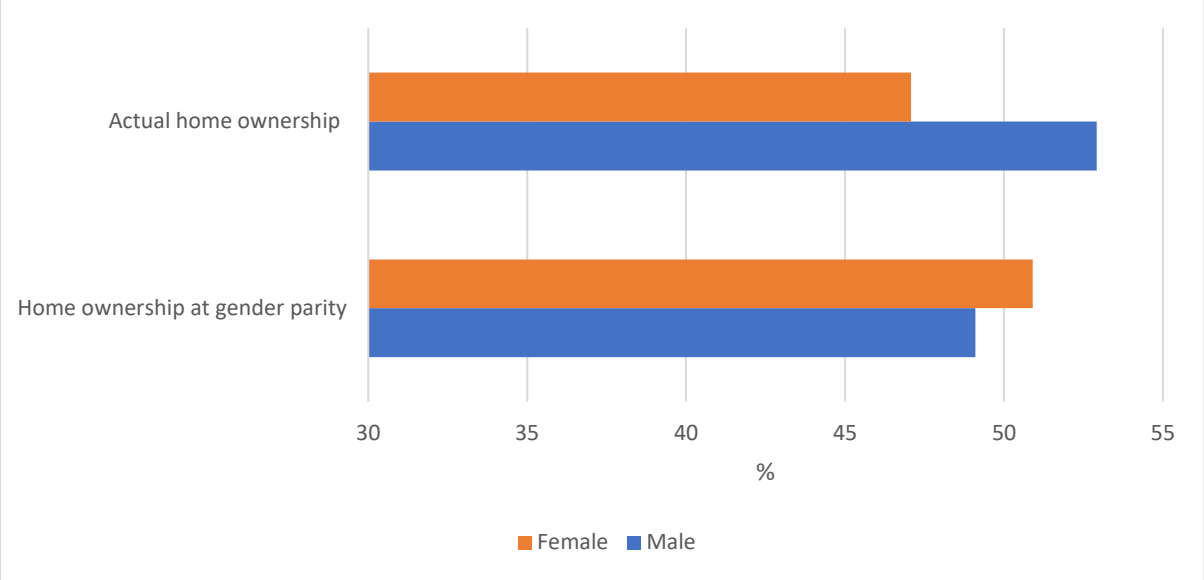


Figure A). Australia-wide, 56.5% of houses are owned by a single person.[47] Of these properties, men owned 52.9% in 2021 and women owned 47.1%. Women make up 50.9% of the population, therefore women own an estimated 100,000 fewer homes Australia-wide than in a gender-equal society.[47] Women report significantly higher housing related financial difficulties than men, whether renting or with a mortgage.[60] Women are more likely to be a private sector renter, less likely to own a house as an owner-occupier, and less likely to own an investment property.[60] Women who do own property are more likely to be experiencing mortgage stress compared with men (more than 1 in 4 women experience mortgage stress compared with less than 1 in 5 men).[60] Women also buy their home later and pay off their mortgage at an older age compared with men.[60]

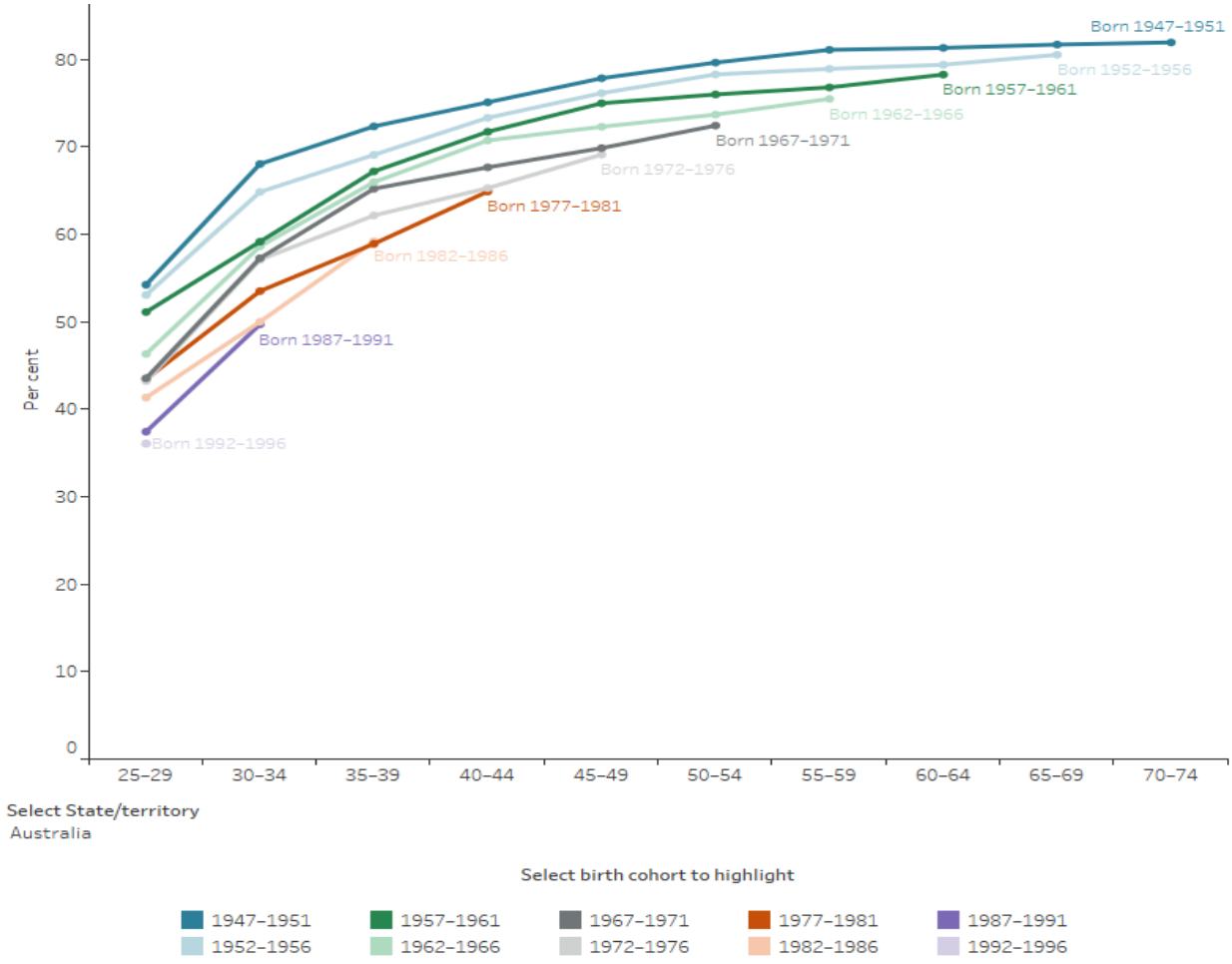


Figure A45: Home ownership rate by birth cohort and age group (Data source: AIHW Home ownership and housing tenure, 2023[53])

The reduction in home ownership rates by birth cohort increased the proportion of Australians renting, but the degree of increase differed by age group. **Figure** presents the proportion of households renting by age group from 1996 to 2021. The increase in the proportion renting was sharper for younger Australians, the increase was smaller among Australians aged 55 and over.[53]

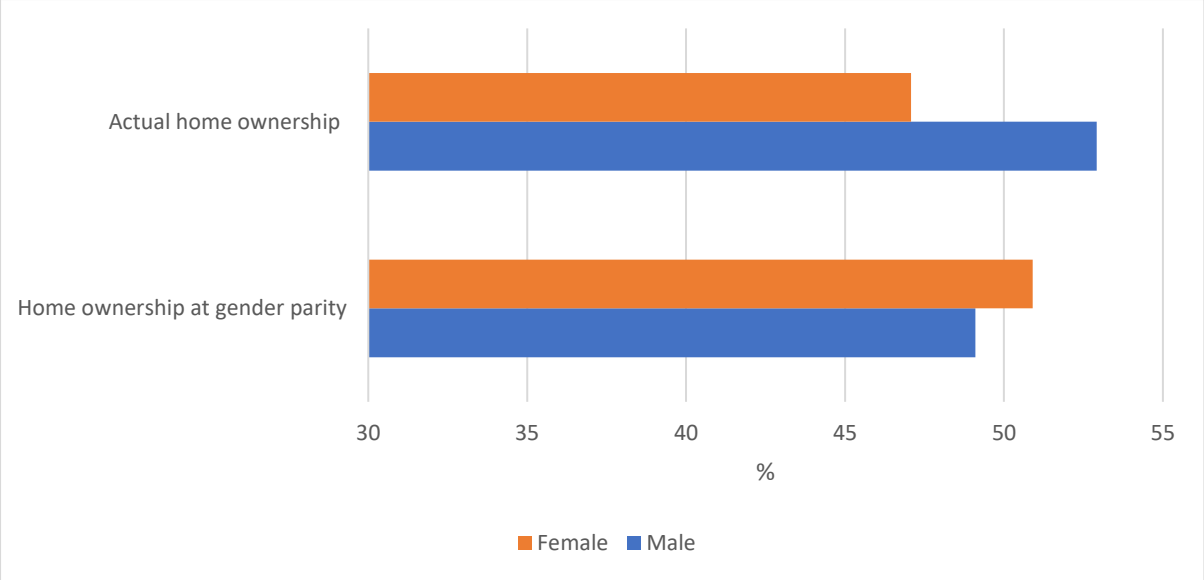


Figure A46: Home ownership by gender (Data source: Per Capita Housing Affordability in Australia report, 2022[47])

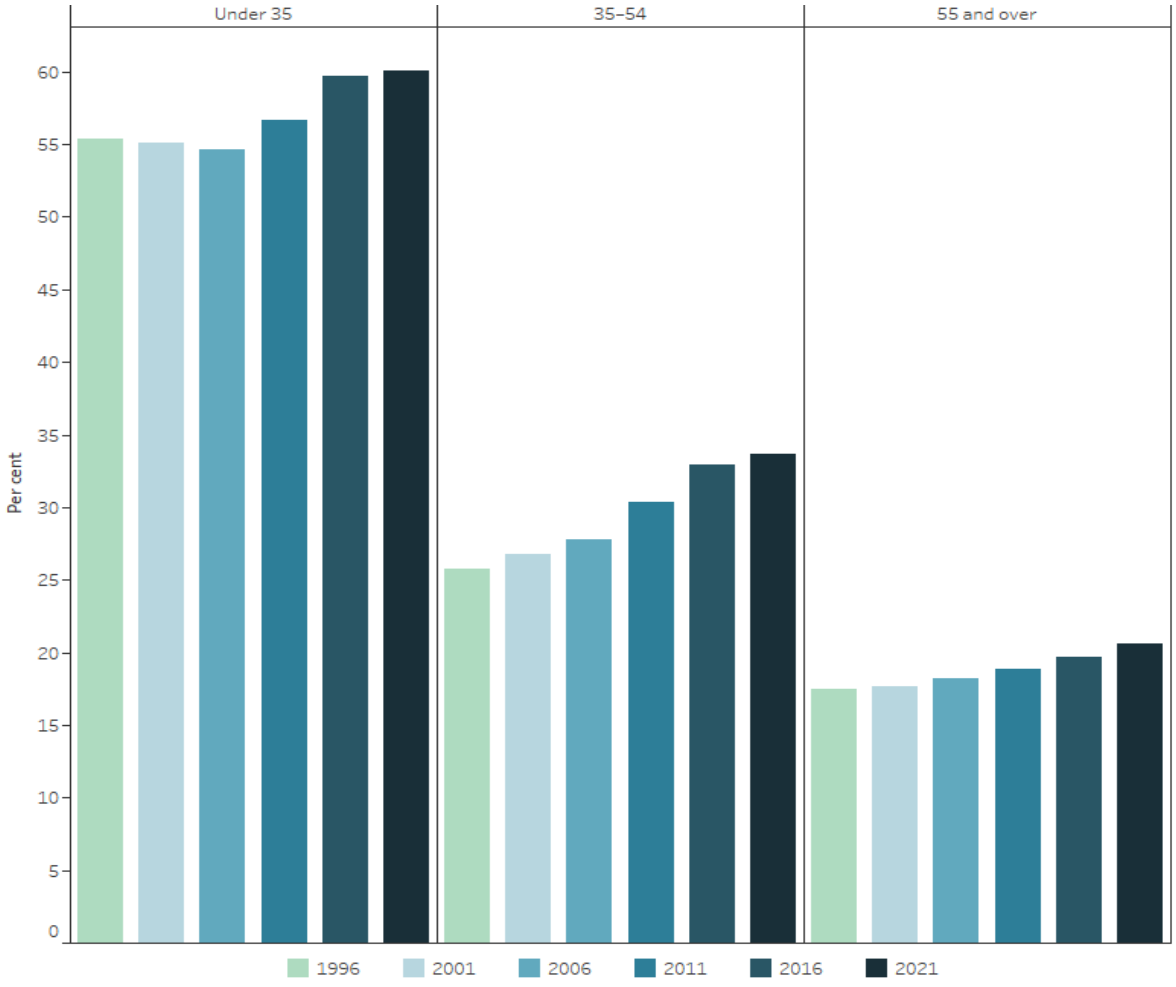


Figure A47: Proportion of households renting, by age of household reference person, 1996 to 2021 (Data source: AIHW Home ownership and housing tenure, 2023[53])

Growth in house prices and rents

Median house prices rose by 31% in the two years following the onset of the COVID-19 pandemic, and rents in many parts of Australia grew by a third.[47] **Figure** presents median weekly rent value from 2006 to 2023. Median rent value increased steadily at a low, stable rate from 2006 until early in 2020, then increased sharply from September 2020 until April 2023. CoreLogic estimated an average annual growth rate of 2.1% nationally from early 2010 to early 2020. The growth rate increased to more than 10% in 2022.[61]

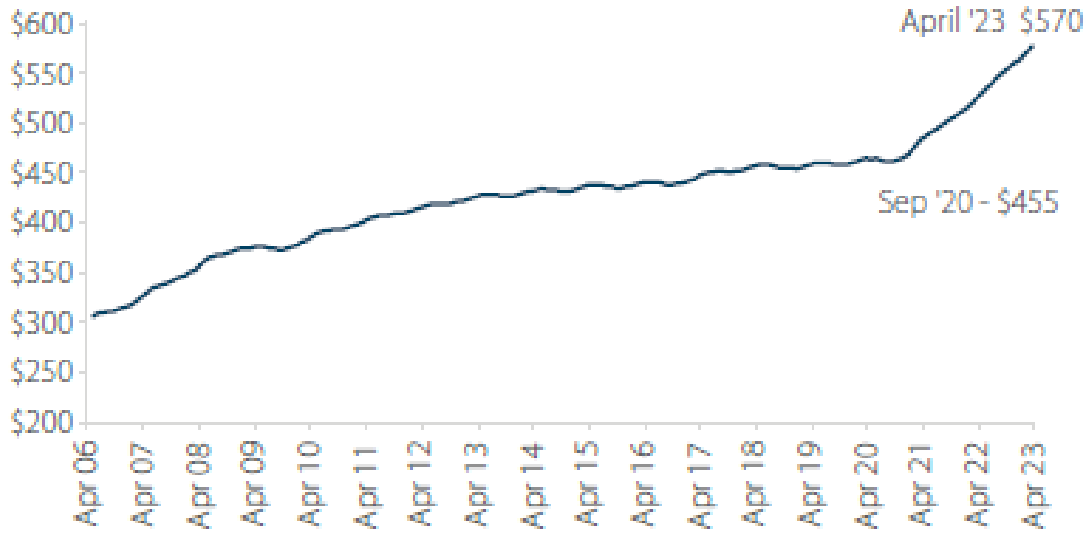


Figure A48: Indexed median weekly rent value from 2006 to 2023, Australia (Data source: ANZ/CoreLogic Housing Affordability Report 2023[61])

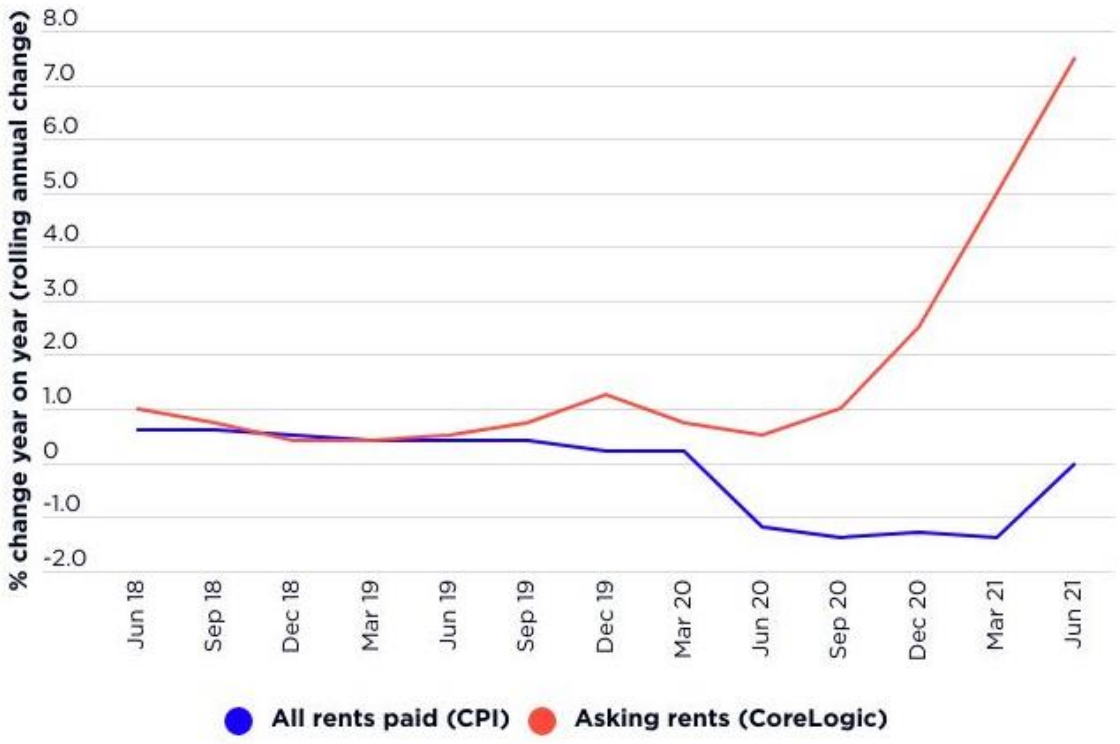


Figure A49: Rent trends, 2018-2021, Australia (Data source: ACOSS, 2021)[62]

Figure A49 presents the trajectories of CPI 'all rents paid' and 'asking rents' (advertised rents which are the asking price for vacant properties) from prior to the pandemic through to mid-2021. In 2020-21 there was a large divergence in the trajectories. It began as a small temporary decline in 'all rents' at the beginning of the pandemic (likely an outcome of tenant-landlord negotiations) and from June 2020 asking rents increased sharply. All rents began to increase as well in March 2021.

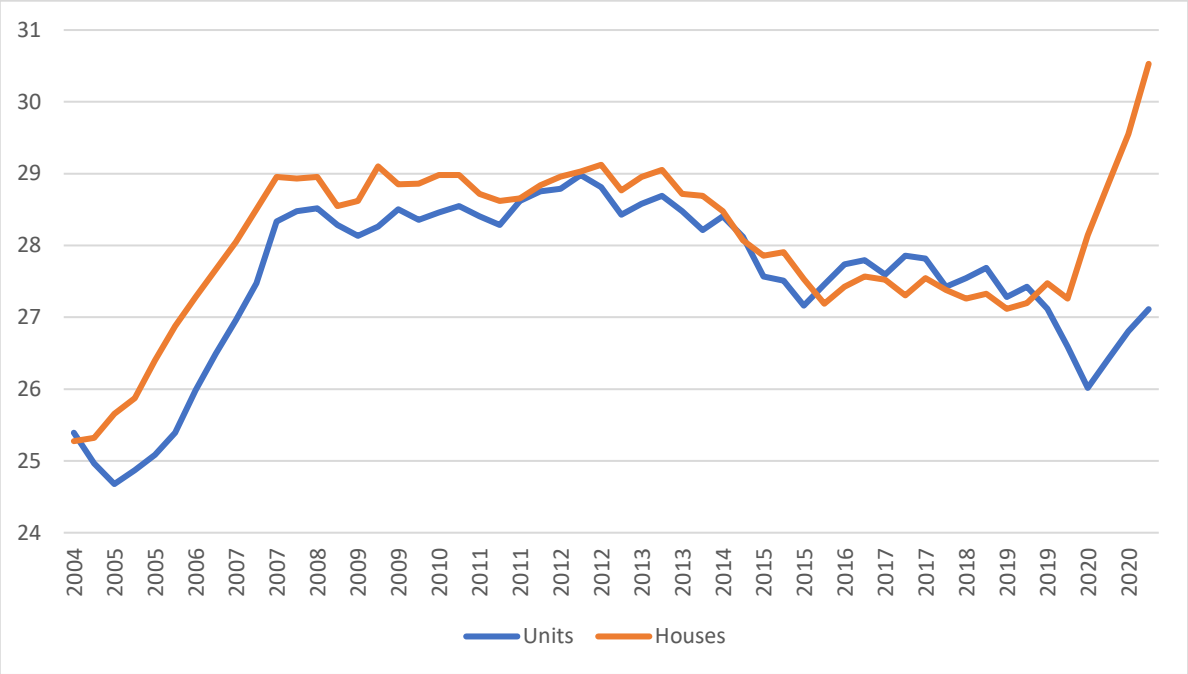


Figure A50: House and unit rental costs as a proportion of income (Data source: Per Capita Housing Affordability in Australia report, 2022[47])

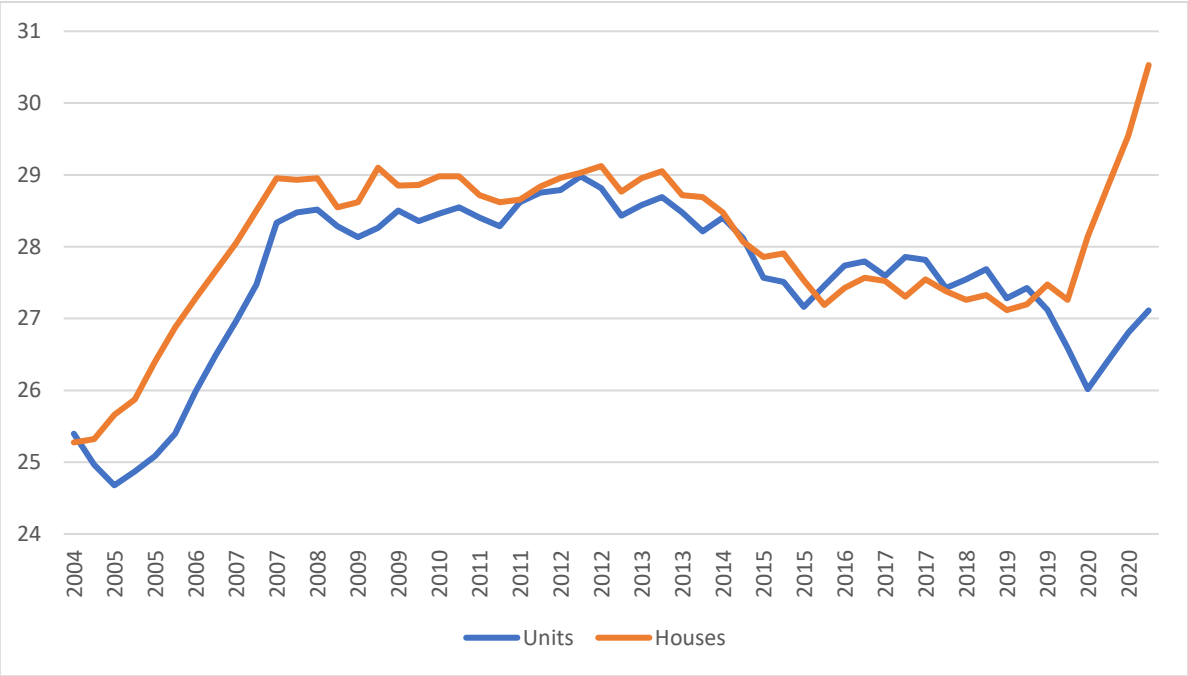


Figure presents median house and unit rental costs as a proportion of income from 2005 until 2020. There was a moderate increase in average affordability in the late 2010s, however it should be noted that median rental costs hide the rising cost of rent for those on low incomes. Median house rental

costs spiked with the onset of the pandemic to more than 30% of income, the highest ever rate and a rate that puts the average renter in a house in rental stress.[47]

The number of people on low income reporting rental stress (30% or more of their disposable income spent on rent) rose from 48% in 1994-95 to 54% in 2017-18.[47]

Jurisdiction analysis: Housing

There are five major housing markets in Australia: Sydney, Melbourne, Brisbane, Adelaide, and Perth. All five of these housing markets have been severely unaffordable since the early 2000s, with price-to-income ratios above 5 (see **Figure A527**). Demographia ranked 94 metropolitan housing markets from most affordable to least affordable in their International Housing Affordability report. Sydney had the least affordable housing market in Australia in 2022, but it was also the second least affordable internationally in 2022 ranking 93rd out of the 94 housing markets. Melbourne was the 86th least affordable, Adelaide was ranked 81st, Brisbane 78th, and Perth 50th. The price-to income ratios in 2022 were 13.3 for Sydney, 9.9 for Melbourne, 8.2 for Adelaide, 7.4 for Brisbane and 5.4 for Perth .[59]

Australia's major housing markets have become more unaffordable since the 1980s. Figure A51 shows the high rises in the price-to-income ratio from the 1980s through to 2022 in the five Australian capital city housing markets included in Demographia's analysis. The rate of rise in median multiple (price-to-income ratio) was high for Sydney over this period, but increases in other capital city housing markets were also high considering the lower price-to-income ratios in 1981 in all other capital cities compared with Sydney. The housing affordability losses were severe following the onset of the COVID-19 pandemic. Median house prices in Adelaide rose by 6.1 times the rate of inflation from 2020 to 2022, Sydney house prices increased by 6.0 times the rate of inflation, Brisbane 5.2 times the rate of inflation, Melbourne by 4.9 times and in Perth house prices rose by 4.2 times the rate of inflation.[59]

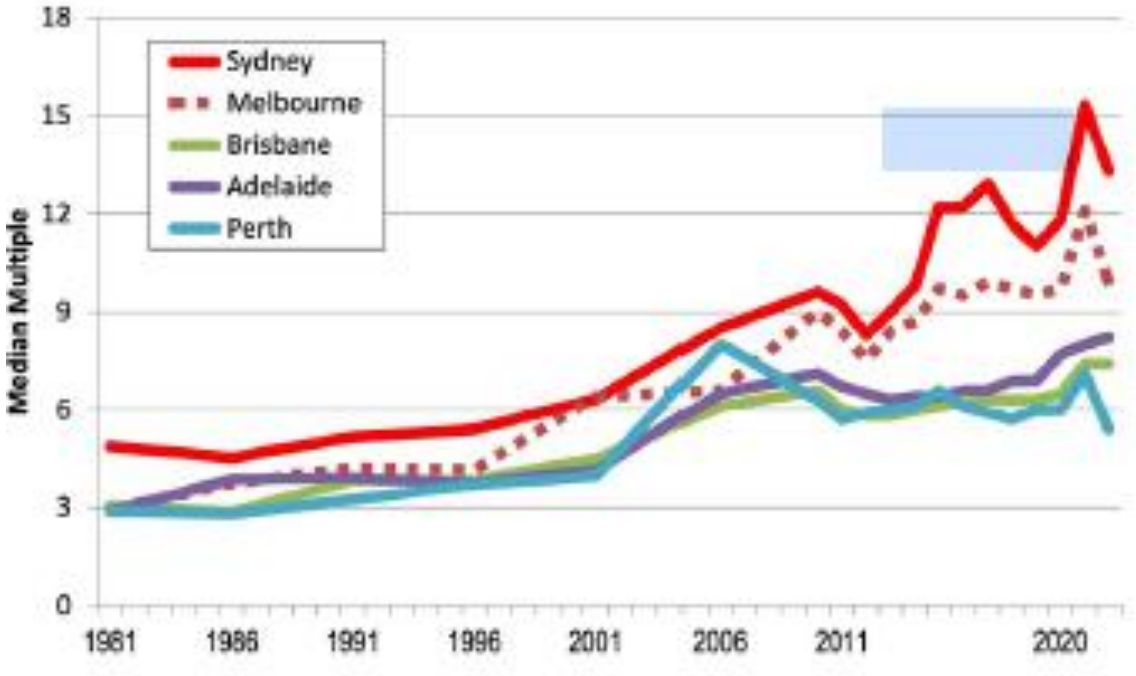


Figure A527: Price-to-income ratio for Australian capital city housing markets 1981-2022 (Data source: Demographia International Housing Affordability report, 2023[59])
Note: the median multiple is the price-to-income ratio: median house price divided by pre-tax median household income

The average national and capital city increase in rental prices was 14% for houses and 8.5% for units between March 2021 and March 2022. The highest increase in unit rental costs was 17.3% in Darwin, followed by 11.9% in Canberra, and 10.9% in Perth. The highest increase in rental costs for a house was 19.5% in Brisbane, followed by 17.1% in Sydney, 16.4% in Canberra, and 15.6% in Adelaide. National residential property rental vacancy rates fell to 1.2% in February 2022 which is a 16-year low. The increase in rental costs and very low vacancy rates represent a national rental crisis.[47]

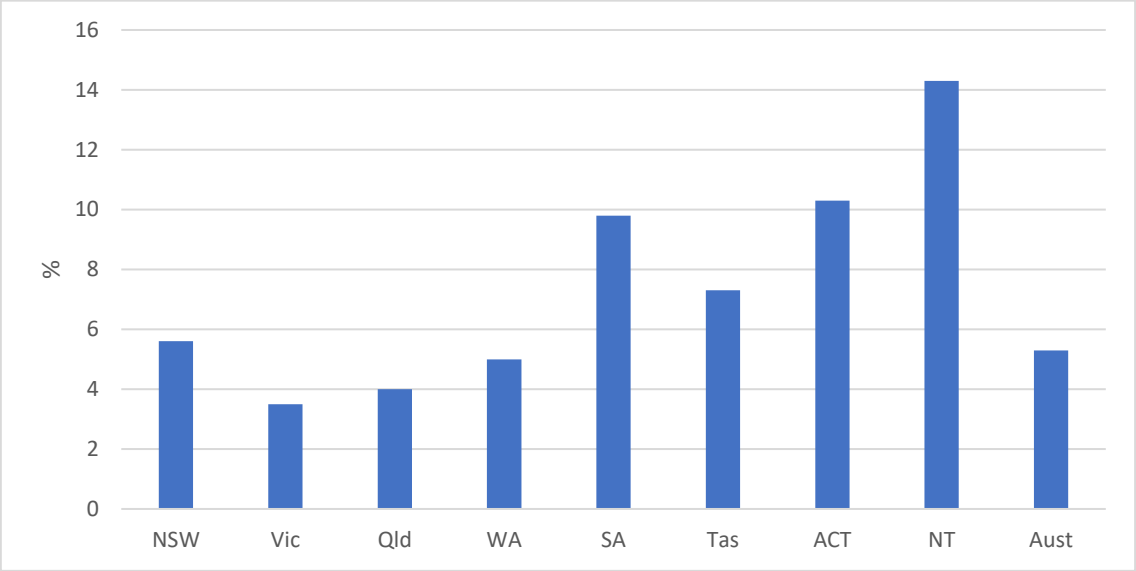


Figure A52 presents the proportion of households residing in public housing in 1996. The national average was 5.3%, and the proportion residing in public housing was above the national average in the NT, ACT, SA, Tasmania, and NSW. The stock of public housing in 1996 provided affordable housing to people on low incomes, giving them safe and secure accommodation.

Table A15 presents Census data on the number of occupied public housing dwellings in each state and territory from 1996 to 2021. Queensland is the only jurisdiction where there was an increase in the number of occupied public housing dwellings according to Census data. The largest decline in occupied public housing dwellings was in South Australia, but there were also large declines in the number of occupied public housing dwellings in Tasmania, NSW, and the ACT. Public housing also declined by a smaller proportion in WA and Victoria. In the NT, the number of occupied public housing dwellings declined from 1996 to 2006 but began increasing again so that the number of occupied public housing dwellings in 2021 was almost the same as in 1996.

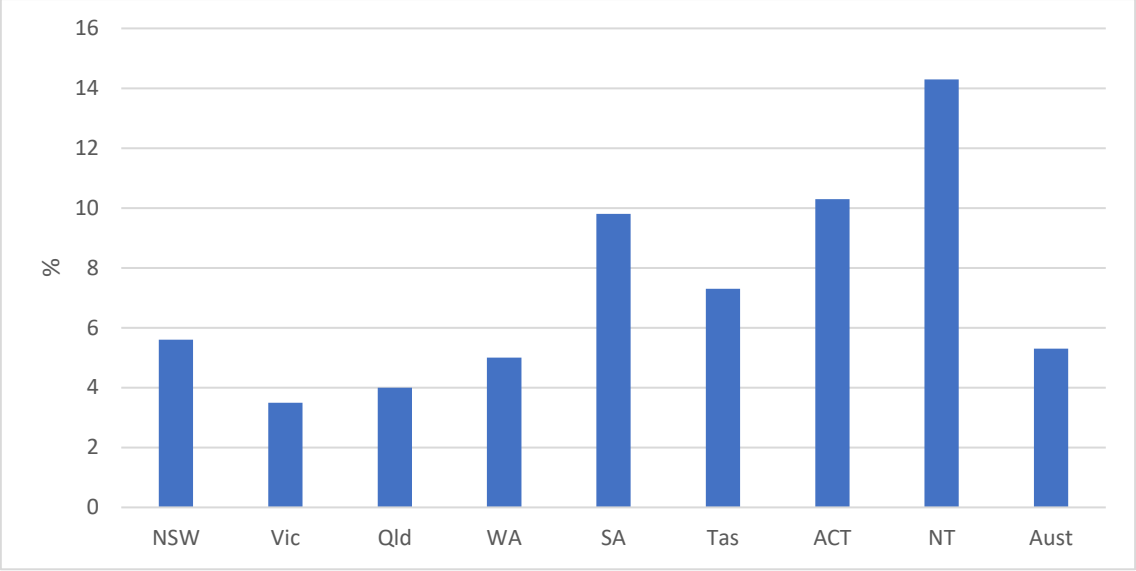


Figure A52: Households residing in public housing, 1996 (Data source: Report on Government Services, 1999[63])

Table A15: Count of Occupied Dwellings Rented from the State or Territory Housing Authority in Australia, 1996 to 2021 (Data source: Census of Population and Housing, Time Series Profile)[54]

	1996	2001	2006	2011	2016	2021
NSW	117,692	114,606	109,494	102,344	99,337	93,563
Vic	51,713	55,024	54,971	51,336	48,737	49,793
Qld	45,721	47,378	48,225	50,627	50,013	50,729
SA	53,023	44,758	40,475	35,720	31,955	29,591
WA	30,754	29,457	28,900	29,750	29,139	28,645
Tas	12,406	11,639	10,452	9,914	8,881	8,946
NT	7,494	5,307	4,710	6,544	6,779	7,474
ACT	10,738	9,884	9,310	8,922	8,142	8,655
Australia	329,830	318,292	306,696	295,301	283,098	277,534

The data presented in Table A15 provides overall numbers of occupied public housing dwellings and trend over time. PHIDU data provides information on the percentage of dwellings rented from the public housing authority by quintile of socioeconomic area disadvantage and by jurisdiction. According to PHIDU data, the percentage of dwellings rented from the public housing authority decreased from 26.9% in 1986 to 11.2% in 2016 for the most disadvantaged areas in South Australia,[14] the areas most in need of public housing. The percentage of dwellings rented from the state government housing authority in South Australia was also almost halved for the fourth quintile, third quintile and second quintile.[14] In the ACT, the percentage decreased to a similar extent to South Australia for the most disadvantaged quintile, from 26% in 1986 to 9.8% in 2016.[64] The ACT and SA were the most impacted jurisdictions (particularly for the most disadvantaged quintile) because these jurisdiction had higher stocks of public housing in 1996.

There is a shortfall in social housing in every jurisdiction. There is a shortfall even in jurisdictions where the number of occupied dwellings is similar in 2021 to 1996 because the stock of public housing had not kept up with population growth. The number of households in Australia grew by 30% between 1996 and 2016.[50] The stock of public housing needed to grow by 30% between 1996

and 2016 to meet the need. In addition, the Productivity Commission has classed 20% of public housing stock in Australia as 'physically unsatisfactory,' in other words in disrepair.[47]

In Queensland, there were 27,933 applications for public housing as of June 2021 (representing 50,301 people). The number of households with applications for public housing increased by 6,691 households between 2019 and 2021, and the typical wait time for public housing is 28 months. NSW has a public housing waiting list of 5,308 priority applicants and 46,087 general applicants, and wait times are often 5-10 years. In Victoria, the shortfall is around 99,264 people and the typical wait time for priority applicants is 11.6 months.[47]

A few of the housing cost figures in this section of the report have been measures of average housing costs. Average housing costs can hide rising housing costs for people on lower incomes, and average percentage of disposable income spent on housing hides the higher percent of income spent on housing costs for lower income groups. Table A16 presents rent as a proportion of income for different household types in 2021 and for each state by region plus the ACT. Darker orange (60% or more) is extremely unaffordable, light orange (38-60%) is severely unaffordable, yellow (31% to 38%) is unaffordable, dark green is moderately unaffordable, light blue (15% to 25%) is acceptable, and dark blue (15% or less) is affordable.

The average rent in every region is either extremely unaffordable or severely unaffordable for a single person on jobseeker. For single pensioners, only rest of SA is below the housing stress threshold of 30%. Even for a pensioner couple, only rest of SA is below the housing stress threshold and rest of Victoria and rest of Tasmania are both at the 30% threshold. For a single part-time worker on benefits, again only rest of SA is below the housing stress threshold. The ACT, Greater Sydney and Greater Perth are the most unaffordable regions.

Table A16: Rent as a proportion of income for selected household types in 2021 (Data source: Per Capita Housing Affordability in Australia report, 2022[47])

	Single person on Job seeker	Single Pensioner	Pensioner Couple	Single Part time earner on benefits	Student share house	Minimum wage couple	Single minimum wage	Single full time working parent	Single income couple with children	Dual income couple with children
Greater Sydney	110%	66%	48%	59%	35%	31%	34%	24%	24%	14%
Rest of NSW	63%	38%	32%	40%	25%	21%	22%	16%	16%	10%
Greater Melbourne	79%	47%	39%	49%	28%	26%	27%	22%	22%	12%
Rest of VIC	58%	35%	30%	37%	24%	19%	22%	16%	16%	10%
Greater Brisbane	92%	55%	42%	52%	28%	27%	32%	22%	22%	12%
Rest of QLD	84%	51%	38%	48%	29%	25%	27%	20%	20%	12%
Greater Adelaide	71%	43%	34%	43%	26%	22%	26%	18%	18%	10%
Rest of SA	46%	28%	23%	29%	19%	15%	16%	12%	12%	8%
Greater Perth*	110%	66%	42%	52%	27%	27%	36%	20%	20%	10%
Rest of WA*	98%	59%	37%	46%	24%	24%	29%	18%	18%	9%
Greater Hobart	79%	47%	40%	49%	31%	26%	27%	21%	21%	13%
Rest of TAS	58%	35%	30%	37%	23%	19%	20%	16%	16%	10%
ACT	113%	68%	51%	63%	37%	33%	40%	24%	24%	14%

Education

People with higher levels of educational attainment generally have better health and longer lifespans compared with people with less education.[65] There are also strong correlations between parental education and child health,[66, 67] particularly maternal education.[68] Skills acquired through education are closely linked with employment and income.

Four joint Federal, State and Territory Declarations of national goals for schooling from 1989, 1999, 2009 and 2019 include goals related to equity and social justice.[69-72] Equality of opportunity, equality of access to education, and equality of learning outcomes are goals in the 1999 Declaration.[70] Goal 1 of the 2009 and 2019 Declarations is for Australian schooling to promote equity and excellence.[71, 72] Lamb et al 2020 note that according to the goals set out in the 2019 Declaration, every learner, no matter where they live, will develop the knowledge and skills to become "personally successful, economically productive, and actively engaged citizens."[73]

Despite explicit goals focused on equity in education in all four Declarations, educational inequality is growing in Australia. Educational inequality can be measured by educational inputs (funding, teachers, classrooms resources, access to curriculum) or outputs (test scores, year 12 completion rates, future income levels). Educational inequality is poor and worsening on almost all of these measures.[74]

Sector of schools and inequities

Australia's 2015 Program for International Student Assessment (PISA) results revealed that a higher proportion of the lowest socioeconomic area schools reported a lack of teaching staff or inadequate or poorly qualified teaching staff, inadequate or poor-quality infrastructure hindering capacity for instruction, and a shortage or lack of educational materials hindered their capacity for instruction compared with high socioeconomic status schools.[75] Students enrolled in schools with high average socioeconomic status tend to perform more highly than students enrolled in schools with low average socioeconomic status regardless of the students' own socioeconomic status background. Inequality in inputs such as teaching staff, infrastructure and educational materials contributes to widening inequality by socioeconomic status of school and socioeconomic status of students.[75]

Figure A53 presents the distribution of enrolment by socioeconomic status quartile and by school sector. Private schools (Catholic, other religions or Independent) have higher average socioeconomic status enrolments than public schools. Private schools on average are also more likely to offer a curriculum that offers wider curriculum choice and facilitates higher tertiary entrance scores. Private schools can offer advanced subjects that offer a higher tertiary entrance ranking, and smaller classes with additional tutoring.[74]

In 2012, the Gonski Review Report emphasised the need for equitable school funding to reduce inequity in education outcomes by recommending funding for schools based on need.[76] The recommendation for equitable school funding was not implemented. **Figure A54** presents the percentage growth in per student funding by school sector from 2012 to 2021. Funding for Catholic schools grew by almost double that of public schools, and funding for Independent schools grew by more than double that of public schools.

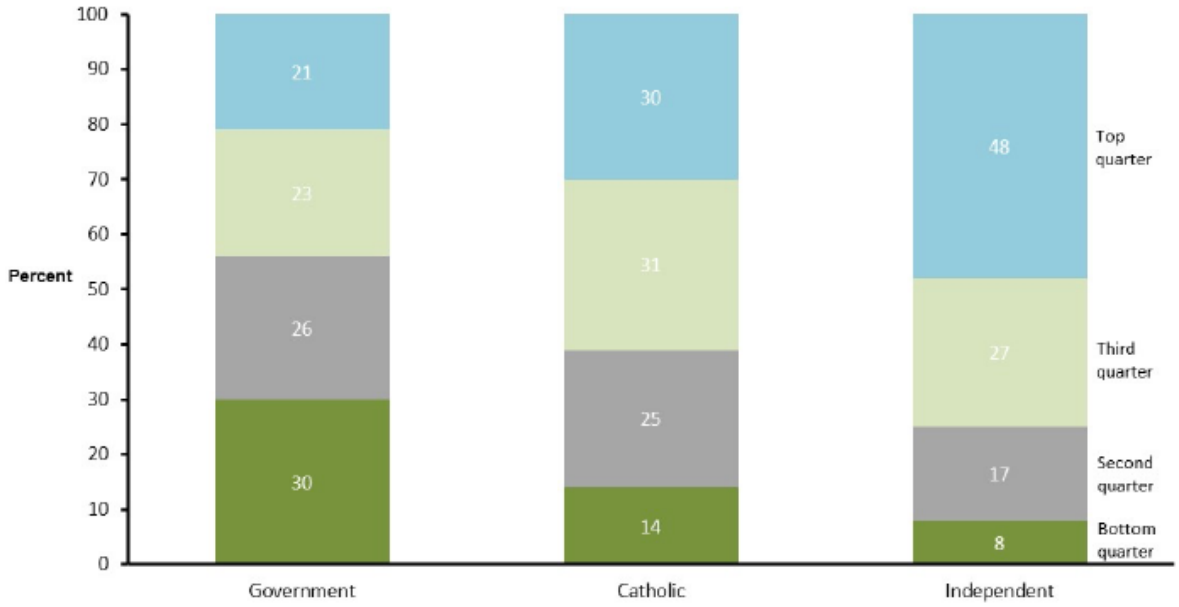


Figure A53: Distribution of SES enrolments by school sector, 2016 (Data source: Hetherington, 2018. What Price the Gap?[74])

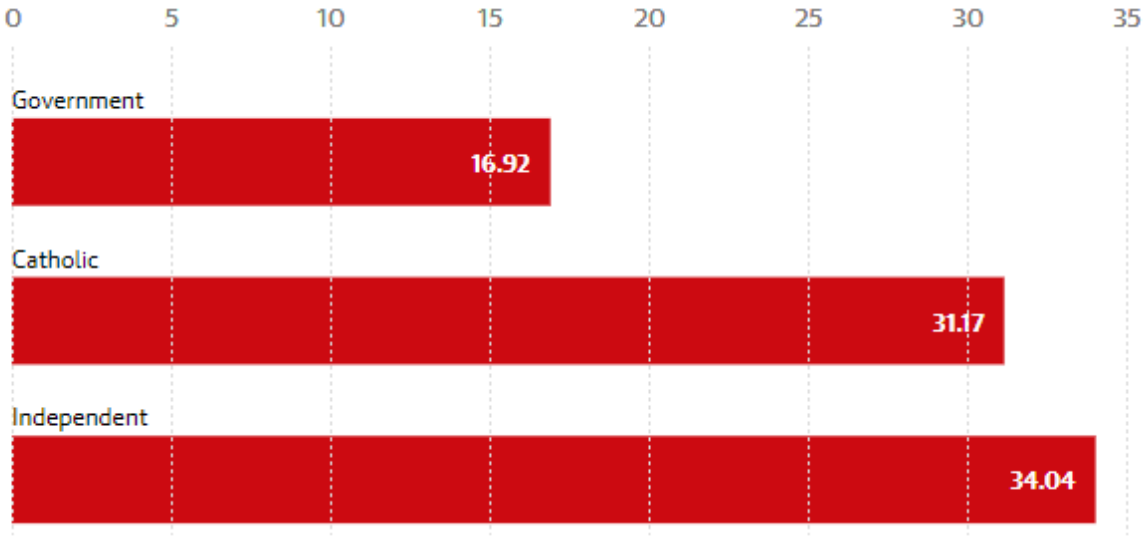


Figure A54: Percentage increase in per student funding to Government, Catholic and Independent schools between 2012 and 2021 (Data source: the Guardian, 2023[77])

Education by socioeconomic status

Table A97 presents the gaps in measures of learning by socioeconomic status from early years to adulthood. Gaps by socioeconomic status exist across all development domains, across all skills, and at all levels of schooling and into adulthood. The gaps are even larger for achievement in the middle years, for mathematics, science and reading achievement in senior years and for both measures of learning in young adulthood. These gaps are unusually wide in Australia and students who are

behind when they start their learning often stay behind. The educational inequality in these results is at odds with the national goals for schooling.[73]

Table A97: Measures of learning by SES from early years to adulthood (Data source: Lamb et al 2020[73])

		High SES	Low SES
Early years	Developmentally on track on all development domains	85.3%	67.7%
	Developmentally on track in literacy and numeracy	90.9%	74.3%
Middle years	Performing above the national minimum standard in both literacy and numeracy	91.3%	50.6%
	Performing at or above the international benchmark in science	85.0%	43.0%
Senior years	Attains a Year 12 certificate or equivalent	91.8%	66.8%
	Meets or exceeds international benchmark standard for age in mathematics, science and reading	86.2%	48.6%
Young adults	Engaged fully in education, training or work	82.0%	50.8%
	Gains post-school qualification	86.3%	52.9%

Early years education

The Australian Early Development Census (AEDC) is conducted every 3 years and measures children's development by the time they start school.[64] The domains included are physical health and wellbeing, social competence, emotional maturity, language and cognitive skills (school based), and communication skills and general knowledge (school based). PHIDU provides data for each of the AEDC domains.

Figure A55 presents the percentage of children developmentally on track for the language and cognitive skills domain by quintile of socioeconomic disadvantage. The percentage of children on track for language and cognitive skills in their first year of school rose for each quintile between 2009 and 2021. The gap in language and cognitive skills between the least disadvantaged and most disadvantaged increased slightly from 15.1% in 2009 to 16.5% in 2021. The increase in this gap suggests an increase in inequality. There is a social gradient in language and cognitive skills, and the percentage of children on track declines with more disadvantage. The rate ratio for language and cognitive skills between the children in the most disadvantaged quintile and those in the least disadvantaged quintile was 0.82 in 2009 and was also 0.82 in 2021.

Figure A56 presents the percentage of children developmentally on track for AEDC communication skills and general knowledge by quintile of socioeconomic disadvantage. The percentage of children on track for communication skills and general knowledge in their first year of school also rose slightly for each quintile between 2009 and 2021. There is a similar social gradient for communication skills and general knowledge as that observed for language and cognitive skills. The gap between the most disadvantaged and least disadvantaged was 13.1% in 2009 and was 13.0% in 2021. The rate ratio for communication skills and general knowledge was 0.83 in 2009 and 0.84 in 2021.

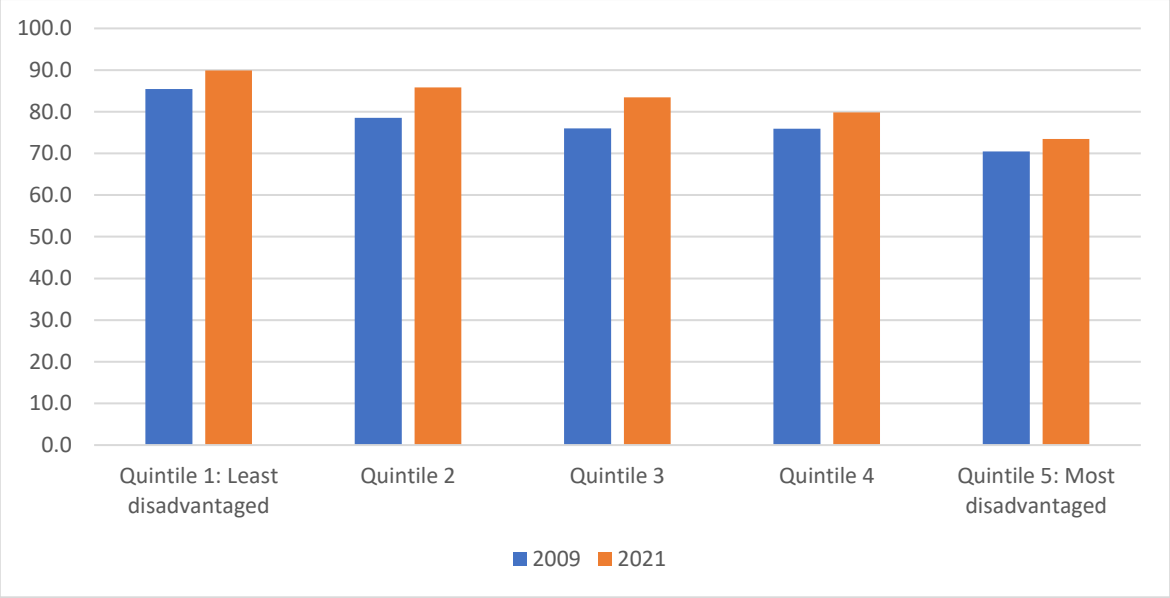


Figure A55: Early childhood development: AEDC, Language and cognitive skills (school based) – developmentally on track, by socioeconomic quintile of disadvantage, 2009 and 2021 (Data source: Social Health Atlas, PHIDU, 2022)

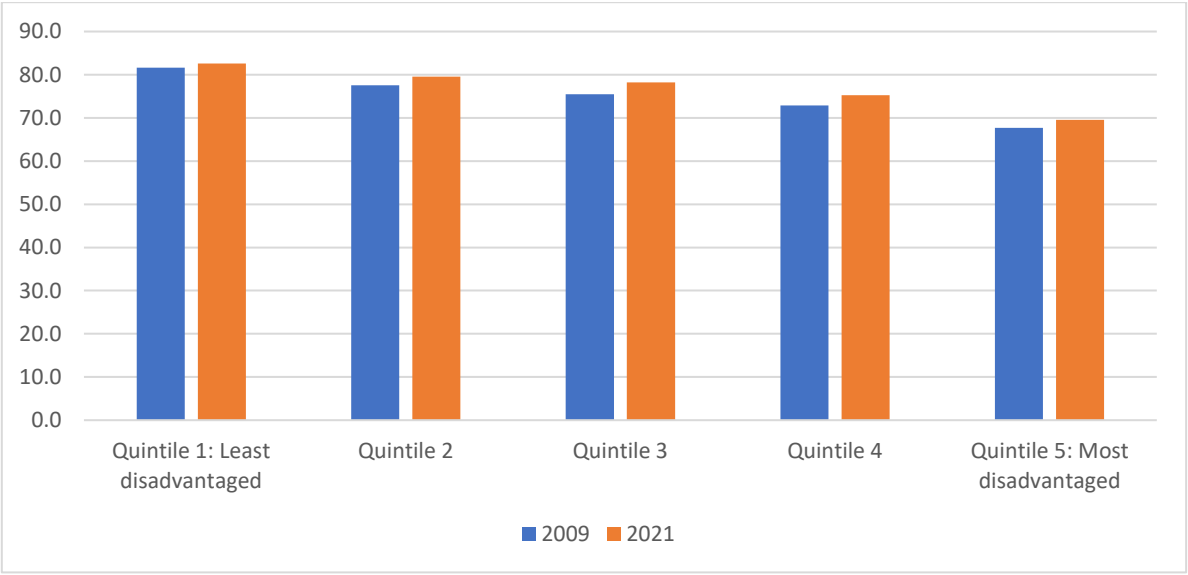


Figure A56: Early childhood development: AEDC, Communication skills and general knowledge – developmentally on track, by socioeconomic quintile of disadvantage, 2009 and 2021 (Data source: Social Health Atlas, PHIDU, 2022)

Figure A28 presents the percentage of children developmentally on track on all AEDC domains in 2018 by gender, jurisdiction, geographic location, socioeconomic status, Indigenous status, and language. A higher percentage of girls were developmentally on track in all domains compared with boys. The percentage of children on track on all domains is lower for non-metropolitan areas, particularly outer regional, remote, and very remote areas. There was a 20.9 percentage point gap in the percentage of Aboriginal and Torres Strait Islander children assessed as developmentally on track on all domains compared with non-Indigenous children. Australia is currently on track to reach the Closing the Gap early childhood education target with the percentage of Aboriginal and Torres Strait Islander children enrolled in a preschool program increasing from 76.7% in 2016 to 99.2% in 2022.[78]

Australia is not on track to reach the Closing the Gap target of increasing the proportion of Aboriginal and Torres Strait Islander children assessed as developmentally on track in all five domains of the AEDC to 55%.[78] AEDC statistics for the Closing the Cap target differ from those reported by Lamb et al. 2020, with only 34.3% of Aboriginal and Torres Strait Islander children assessed as developmentally on track in all five domains in 2021 compared with 35.2% in 2018.[78]

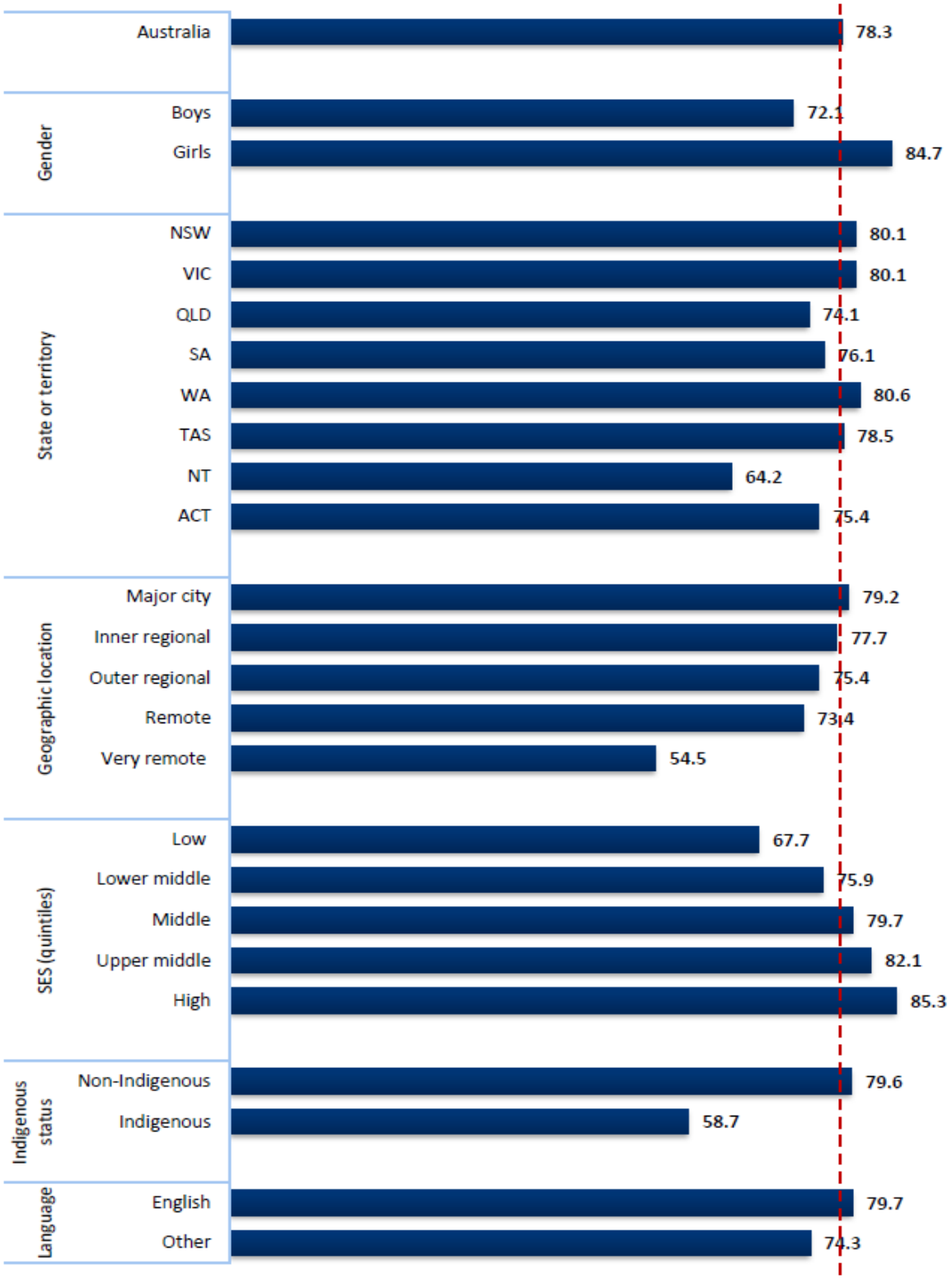


Figure A287: Percentage of children assessed as developmentally ready on all AECD domains in the first year at school, 2018 (Data source: Lamb et al 2020)

There was a 5.4 percentage point gap between the percentage of children who spoke English at home assessed as developmentally on track compared with children who spoke a language other than English. The difference in the percentage on track by socioeconomic status corresponds with the differences observed in **Figure A55** and **Figure A56**, but the 17.6 percentage point between high socioeconomic status and low socioeconomic status is larger when assessing development on all five domains. There was a 12.6 percentage point gap by gender, with almost 85% of girls assessed as developmentally ready on all domains compared with 72% of boys.

Primary school education

The inequality in early years school based measures of development is also observed in measures of inequality in achievement at Grade 4, in middle years of schooling, and measures of inequality in achievement at age 15. UNICEF assessed the gap in reading scores at Grade 4 between the top decile and the bottom decile in each school system for 29 countries using 2016 data. The gap in reading scores was 212 in Australia, the 5th highest gap compared with other OECD and European Union countries.[79]

Figure A8 presents estimates of the proportion of students in 2018 who achieved above the national minimum standard for reading and numeracy in Year 7. The inequities visible in Figure A58 in the first year of school are even starker for Year 7 for geographical location, socioeconomic status, and Indigenous status. The proportion of Year 7 students who achieved above the national minimum standard follows a gradient by socioeconomic status, and the proportion declines with increasing remoteness. There was a 33.5 percentage point gap between major cities and remote/very remote areas, a 40.7 percentage point gap between highest socioeconomic status and lowest socioeconomic status, and a 27.3 percentage point gap between Aboriginal and Torres Strait Islander students and non-Indigenous students. There is a much smaller gender gap (approximately 4 percentage points) in the percentage who achieved above the national minimum standard in year 7 compared with the percentage assessed as developmentally on track in early years education.

Lamb et al 2020 used data from the Longitudinal Survey of Australian Children to match children and their NAPLAN results in reading and numeracy in year 3 and Year 9 (see **Figure A59**). The longitudinal estimates show the change in the proportion of students above the national standard in reading and numeracy over time. There is a decline in the proportion above the national standard from Year 3 to Year 9 for all students, but the decline is smallest for the highest socioeconomic status students (from 91.7% to 88.5%). There was a larger decline for upper middle socioeconomic status students compared to high socioeconomic status students, but a smaller change for lower middle socioeconomic status students. The largest decline was among the lowest socioeconomic status students, from 69.3% achieving above the national standard in Year 3 to 56.6% in Year 9. The achievement gap by socioeconomic status grew over the six years from Year 3 to year 9.[73]

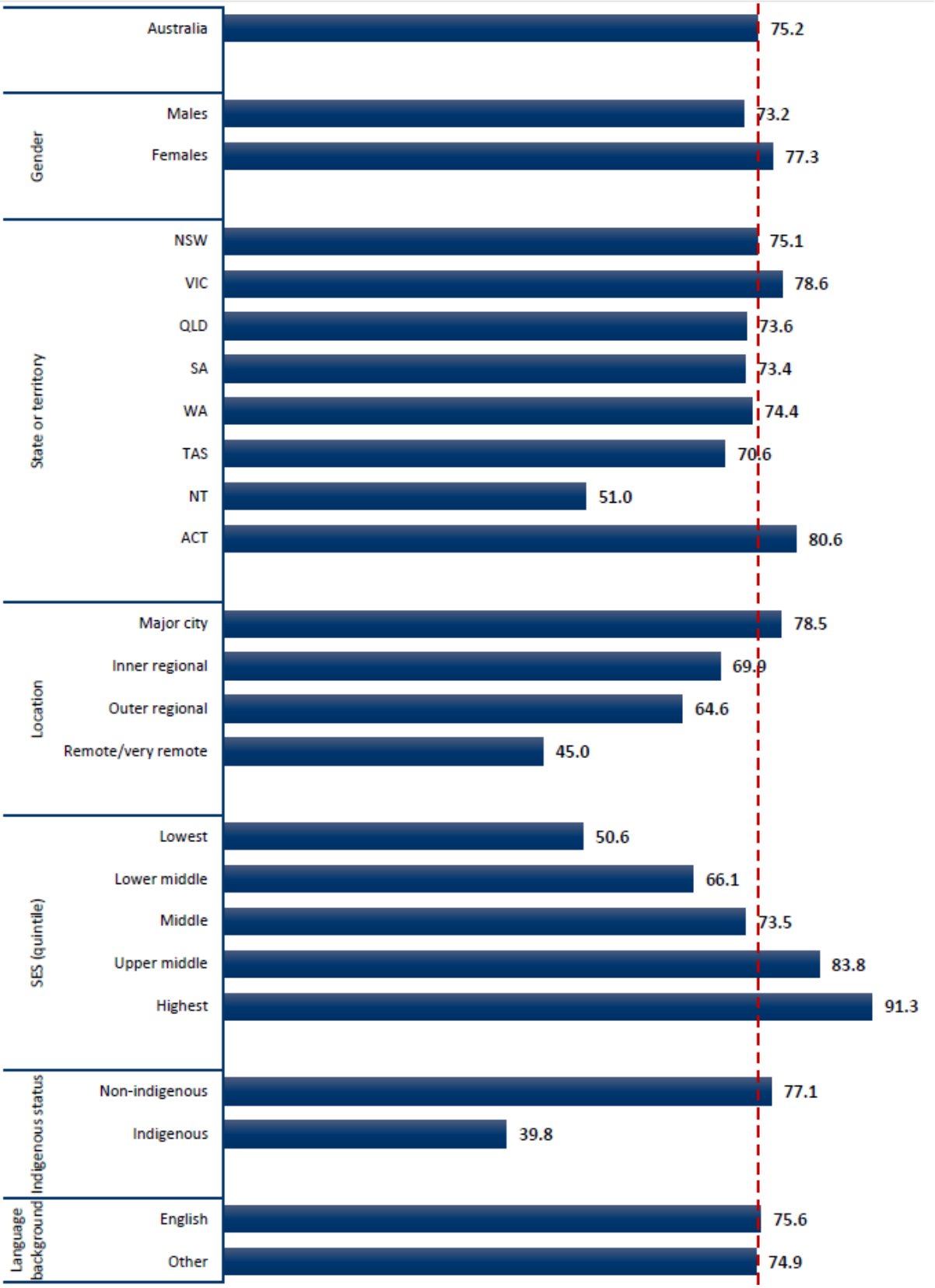


Figure A58: Percentage of Year 7 students achieving above the national minimum standard of proficiency in both Reading and Numeracy, by student characteristics, 2018 (Data source: Lamb et al 2020)

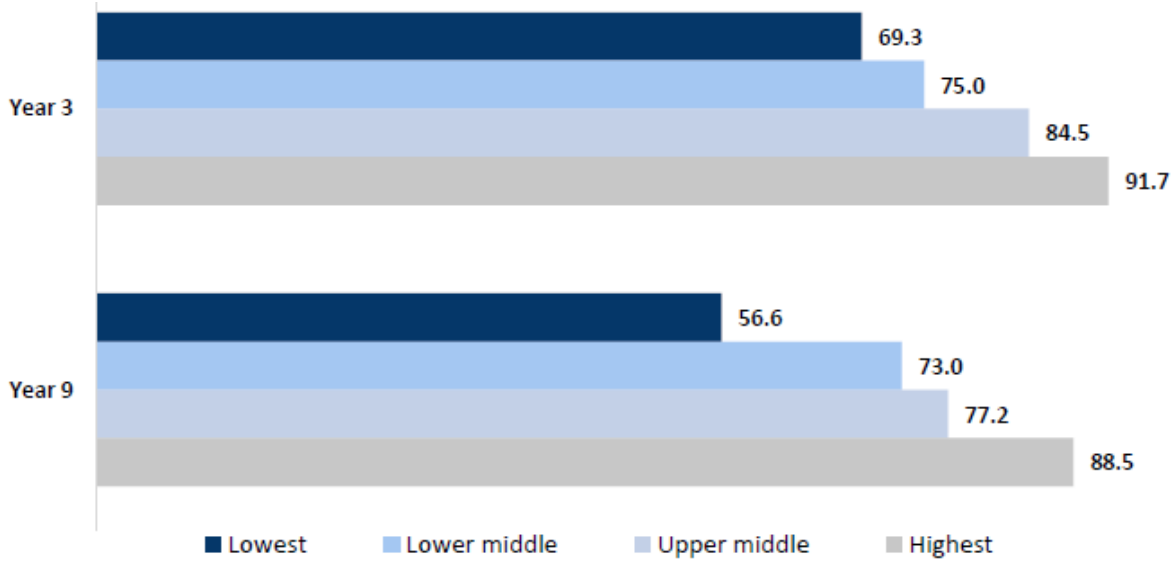


Figure A59: Percentage of students above the national minimum standard in both reading and numeracy, by year level and SES, 2014 (Data source: Lamb et al 2020)

International data on inequality in education

UNICEF produced a league table of educational inequality in preschool, primary school and secondary school for their 2018 Office of Research Innocenti Report Card on inequality in children's education in high income countries.[79] Australia was ranked 36th out of 41 high income countries for educational equality in preschool and has one of the most unequal education systems among high and middle-income countries that are OECD and/or European Union members. Australia was ranked 25th out of 29 for educational equality in primary school and was ranked 30th out of 38 for educational equality in secondary school.[79]

The UNICEF report identified key policies and practices that contribute to educational inequalities. These policies and practices include schools grouping students by ability in classes, grade repetition, and attending different schools based on academic performance. Australia had the fifth highest proportion of within-school ability grouping according to the 2015 PISA survey (88%), and the fifth highest percentage of private school enrolment (43.7%). These policies and practices reduce diversity of children within schools and lead to overrepresentation of children from less privileged families in the lower tracks of the ability groupings, reducing their future opportunities.[79]

UNICEF assessed the gap in the reading achievement scale between the top decile and the bottom decile at age 15 for 38 countries using 2016 data. The gap for Australia was 265 points, larger than the gap for Grade 4. Australia's gap in reading achievement was the 30th largest, with only 8 OECD and European Union countries having a larger gap in reading achievement.

OECD PISA results for 15 year olds in Australia

Figure presents the percentage of 15 year olds performing at or above the minimum international standard in proficiency in mathematics, science, and reading based on 2018 PISA results. Overall, 72.2% of 15 year olds performed at or above the minimum international standard. Inequities in **Figure** for 15 year olds mirrored those for Year 7 students in **Figure A**8. There was a gradient by socioeconomic status whereby the proportion of 15 year olds achieving at or above national minimum standard declined with disadvantage. There were very large differences in the proportion achieving at or above minimum standard when comparing the highest socioeconomic status deciles

with the lowest socioeconomic status deciles. There was a gender gap of 3.3 percentage points with a higher percentage of girls achieving above the national minimum standard. There were also large differences by geographical location, and a large gap by Indigenous status.

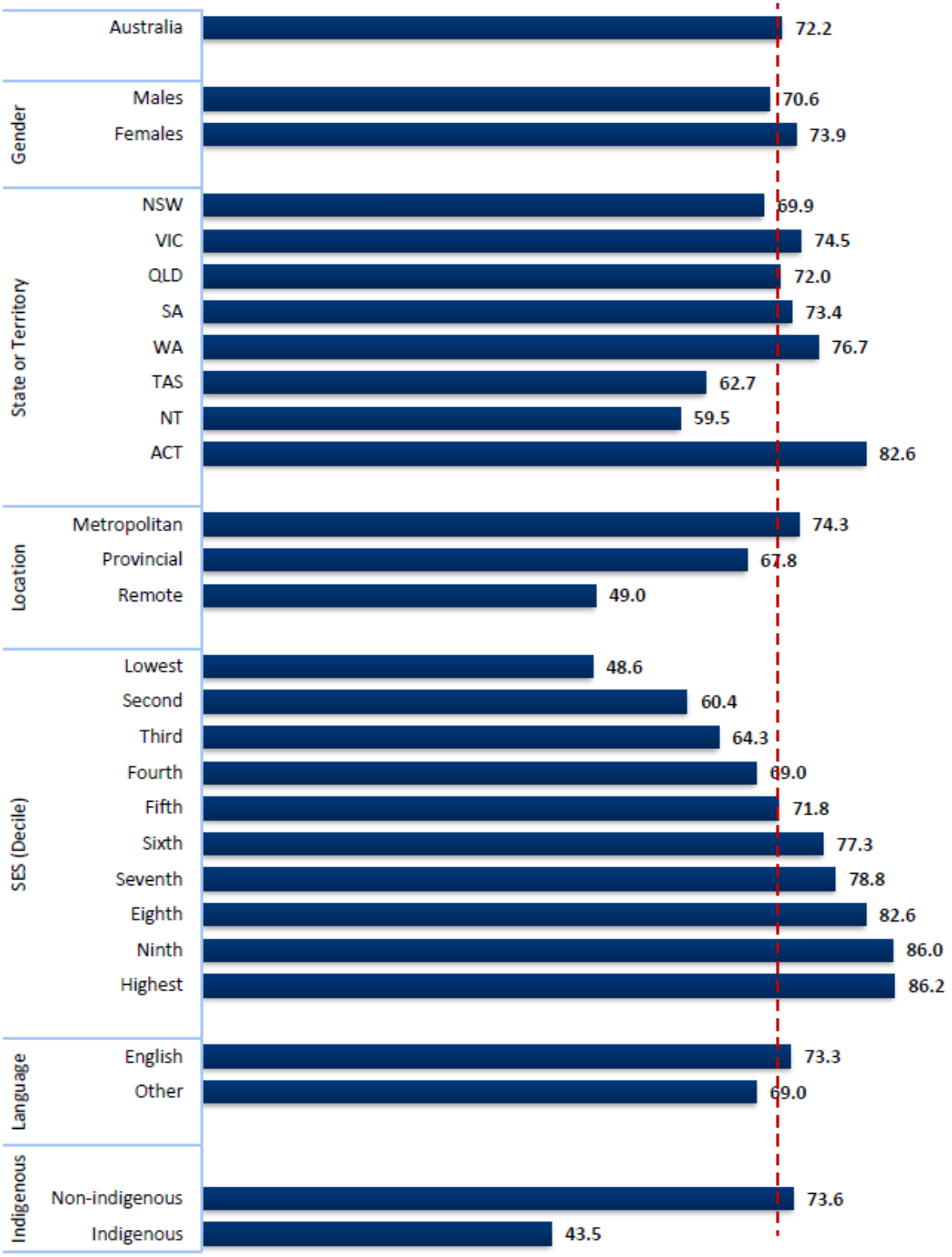


Figure A60: Percentage of 15 year olds performing at or above the minimum international standard of proficiency in mathematics, science and reading, 2018 (Data source: Lamb et al 2020)

Median Australian PISA scores in maths, reading and science fell consistently between 2000 and 2015. Maths scores fell by a total of 39 points, reading by 25 points and science by 19 points. Hetherington (2018) analysed the change in scores between 2009 and 2015 when test formats where comparable, calculating the average fall in scores by subject and decile (**Figure**). The average decline in scores by percentile offer a way to assess inequality by comparing changes (declines) in scores for 10th percentile and 25th percentile (students who are on average achieving well below the median) with scores for the 75th percentile and 90th percentile. The lowest overall fall in scores was for reading, but the highest increase in inequality was in reading scores. The gap between the bottom decile and the top decile increased by 11.8 points. Maths scores fell the most on average, but inequality in maths scores did not change significantly. The largest fall in scores for students in the bottom decile was in science, and there was an 8 point increase in inequality in science between the bottom decile and the top decile. While all cohorts of students fared worse between 2009 and 2015, the performance of those in the bottom decile fell by 50% more than those in the top decile.[74]

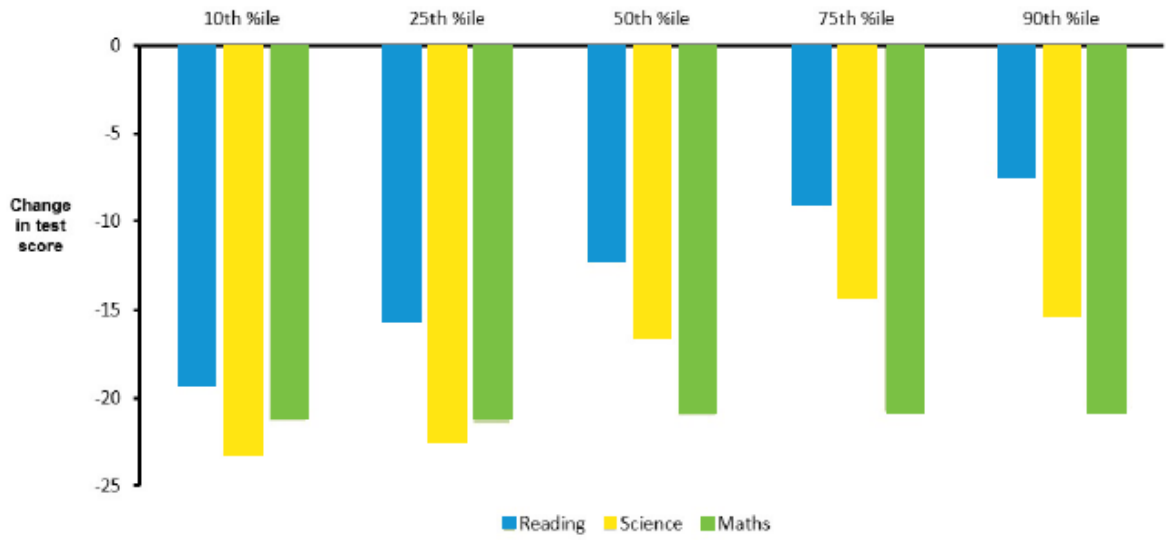


Figure A61: Fall in Australia PISA scores by subject and percentile (Data source: Hetherington, 2018, What Price the Gap?)

The decline in student academic performance in Australia between 2000 and 2015 was large, both in comparison with other countries and within Australia. Australia was ranked 6th in the OECD in Year 9 maths in 2000 and was ranked 20th in 2015. The ranking for reading fell from 4th in the OECD in 2000 to 12th in 2015. The ranking for science fell by less, but still fell, from 8th in 2000 to 10th in 2015. The decline in maths performance between 2003 and 2015 was equivalent to the loss of one year of schooling. The decline in reading performance between 2000 and 2015 was equivalent to 10 months of schooling. Between 2006 and 2015, the decline in performance in science equated to 7 months of schooling. These declines in performance are average figures, but the decline for students at the bottom has been larger than those at the top.[74]

The 2022 PISA results were released in late 2023. The gap between the between the highest scoring students (the 10% with the highest scores) and the 10% of students with the lowest scores widened between 2018 and 2022 in mathematics and science.[80] The latest PISA results add to the evidence of increasing educational inequality in Australia.[80]

Secondary school participation and year 12 certification

On a positive note, there was a large increase in participation in secondary school at age 16 between 1986 and 2021 (**Figure**). Socioeconomic inequality in participation in secondary school at age 16 remains, with 77.5% of those in the most socioeconomically disadvantaged areas participating compared with 92.8% in the least disadvantaged areas, but inequality has decreased. The increase in full time participation in secondary school at age 16 was 48.5% for the most disadvantaged quintile compared with 29% for the least disadvantaged quintile. There is still a social gradient in full time participation in secondary school at age 16, but it is flatter than it was. The rate ratio has also improved from 0.72 in 1986 to 0.83 in 2021.

Figure presents Year 12 certification rates from 2009 to 2021 by socioeconomic status. Low socioeconomic status is the average of the lowest three deciles of Index of Socio-Economic Disadvantage, medium socioeconomic status is the average of the middle four deciles, and high socioeconomic status is the average of the top three deciles. Year 12 certification rates have increased over the period from 2009 to 2021 (with the exception of lower certification rates in 2014 and in 2019). This increase has occurred for low socioeconomic status, medium socioeconomic status, and high socioeconomic status students. A higher increase in certification rates for low socioeconomic status students compared with high socioeconomic status students has narrowed the gap from a 19 percentage point difference in 2009 to an 11 percentage point difference in 2021.

The grouping of deciles of socioeconomic status in **Figure** hides differences within low, medium, and high socioeconomic status deciles and also hides the larger differences between the lowest decile and the highest decile. **Figure** presents differences in Year 12 attainment of 19 year olds in 2016 by gender, jurisdiction, location, decile of socioeconomic status, language background and Indigenous status. There was a gap of 25 percentage points between the percentage of young people in the highest decile of socioeconomic status who had attained year 12 (91.8%) and the percentage in the lowest decile who had attained year 12 (66.8%).

The gap in Year 12 attainment by remoteness is also very large. There was a 15 percentage point gap between Year 12 attainment in major cities and year 12 attainment in remote areas, and the gap between major cities and very remote areas is almost 37 percentage points. Females have higher Year 12 attainment than males, as was the case for achievement at age 15, in year 7, and early years education. Young people with a language background other than English also had a higher percentage of Year 12 attainment compared with students with an English language background. There is a gap in Year 12 attainment by Indigenous status.

Figure presents the age-standardised rate of participation in Vocational Education and Training (VET) in 2001 and 2020. The rate of participation in VET increased between 2001 and 2020 for all quintiles of socio-economic disadvantage but by slightly more for more disadvantaged areas. The higher age-standardised rates of participation in VET for more disadvantaged quintiles suggest that VET offers a more accessible pathway to post school qualifications for more disadvantaged areas but it must be acknowledged that **Figure** does not distinguish between participation in VET qualifications that are post school qualifications and VET qualifications that are equivalent to Year 12 attainment.

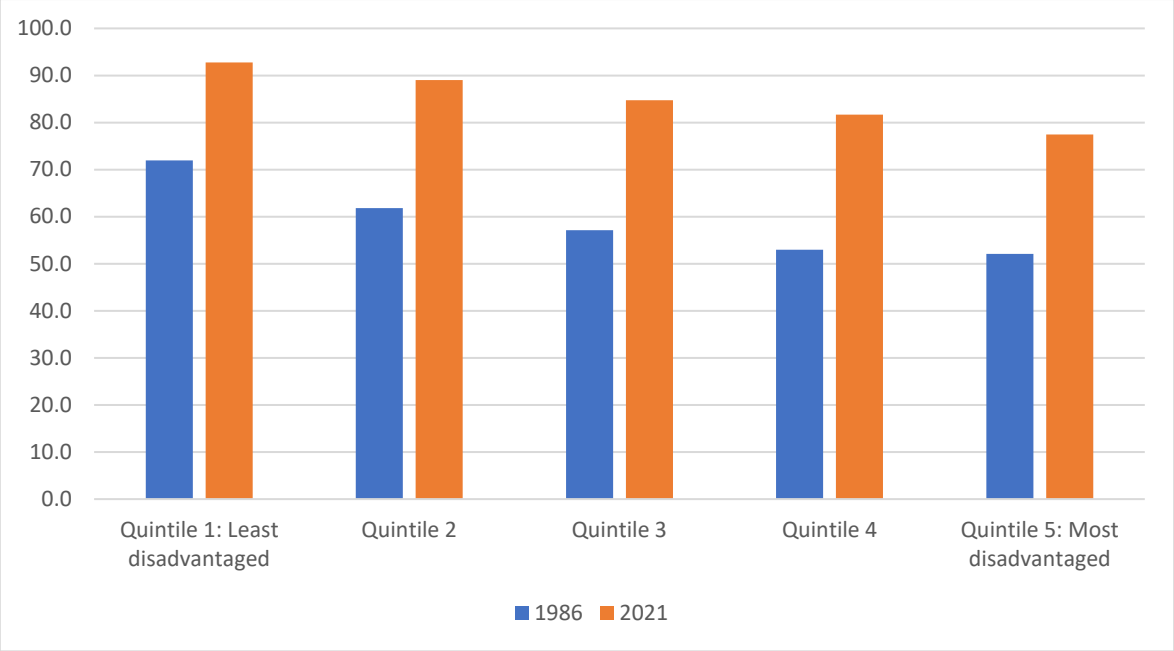


Figure A62: Percentage full time participation in secondary school at age 16, 1986 and 2021 (Data source: Social Health Atlas, PHIDU, 2022)

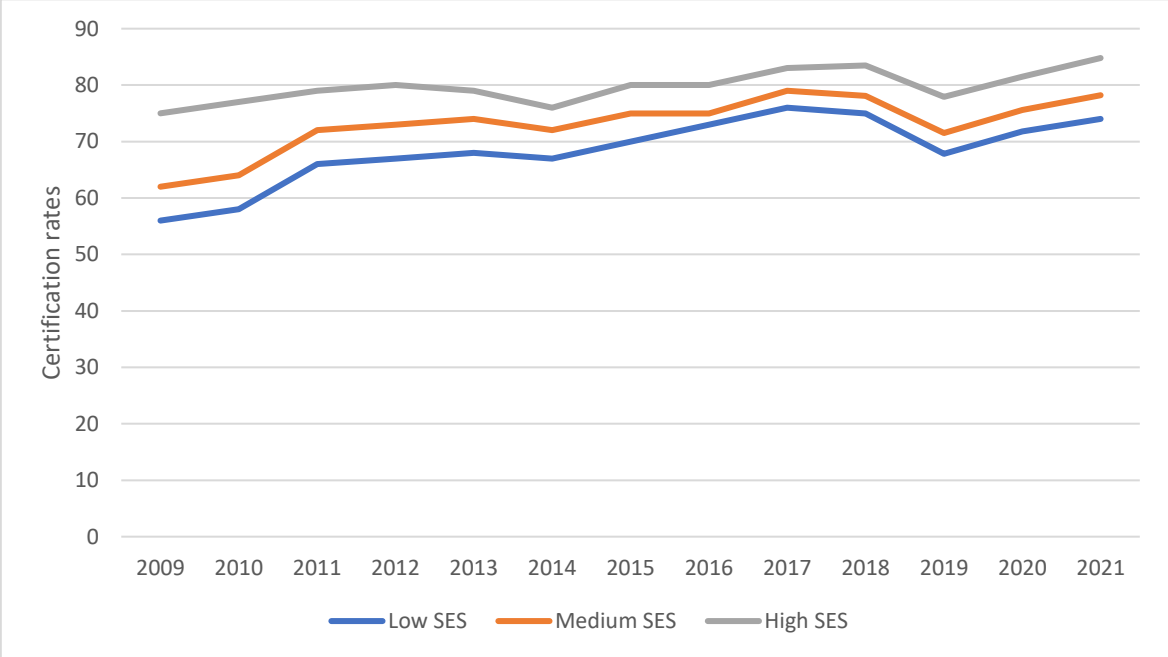


Figure A63: Year 12 Certification Rates by SES, 2009 to 2021, Australia (Data source: ACARA)

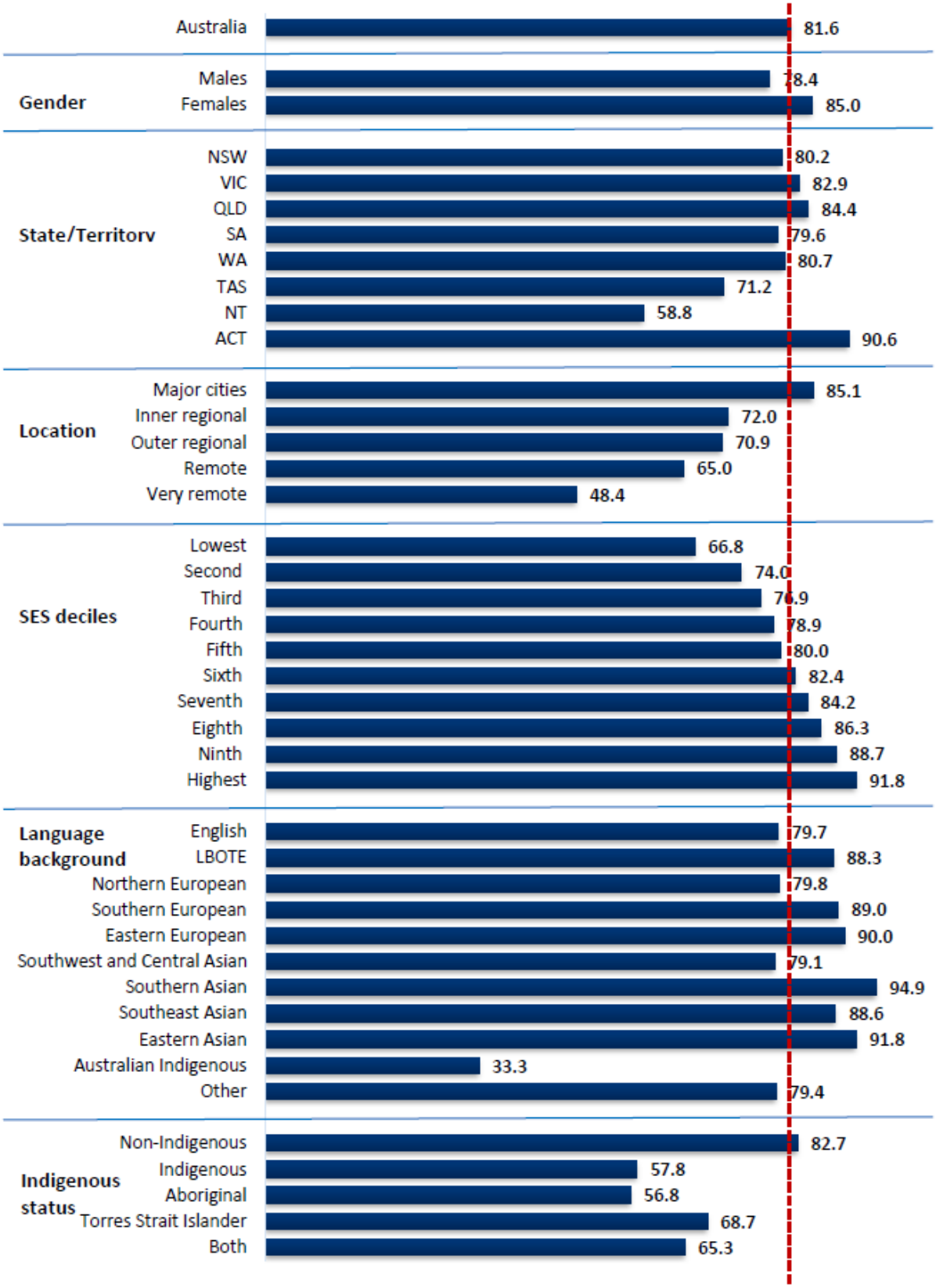


Figure A64: Percentage of 19 year olds who have completed a Year 12 or equivalent qualification, by selected background characteristics, 2016 (Data source: Lamb et al, 2020)

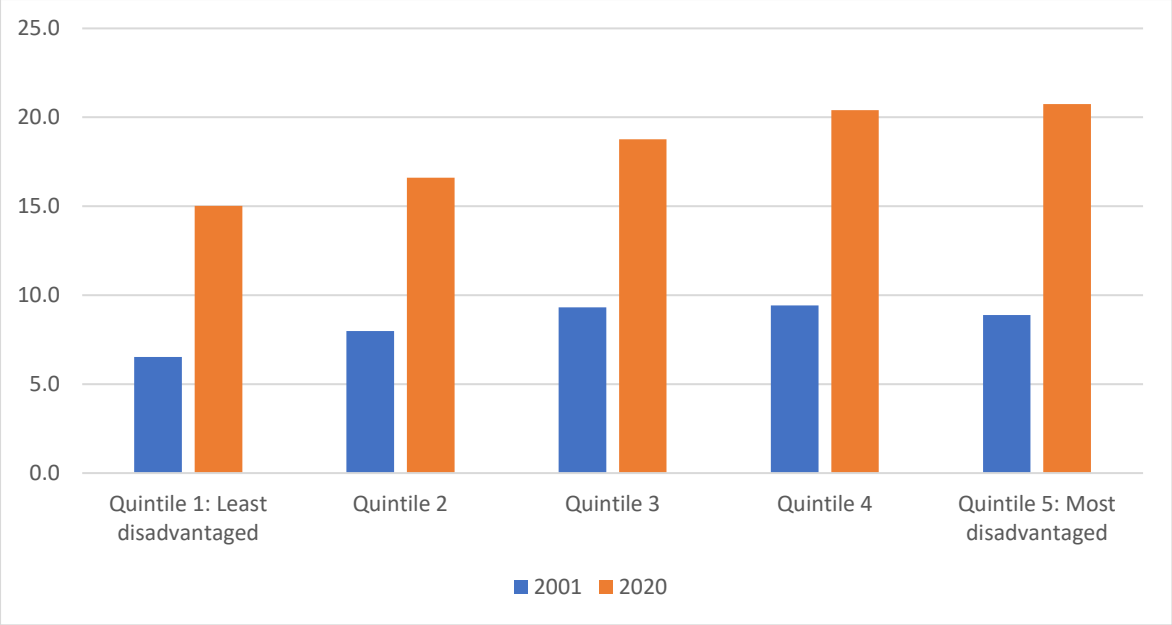


Figure A65: Age-Standardised Rate of Participation in Vocational Education and Training, Total Population, by Quintile of Socio-economic Disadvantage, Australia, 2001 and 2020 (Data source: Social Health Atlas, PHIDU, 2022)

Figure presents the percentage of 24 year olds who had attained a VET Certificate III or higher or who were currently enrolled in one in 2016 by gender, jurisdiction, remoteness, socioeconomic status, Indigenous status and language background. The higher rates of VET participation in more disadvantaged areas in **Figure** are also evident in **Figure** for lower deciles of socioeconomic status. The percentage who had attained or were enrolled in a VET qualification at Certificate III or higher were similar in major cities and very remote areas, but higher in regional and remote areas. The percentage of Aboriginal and Torres Strait Islander people who had attained or were enrolled in a VET qualification at Certificate III or higher was slightly higher than for non-Indigenous people. A much higher percentage of males had completed or enrolled in a VET certificate III or higher compared with females.

The percentage of school leavers participating in higher education also increased between 2011 and 2021 for all quintiles (see **Figure**), but the increase was lowest for the most disadvantaged quintile. The highest proportional increases in participation in higher education were for quintile 2 and quintile 4, but the increase for quintile 4 is from a much lower percentage in 2011 compared with that for quintile 4. The increase in participation in secondary education and increase in Year 12 attainment rates in more disadvantaged areas has not translated into a corresponding increase in participation in higher education for the areas represented by the most disadvantaged quintile. Inequality in participation in higher education increased, with the rate ratio decreasing from 0.59 in 2011 to 0.49 in 2021. The percentage for the least disadvantaged quintile was more than double that for the most disadvantaged quintile in 2021.

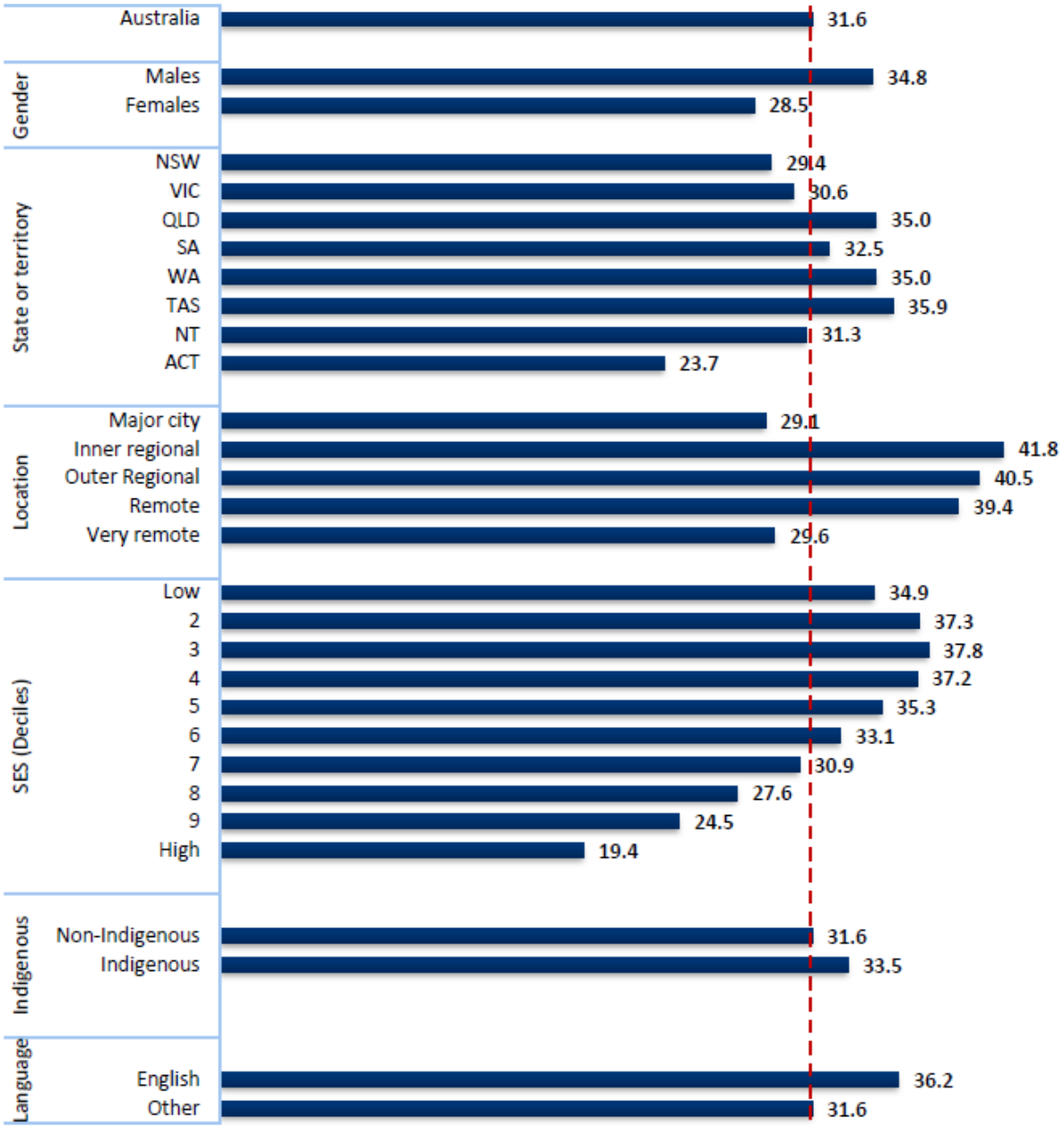


Figure A66: Percentage of 24 year olds who have attained a Vocational Education and Training Certificate at AQF Level III or Higher or are currently enrolled in one, by selected background characteristics, 2016 (Data source: Lamb et al 2020)

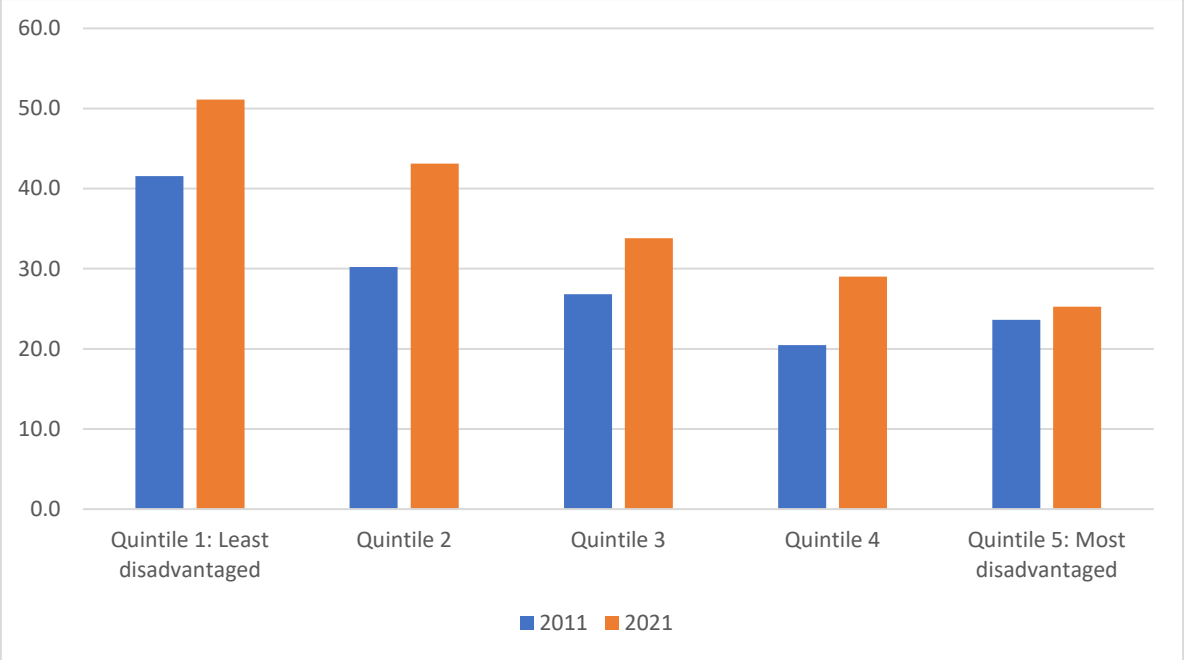


Figure A67: School leaver participation in higher education, by Quintile of Socio-economic Disadvantage, Percent, 2011 and 2021, Australia (Data source: Social Health Atlas, PHIDU, 2022)

The onset of the COVID-19 pandemic resulted in school closures to contain the spread of the virus. The school closures exposed the differential access to resources by students, families, and schools within and between school sectors.[81] McDaid et al (2021) identified three cohorts of children as being at risk of falling further behind: 1) young children who started school already behind; 2) older students who were already at risk of disengagement; and 3) children and young people who have had contact with the child protection system.[82] McDaid et al (2021b) examined children and young people's lived experience of COVID-19 for children, young people and families experiencing disadvantage.[83] They examined the impact on educational outcomes, engagement with school, and service providers response to COVID-19 and found no substantial worsening of educational inequality during the pandemic.[83] It is unknown why COVID-19 did not greatly increase education inequality, but possible reasons provided include short periods of school closures (outside Victoria), the substantial increase to Jobseeker and provision of JobKeeper, widespread support for online learning, increased crisis support from service providers, and national initiatives to stabilise housing.[82]

Jurisdiction analysis: Education

Funding to public schools by jurisdiction

Changes to the funding model for public schools in 2017 to introduce a commonwealth funding cap of 20% further undermined public school funding, as it required the state government to cover the remainder of public school funding. The Gonski review recommended that the Commonwealth contribute more to public schooling, not less. States were not held accountable for delivering the full share of funding for public schools. **Figure 29** shows that between 2012 and 2021 WA and the NT decreased their funding to public schools in real terms (after adjusting for inflation).[5]

[5] Note that the commonwealth funding cap of 20% impacted public school funding over the latter part of the 2012 to 2021 period in Figure 16 (from 2017 to 2021) and % increase was much larger pre the 2017.change.

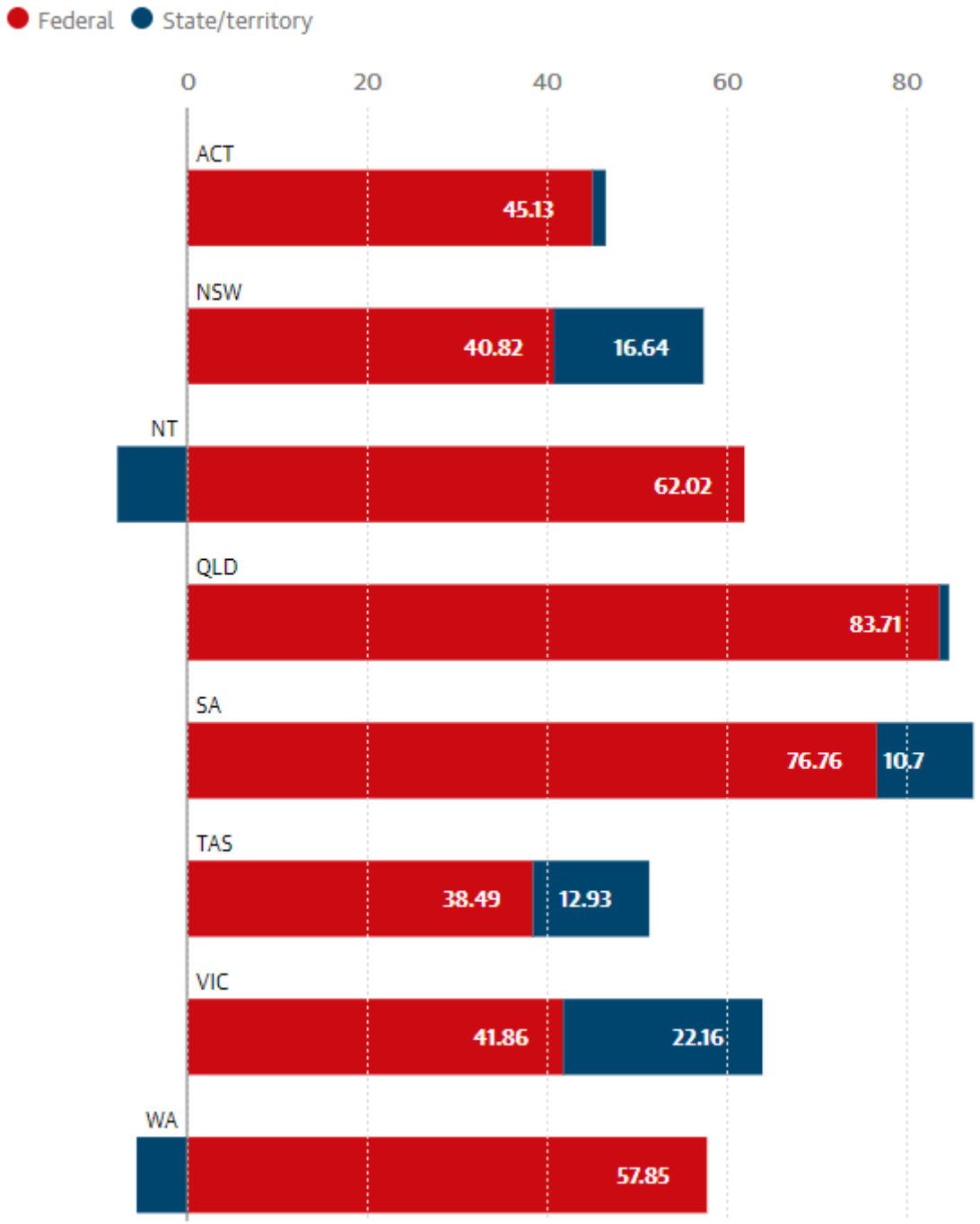


Figure 298: Percentage increase or decrease in public school funding in real terms between 2012 and 2021, by source of funding (Data source: the Guardian, 2023[77])

Early years education by jurisdiction

Data by jurisdiction for AEDC language and cognitive skills in **Figure** suggests that a lower percentage of children were developmentally on track in Qld, NT, and WA in 2009 (particularly for the most disadvantaged areas in the NT). Qld and WA had caught up with other jurisdictions by 2021. There were very high socioeconomic inequalities in the percentage on track for language and cognitive skills in the NT (a gap of more than 57 percentage points between least and most disadvantaged) and inequality was higher in 2021. Inequality also increased in Tasmania, Victoria, NSW, and the ACT.

Inequality decreased in Qld and was little changed in SA and WA. The ACT had the lowest inequality, with a rate ratio of 0.91 in 2021 and a gap of 7.5 percentage points between the least and most disadvantaged.

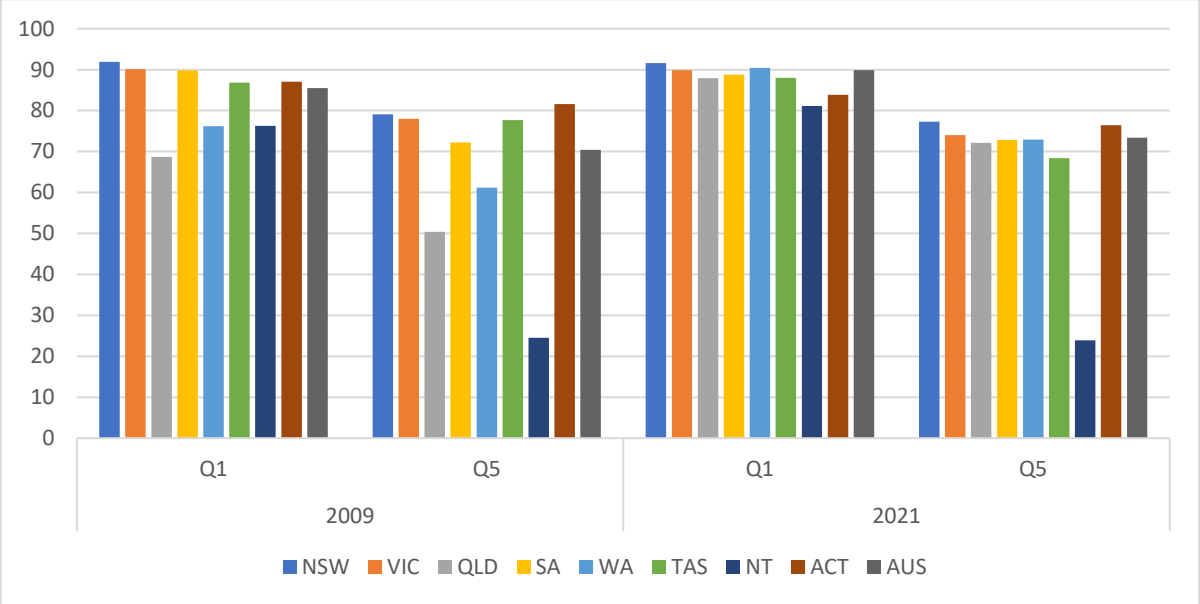


Figure A69: Early childhood development: AEDC, Language and cognitive skills (school based) – developmentally on track in each State and Territory in Australia, by quintile 1 (Q1, least disadvantaged) and quintile 5 (Q5, most disadvantaged, 2009 and 2021 (Data source: Social Health Atlas, PHIDU, 2022)

Figure presents the percentage of children developmentally on track for AEDC communication skills and general knowledge for each jurisdiction and for Australia for the least disadvantaged quintile (Q1) and the most disadvantaged quintile (Q5) for 2009 and 2021. Inequality decreased slightly in the NT and was little changed in other jurisdictions. NT had the highest inequality followed by Tasmania, and the ACT had the lowest inequality.

The NAPLAN results for Year 3 differ from the PISA results by jurisdiction which measure achievement of 15 year olds. The proportion who reached the National proficient standard in reading literacy in PISA was lower in all jurisdictions than any of the proportions by jurisdiction who reached the national minimum standard or above in Year 3. Only 48% of Tasmanian students reached the National proficient standard in reading literacy in 2015, compared with 51% in the NT, 59% in NSW, 60% in Qld, 61% in SA, 63% in Victoria and WA, and 65% in the ACT.[75] There was no significant decline in reading scores in Victoria, Qld and the NT between 2000 and 2015, but there was a significant decline in reading scores in all the other jurisdictions. The largest decline in scores was in the ACT, followed by NSW, SA. WA had the smallest decline in scores.[75]

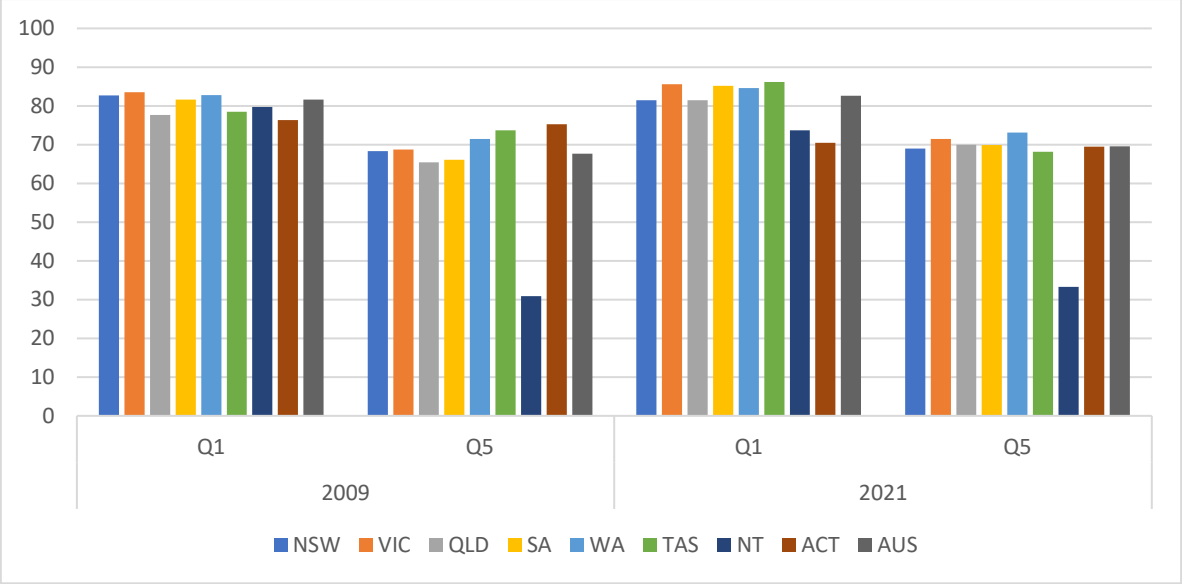


Figure A70: Early childhood development: AEDC, Communication skills and general knowledge – developmentally on track in each State and Territory in Australia, by quintile 1 (Q1, least disadvantaged) and quintile 5 (Q5, most disadvantaged, 2009 and 2021 (Data source: Social Health Atlas, PHIDU, 2023)

OECD PISA results for Australia by jurisdiction

The proportion of 15 year olds who reached the PISA National Proficient Standard for mathematical literacy in 2015 was 44% in Tasmania, 47% in the NT, 53% in Qld, 54% in SA, 55% in NSW, 58% in Victoria, 60% in WA, and 61% in the ACT. There was no decline in mathematical literacy scores in Victoria and the NT between 2003 and 2015, but all other jurisdictions experienced a significant decline in the proportion who reached the National Proficient Standard. The largest declines were in SA, then WA, the ACT, Tasmania, Queensland, then NSW.[75]

According to 2015 PISA results, the proportion of 15 year olds who reached the National Proficient Standard for scientific literacy was 48% in Tasmania, 51% in the NT, 59% in NSW, 60% in SA and Qld, 63% in Victoria, 65% in WA, and 68% in the ACT. There was no decline in scientific literacy in Victoria and the NT between 2006 and 2015, but there was a significant decline in all other jurisdictions. The largest declines were in NSW, followed by SA, Tasmania, WA and the ACT, then Queensland.

Victoria was the only jurisdiction in Australia that was placed as high equity in PISA results. This high equity placing was due a weaker relationship between socioeconomic status and performance than the OECD average.[75]

Educational outcomes by jurisdiction and remoteness

There are differences in educational outcomes by remoteness within jurisdictions. Student attendance rates and year 12 attainment rates are generally highest in major cities, followed by inner regional areas, then outer regional, remote and very remote areas.[58] Exceptions to this are the higher attendance rates in very remote areas within Tasmania, and high attendance rates in remote areas within Victoria.[58] The NT has no areas classed as major cities but had Year 12 attainment rates on par with the national average for inner and outer regional areas, and lower attainment rates in remote and very remote areas.[58] Tasmania had lower attainment rates than the national average, but also has no areas classed as major cities.[58] The ACT had high Year 12 attainment rates, but the ACT is classed as major city only[58]. Attainment rates in Victoria were highest in remote areas, and Victorian

attainment rates were higher than the national average however there are no very remote areas in Victoria.[58]

The figures from Lamb et al in the national section of the education section include statistics by jurisdiction and statistics by socio-economic status for different stages of education and those figures suggest inequality by socioeconomic status in addition to inequality between jurisdictions.

Participation in Vocational Education and Training

PHIDU data are able to provide a better picture of inequality in education by jurisdiction for indicators where PHIDU data are available. Figure A71 presents PHIDU data on participation in VET in each state and territory and for Australia for the least disadvantaged quintile (Q1) and the most disadvantaged quintile (Q5) for 2001 and 2020. Participation in VET was much higher in 2020 in every jurisdiction and in almost every socio-economic quintile compared with 2001. There was higher participation in VET for the most disadvantaged quintile in 2020, with the exception of the NT, and this higher VET participation for quintile 5 is also evident in 2001.

NT had the highest VET participation in 2020 for the least disadvantaged quintile, and the lowest VET participation for the most disadvantaged quintile (VET participation for the most disadvantaged quintile in the NT decreased between 2001 and 2020). The NT, Victoria, NSW, and SA had rates of VET participation that were higher than the national average for the least disadvantaged quintile. Queensland had the highest VET participation for the most disadvantaged quintile in 2020, followed by SA and NSW. As with the national figure, VET appears to be a more accessible pathway to qualifications compared with tertiary education.

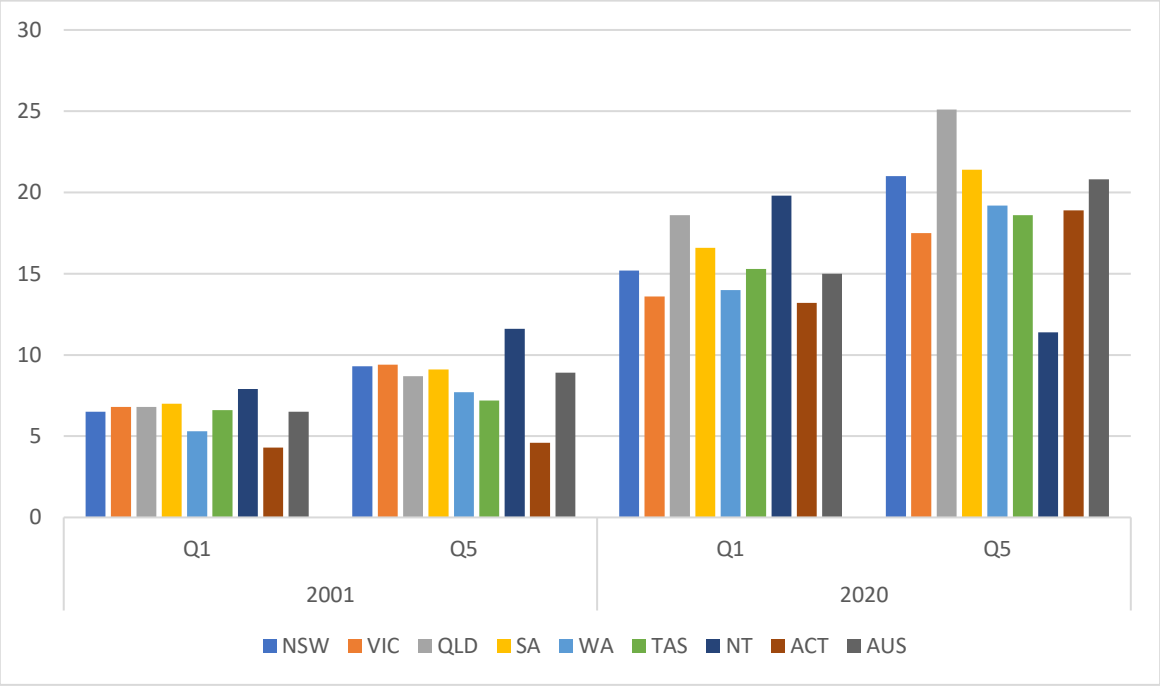


Figure A71: Age-Standardised Rate of Participation in Vocational Education and Training in each State and Territory in Australia, by quintile 1 (Q1, least disadvantaged) and quintile 5 (Q5, most disadvantaged, Total Population, Australia, 2001 and 2020 (Data source: Social Health Atlas, PHIDU, 2022)

Participation in higher education by jurisdiction

Figure A72 illustrates that there are barriers to participating in higher education for the more disadvantaged, particularly when compared with participation rates in VET education. Nationally, school leaver participation in higher education was higher in each quintile of socioeconomic disadvantage in 2021 compared with 2011. This was not the case when examining data by jurisdiction, a lower percentage participating in higher education in 2021 for the most disadvantaged quintile compared with 2011 in NSW, WA, Tasmania, the NT, and lower participation in higher education in all quintiles in the ACT. Data was unavailable for Queensland. School leaver participation in higher education was highest in Victoria, followed by SA, then Tasmania and NSW. Inequality in participation in higher education was highest for the NT (the percentage for the least disadvantaged quintile in 30.8 times that of the most disadvantaged quintile), followed by WA, and Tasmania. Socio-economic inequality in school leaver participation in higher education is very high in all jurisdictions.

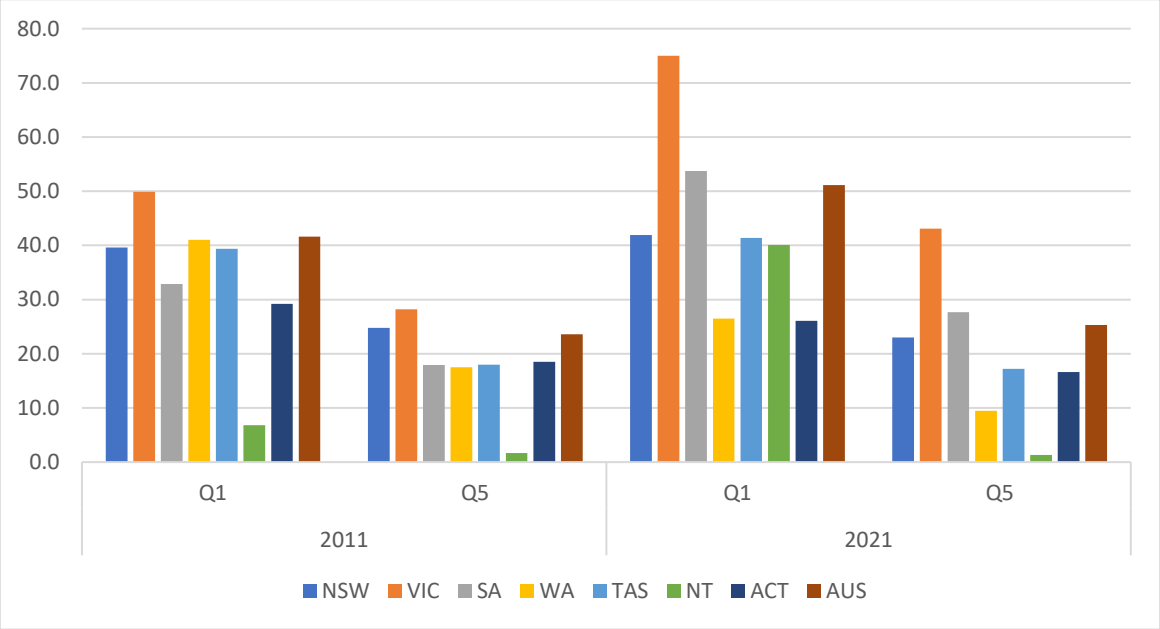


Figure A72: School leaver participation in higher education in each State and Territory in Australia, by quintile 1 (Q1, least disadvantaged) and quintile 5 (Q5, most disadvantaged, Percent, 2011 and 2021, Australia (Data source: Social Health Atlas, PHIDU, 2022)

Employment

Unemployment negatively impacts on health but poor working conditions including insecure work and physically demanding work can also adversely affect health. Employment, income, and education are related and interact. People with lower education are more likely to be unemployed, and the unemployed have low income. People with low education, low income, and unemployment experience multidimensional disadvantage. This section presents data and analysis on two components related to employment: 1) unemployment and labour force participation; and 2) characteristics of employment. It also presents some data and analysis on interactions between aspects of employment, education, and income.

Research by ACOSS demonstrates that public policy, including policy on social determinants such as housing and employment, plays a role in determining the rate of poverty and inequality in Australia.[84] The rate of unemployment accepted in Australian employment policy determines how many Australians are able to obtain paid work and the higher income associated with employment (and how many are unable to obtain paid work).

Current policy in Australia relies primarily on monetary policy and the setting of interest rates by the Reserve Bank to provide stable inflation and a stable economic environment. This policy has implications for employment. The Reserve Bank increased the cash rate 12 times between May 2022 and June 2023, and stated that unemployment in Australia would need to rise to 4.5% to curb inflation.[85] These Reserve Bank decisions are based on the economic principle that there is a trade-off between inflation and unemployment, however this trade-off relies on inflation being caused by consumer demand and employees having the bargaining power to demand higher wages. The OECD, International Monetary Fund, European Central Bank and the Australia Institute have provided evidence that recent inflation is primarily caused by profits.[86] Wage increases were continually below the inflation rate in 2022 and 2023, resulting in decreasing real wages.[87] The RBA plan to increase unemployment will increase existing inequities in the labour market, and still may not be effective in reducing inflation as it does not treat the current main cause.

Unemployment and labour force participation

Unemployment

Figure A72 presents the unemployment rate in Australia by sex from 1991 to 2022. Male unemployment was slightly higher than female unemployment from the early 1990s until 2002 but there was little difference in unemployment rates by sex over the past 20 years. The unemployment rate declined steadily from around 10% in 1991 to 3.9% for men and 4.6% for women in 2007. The Global Financial Crisis resulted in higher unemployment, however the unemployment rate was still much lower than in the early 1990s, peaking at around 6% in 2015. The unemployment rate began declining again from 2015 until 2019, and spiked temporarily to 7.1% for men and 6.3% for women with the onset of the pandemic. In 2022 the unemployment rate was the lowest it had been in many decades.

The unemployment rate is higher for Aboriginal and Torres Strait Islander people, but it has improved. According to Census data, the unemployment rate for Aboriginal and Torres Strait Islander people aged 25-64 decreased from 15% in 2016 to 10% in 2021. The gap in the unemployment rate between Aboriginal and Torres Strait Islander people and non-Indigenous Australians also improved, decreasing from 9.7 percentage points to 6.0 percentage points.[88] The unemployment rate is also higher for recent migrants to Australia. According to 2021 Census data, the unemployment rate for recent migrants was 7.2% compared with 4.8% for people born in Australia. The unemployment rate also differs by country of birth. In 2023, the unemployment rate for people born in North Africa and

the Middle East was 7.5% compared with an unemployment rate of only 2.4% for people born in the Americas.[89]

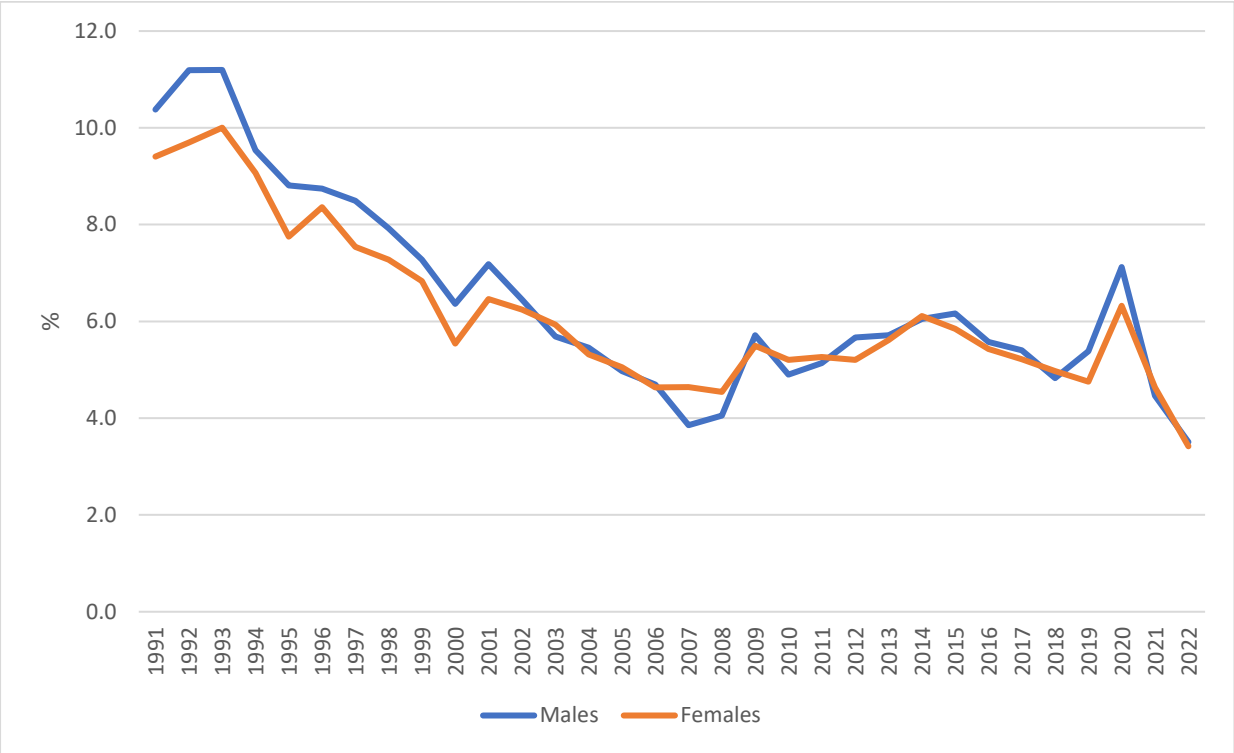


Figure A72: Unemployment rate, by sex, Australia, 1991 to 2022 (Data source: Labour Force Australia, ABS, 2023)[90]

The unemployment rate does differ by age as well as by sex. **Figure A73** presents the unemployment rate for 15-24 year olds (the youngest age bracket included in ABS employment statistics) and by sex from 1986 to 2022. The unemployment rate was much higher for 15-24 year olds compared with the overall unemployment rate, and 15-24 year old men had a higher unemployment rate than women in almost every year in **Figure A73**. The unemployment rate for 15-24 year olds was 14.8% for women and 15.5% for men in 1986, decreased between 1986 and 1989, then increased sharply to a peak of 20.3% for men in 1992 and 17.3% for women in 1993. Unemployment for younger people then declined until 2008 (as with the overall unemployment rate) and was 8% for women and 9.3% for men just prior to the Global Financial Crisis. The unemployment rate increased more for young men than young women after the Global financial crisis. While the unemployment rate for 15-24 year old women declined below 10% prior to the onset of the pandemic, the unemployment rate for 15-24 year old men was still above 13%. The pandemic peak in the unemployment rate for 15-24 year olds was 15.6% for men and 12.7% for women. In 2022, the unemployment rate for 15-24 year olds was the lowest it had been in at least 35 years, 8.5% for men and 6.5% for women.

The unemployment rate for 15-24 year old Aboriginal and Torres Strait Islander people is higher than that for non-Indigenous Australians.[88] The overall unemployment rate between the 2011 and 2021 averaged at 15.8% for migrant youth compared with 12.6% for the overall youth unemployment rate.[89]

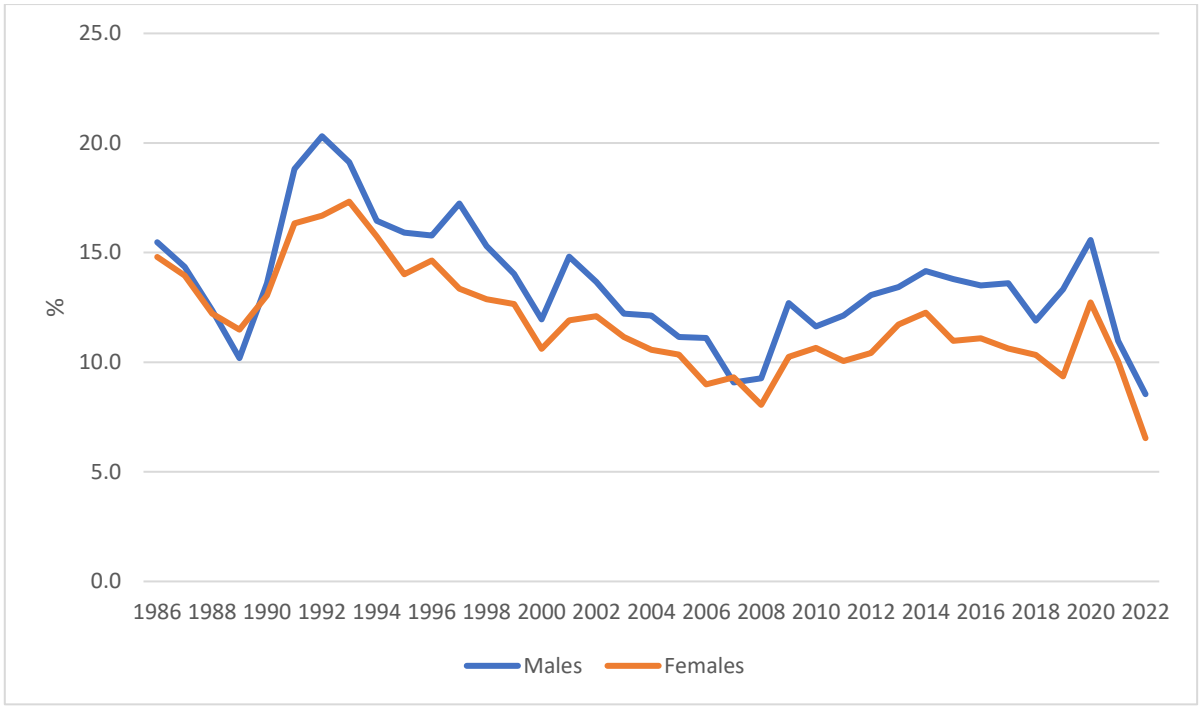


Figure A73: Unemployment of 15-24 year olds, by Sex, Australia, 1986 to 2022 (per cent) (Data source: Labour Force Australia, ABS, 2023)[90]

ABS data provides information on the trend in unemployment and differences in unemployment rates by sex, age, and jurisdiction. PHIDU data provides information on the socioeconomic distribution of unemployment in 1986 and 2021 for Australia (**Figure A74**). There is a social gradient in unemployment, with the unemployment rate increasing with increasing disadvantage. ABS data reported an overall unemployment rate of around 10% in the early 1990s. PHIDU data shows that the unemployment rate was 9.1% for the middle quintile in 1986 and above 10% for quintiles 4 and 5 (the most disadvantaged quintiles). The unemployment rate was much lower in the less disadvantaged quintiles.

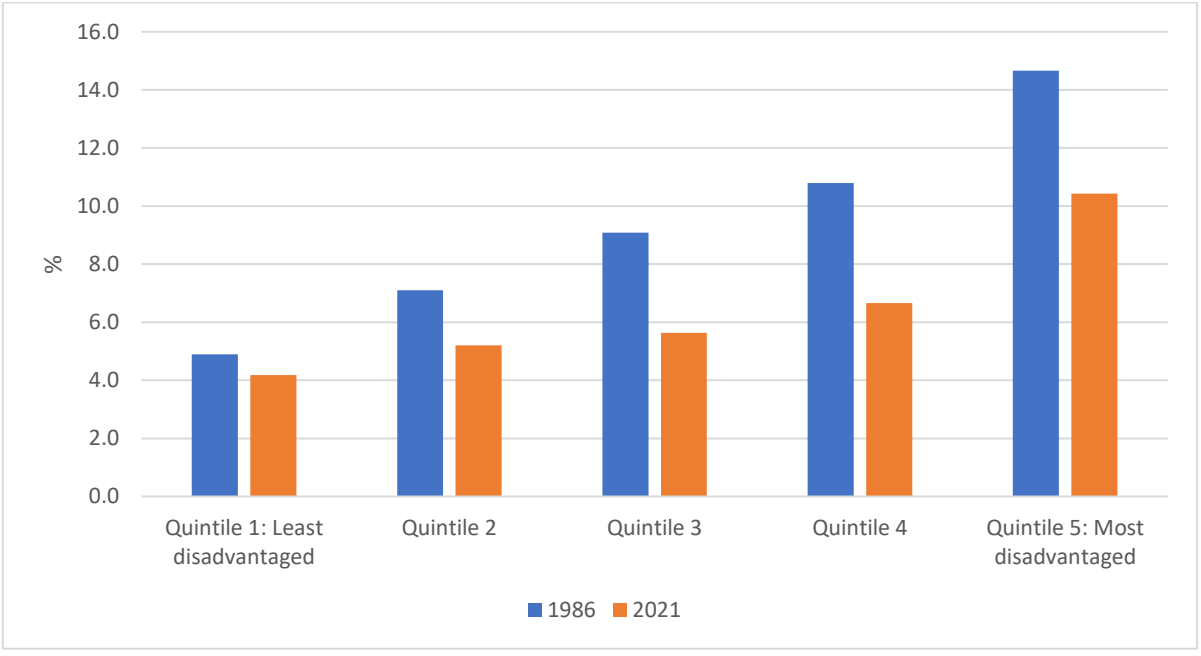


Figure A74: Rates of unemployment by quintile of socioeconomic disadvantage, 1986 and 2021, Australia (Data source: Social Health Atlas, PHIDU, 2022)[14]

Unemployment decreased for all quintiles between 1986 and 2021. **Table A10**8 presents the percentage reduction in the unemployment rate by quintile. The decrease was much smaller for the least disadvantaged quintile. The gradient in unemployment was not as steep in 2021 compared with 1986 because reductions in unemployment were larger for more disadvantaged quintiles. The rate ratio for unemployment was 3.0 in 1986 and decreased to 2.5 in 2021, indicating slightly lower inequality in unemployment in 2021.

Table A108: Table of proportional reduction in the unemployment rate by quintile between 1986 and 2016

Quintile 1 (least disadvantaged)	14.5%
Quintile 2	26.7%
Quintile 3	38.0%
Quintile 4	38.3%
Quintile 5 (most disadvantaged)	28.9%

Labour force participation

The unemployment rate is the percentage of the labour force that is unemployed and looking for work. The labour force participation rate is the percentage of the civilian working-age population (aged 15 and over) that are either employed or are unemployed and looking for work. The ABS has historical data on the labour force participation rate by sex from the mid-1960s until now. **Figure A75** presents the labour force participation rate for all years available from the ABS, with each data point being from August in each year. The labour force participation rate for men was 84.2% in 1966 and gradually declined over the past almost 6 decades to 69.4% in 2021 before increasing to 71.2% in 2022. The female labour force participation rate shows the opposite trend, starting at a low 36.6% in 1966 and climbing to 62.3% in 2022. Women's labour force participation is currently the highest it has ever been.[91]

Even though women's labour force participation rate is at a record high in Australia, it is lower than it could be and lower than the female labour force participation rate in many other countries. **Figure A76** presents the female labour force participation rate in OECD countries where the measure of the labour force participation rate is comparable to that in Australia. Eighteen OECD countries have a higher female labour force participation rate than Australia. The female labour force participation rate in Sweden, Iceland, Portugal, and Switzerland is above 85%, providing evidence that if action is taken to address barriers to participating in the labour force a much higher female labour participation rate can be achieved.

The labour force participation rate in 2021 was also slightly higher for Aboriginal and Torres Strait Islander men compared with Aboriginal and Torres Strait Islander women (62% compared with 58%).[88] The labour force participation rate of recent migrants was 72.4% in 2021, higher than the overall participation rate of 66.3% for the Australian born population. For recent migrants born in main English speaking countries the labour force participation rate was 83.4%, and recent migrants born in other than English speaking countries had a labour force participation rate of 70.1%.[89]

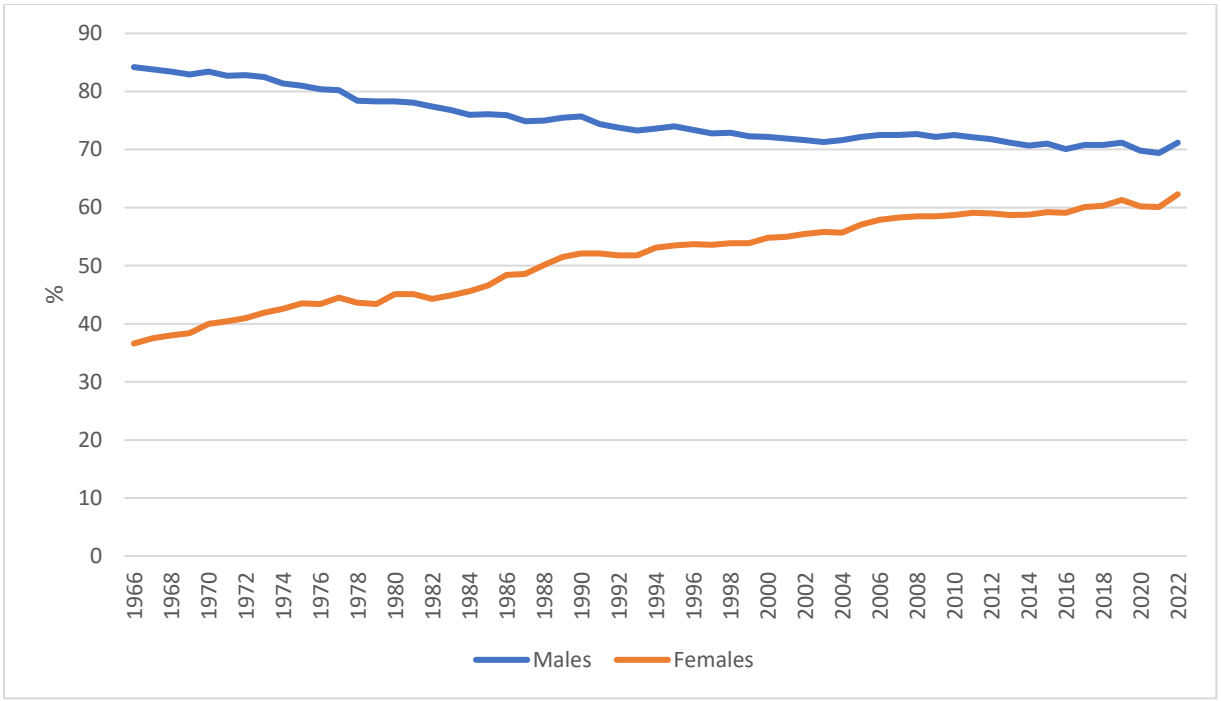


Figure A75: Labour force participation rate, by Sex, Australia, 1966 to 2022 (Per cent) (Data source: ABS Historical Charts, 2023)[92]

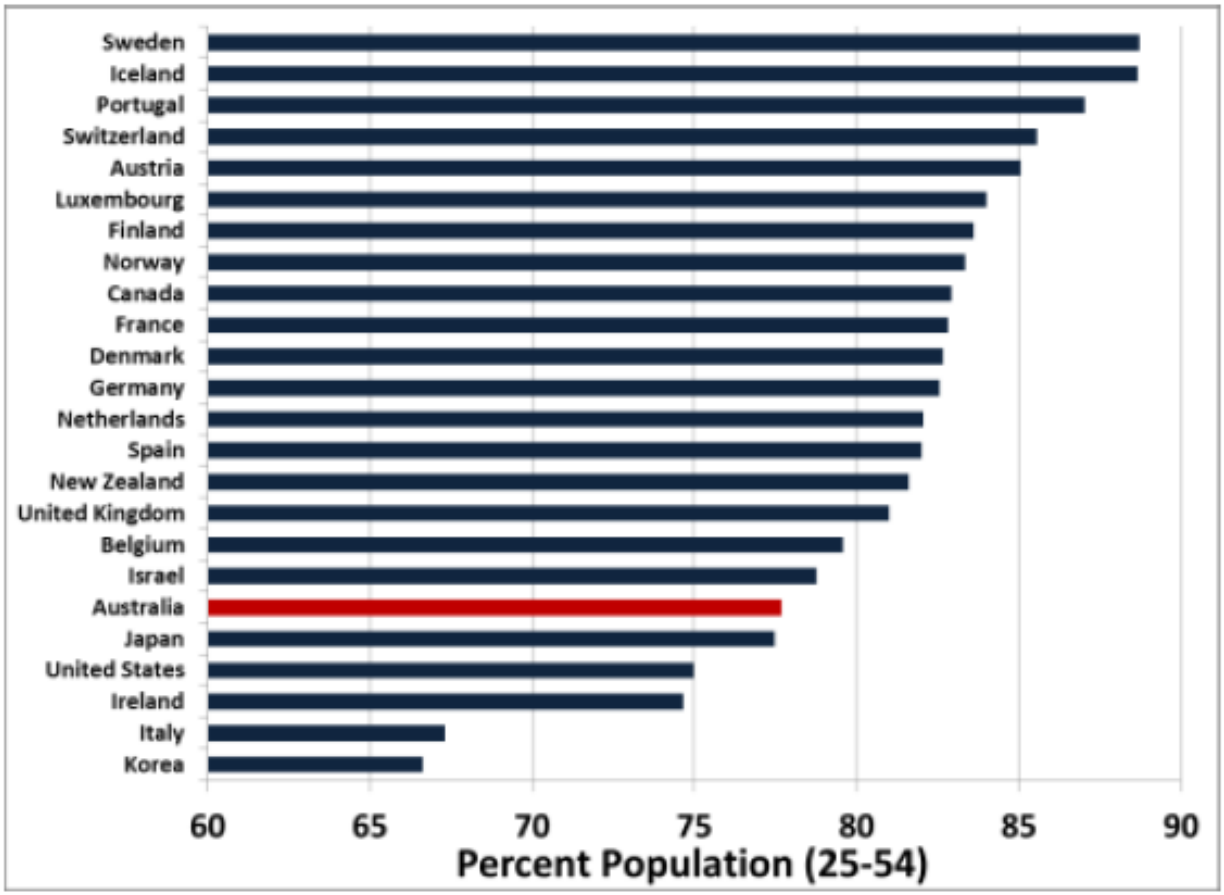


Figure A76: Female labour force participation, Selected OECD Countries (% of the population aged 25-54) (Data source: Pennington and Stanford, 2020, Figure 5)[91]

Examining the labour force participation rate by age and sex shows the impact of parenting and household responsibilities on women's labour force participation (**Figure A77**). Labour force participation rates by sex are fairly equal for 15-19 year olds and 20-24 year old by sex. The difference in labour force participation rates starts with 25-29 year olds, but the largest decline is when women are in their 30s, the most common age to have children. Male labour force participation increases when men are in their 30s. While the female labour force participation rate is much closer to male labour force participation rates for age groups in their 40s and 50s, absence from paid work in their 30s has a large impact on women's lifetime earnings, superannuation accumulations and retirement incomes.[91]

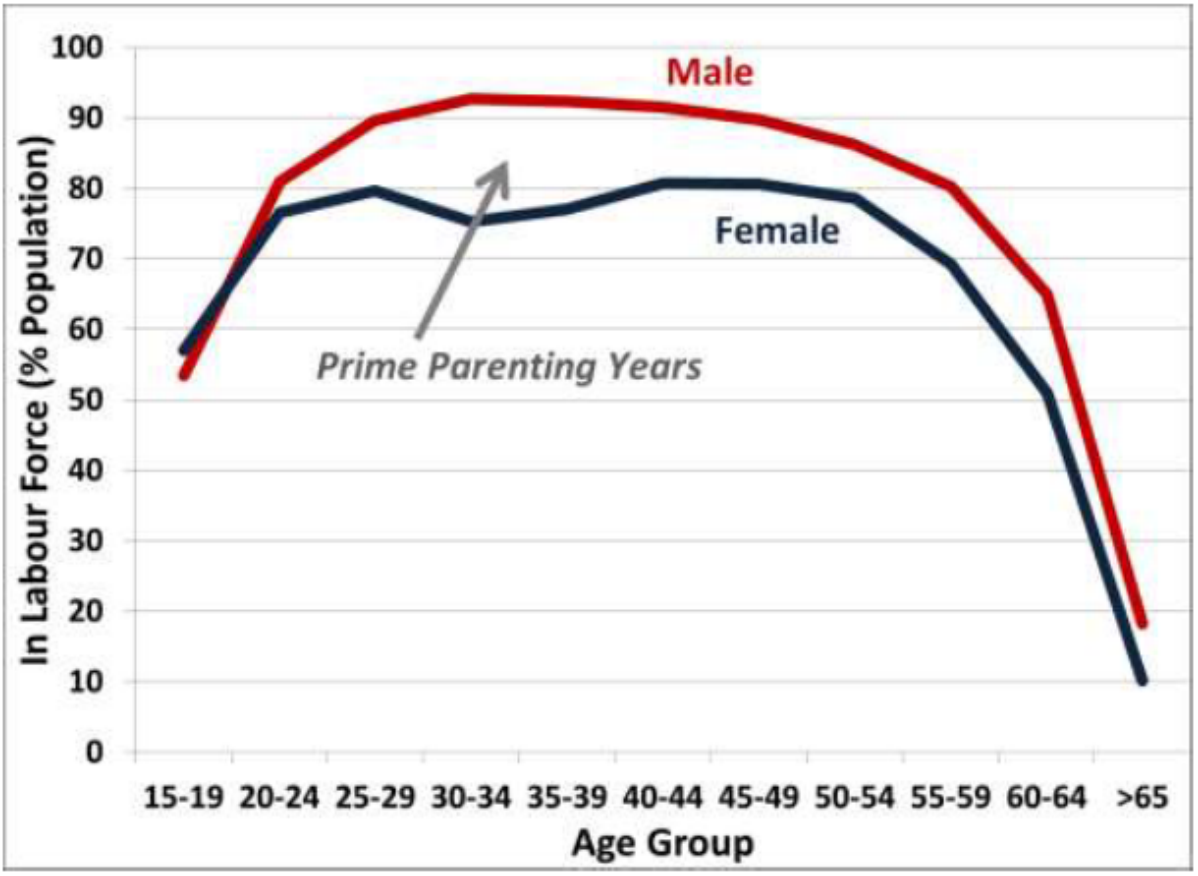


Figure A77: Labour force participation by age and gender, 2018 (Data source: Pennington and Stanford, 2020, figure 3)[91]

Figure A30 presents the labour force participation rate by quintile of socio-economic area disadvantage in 1986 and 2021. There is a clear social gradient in the labour force participation rate which is lower with increasing disadvantage in 1986 and in 2021. The labour force participation rate increased for every quintile between 1986 and 2021, and this was driven by the increase in the female labour force as illustrated in **Figure A75**. The degree to which the labour force participation rate increased differed by quintile, with only small increases in the percentage participating in the labour force for quintiles 4 and 5 (the more disadvantaged quintiles).

The labour force participation rate increased by only 0.7 percentage points for the most disadvantaged quintile and increased by only 1.3 percentage points for quintile 4. This contrasts with increases of 8.3, 8.4, and 7.3 percentage points for quintiles 1, 2 and 3 respectively. The larger increases in the labour force participation rate for less disadvantage quintiles resulted in increasing inequality in labour force participation, and the social gradient for the labour force participation rate

was steeper in 2021 than in 1986. The labour force participation rate for the most disadvantaged quintile was 0.78 that of the least disadvantaged quintile in 2021 compared with 0.87 in 1986.

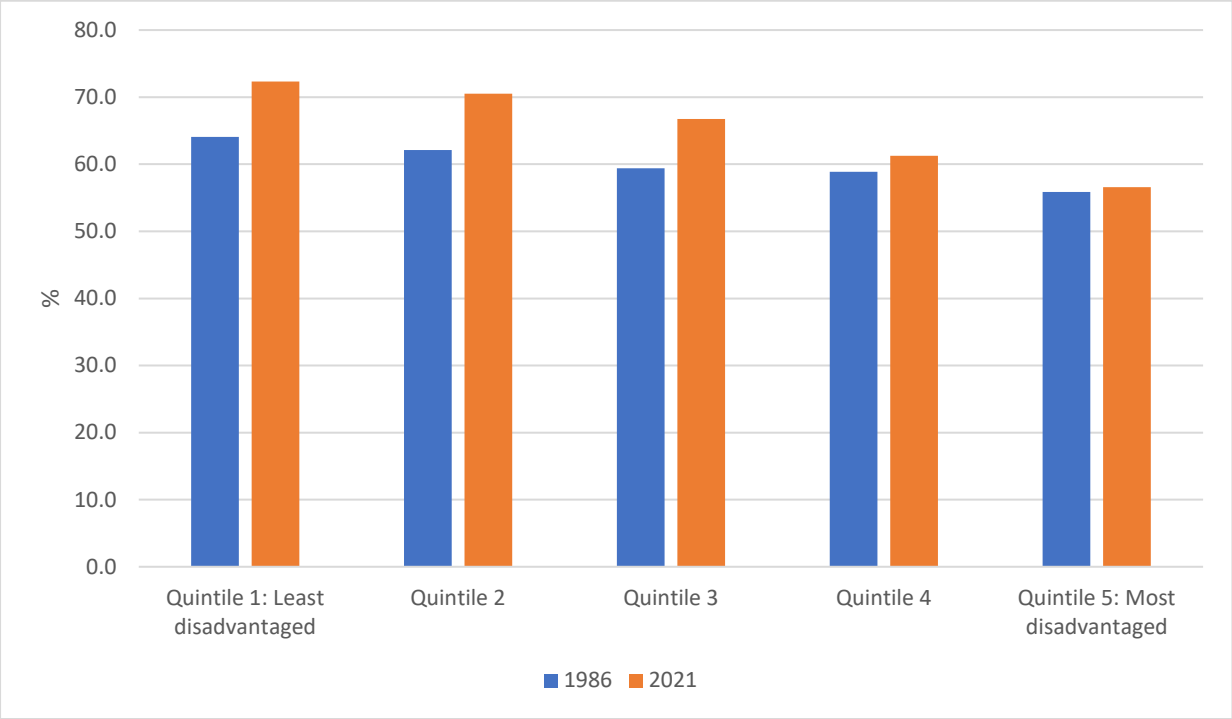


Figure A308: Rates of labour force participation by quintile of socioeconomic disadvantage, 1986 and 2021, Australia (Data source: Social Health Atlas, PHIDU, 2022)

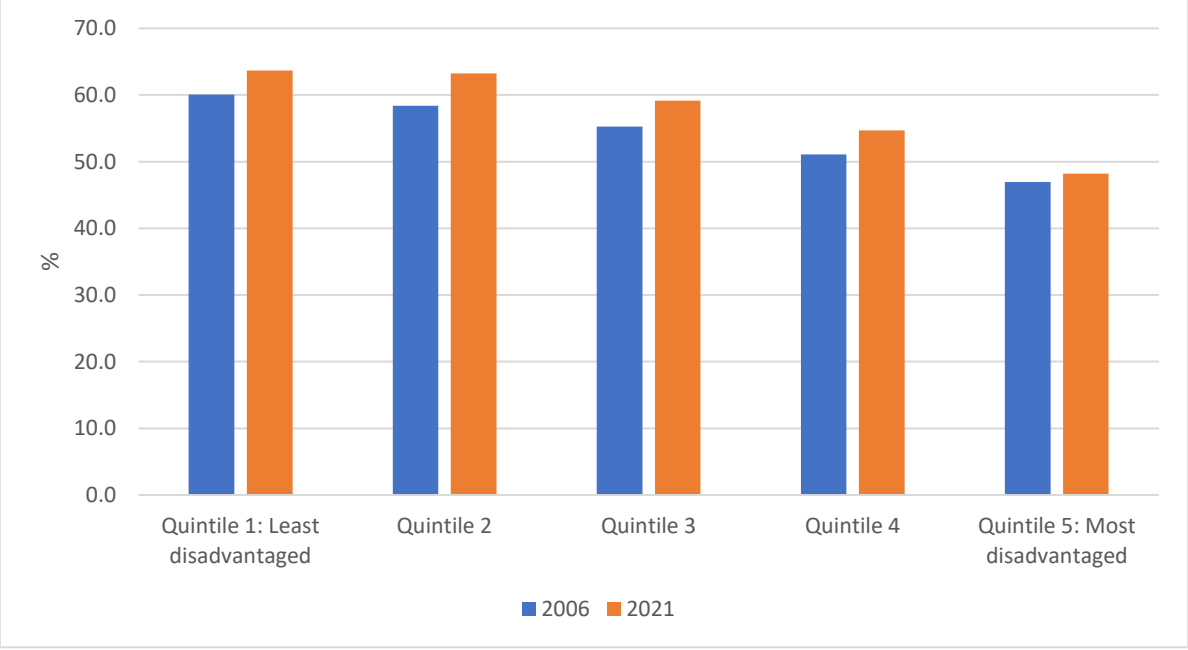


Figure A79: Rates of female labour force participation by quintile of socioeconomic disadvantage, 2006 and 2021, Australia (Data source: Social Health Atlas, PHIDU, 2022)

Figure A79 presents the female labour force participation rate by quintile of socio-economic area disadvantage in 2006 and 2021. The social gradient evident in the overall labour force participation rate is even more pronounced for the female labour force participation rate which differs more by disadvantage. While the time points in **Figure A79** only capture part of the time period in which female labour force participation was increasing, there was an increase in the labour force participation rate for every quintile between 2006 and 2021.

The smallest increase in the female labour force participation rate was for quintile 5, the most disadvantaged quintile, only 1.2 percentage points. Female labour force participation rates increased by 3.5, 4.8, 3.8, and 3.6 percentage points for quintiles 1, 2, 3 and 4 respectively. While the difference in the female labour force participation rate widened between the most and least disadvantaged quintiles between 2006 and 2021, the middle quintiles had larger increases in labour force participation compared with the least disadvantaged quintile.

Employment to population ratio

The unemployment rate and the labour force participation rate are indicators of engagement in employment for the working age population. Population growth influences measures of trends in employment. If population growth is slower in one jurisdiction compared with others, growth in employment will also be slower. We calculated the growth in employment and growth in the working age population between 1996 and 2021 using Census Time Series Profiles. The working age population in Australia grew by 49% between 1996 and 2021. Employment grew faster than population growth over this period, growing by 58%. Employment growing faster than population growth contributed to the increase in labour force participation and decrease in the unemployment rate.

The employment to population ratio is a measure of engagement in employment which accounts for population growth. **Figure A80** presents the employment to population ratio by sex from 1991 to 2022. The employment to population ratio is influenced by labour demand (how many people do employers want to hire) and labour supply (how many people are wanting to work given current real wages). The higher employment to population ratio for men reflects the higher male labour force participation rate. The employment to population ratio for women steadily increased from 1993 (after the early 1990s recession) until 2008, just before the Global Financial Crisis. The male employment to population ratio rose from 1993 until 2000, then rose again from 2002 until 2008. The male employment to population ratio was lower in all post GFC years compared with just prior to the GFC. The female employment to population ratio rose in most years from 2015 onwards and was at its highest in 2022, almost 60%. The larger increase in the employment to population ratio for women compared with men between 1991 and 2022 reflects the decrease in the male labour force participation rate over this period and the increase in the female labour force participation rate. The increase in the overall employment to population ratio over this period also reflects employment growth outpacing population growth.

The employment rate is a slightly different measure of employment than the employment to population ratio, with the employment rate in the Aboriginal and Torres Strait Islander Health Performance Framework referring to the number of employed people aged 15 to 64 as a percentage of the population.[88] Overall, 52% of Aboriginal and Torres Strait Islander people aged 15-64 were employed, lower than the 75% employment rate for non-Indigenous people.[88] The employment rate for Aboriginal and Torres Strait Islander people differed by remoteness. It was 58% in major cities, 55% in inner regional areas, 51% in outer regional areas, 42% in remote areas and 32% in very remote areas.[88] The employment rate is highest in major cities for non-Indigenous people as well,

which may be due to lower access to paid work outside major cities and a higher number of retired older people outside major cities.[93]

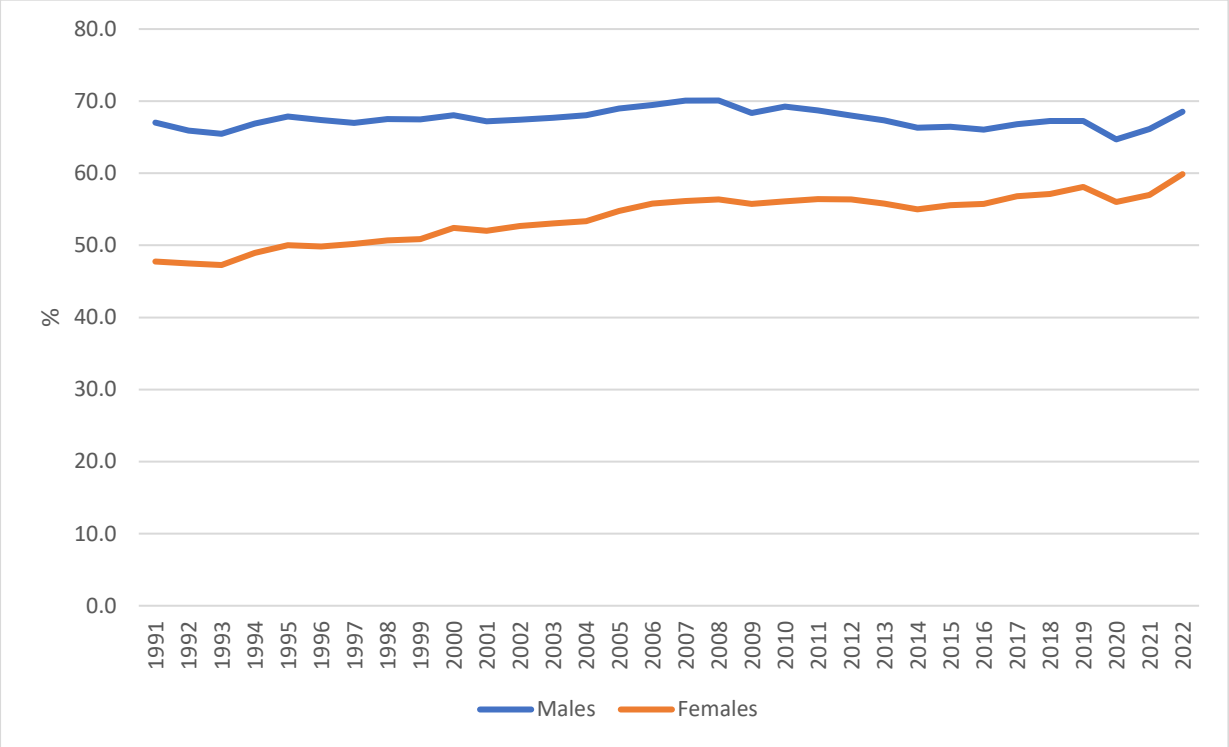


Figure A80: Employment to population ratio[6], by Sex, Australia, 1991 to 2022 (per cent) (Data source: Labour Force Australia, ABS, 2023)[90]

In 2014-15, the National Aboriginal and Torres Strait Islander Social Survey recorded the main reasons for not looking for a job and not being in the labour force. The most common responses were childcare (22%), studying or returning to study (20%) and having a long term health condition or disability (18%).[88] In addition to these reasons for not being in the labour force, lower levels of training and education, experiences of discrimination, lower levels of job retention and much higher levels of contact with the criminal justice system contribute to lower levels of employment for Aboriginal and Torres Strait Islander people.[95] Many Aboriginal and Torres Strait Islander people in remote areas who are not in the labour force are engaged in productive activities supporting their community.[96]

Jobless families

Figure A81 presents the percentage of families with children aged under 15 where there is no parent employed, by quintile of socioeconomic disadvantage in 2001 and 2021. The percentage of jobless families decreased for every quintile between 2001 and 2021, reflecting the strong growth in employment and reductions in unemployment over this period. The decrease in the percentage of jobless families was much smaller in the most disadvantaged areas, with 23% of families with children aged under 15 in the most disadvantaged quintile jobless in 2021. There was a social gradient in the percentage of jobless families with the percentage increasing with more disadvantage

[6] The ABS defines the employment to population ratio as the number of people aged 15 and over that are employed as a percentage of the civilian population aged 15 and over.94. Australian Bureau of Statistics. Australian Labour Market Statistics 2013 [Available from: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/A9911868BFD9C924CA257BA300137E3C?opendocument.

in 2001 and in 2021. Large reductions in the percentage of jobless families reduced the difference by quintile for all except quintile 5. The percentage of jobless families in the most disadvantaged quintile was 3.3 times that of the least disadvantage quintile in 2001. In 2021, the percentage of jobless families in the most disadvantaged quintile was 4.5 times that of the least disadvantaged quintile.

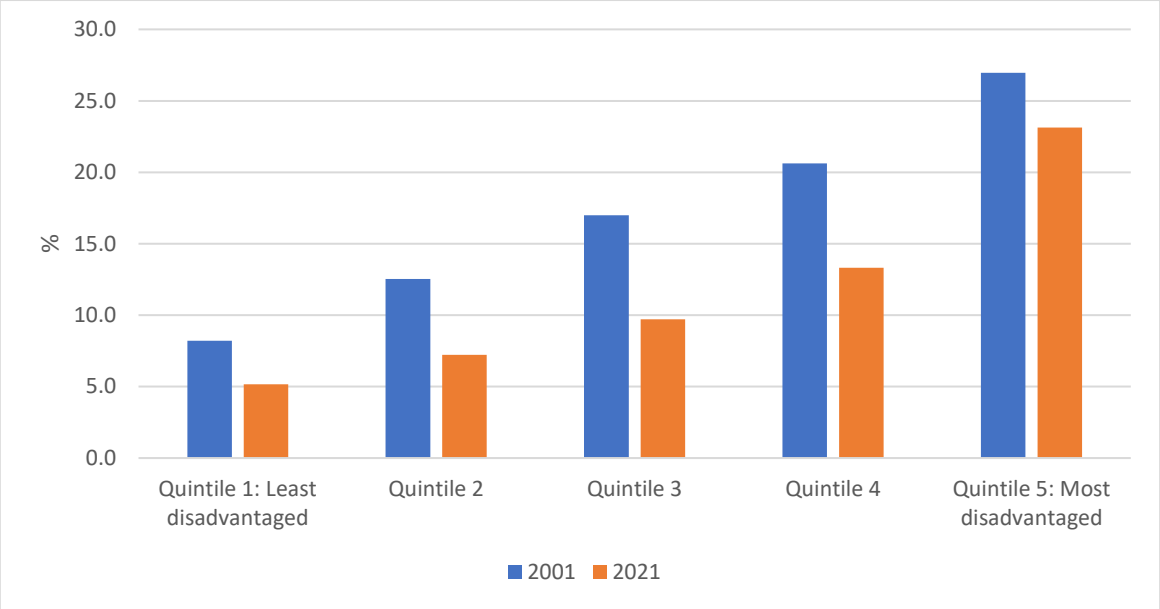


Figure A81: Jobless families with children aged less than 15 years by quintile of socioeconomic disadvantage, 2001 and 2021, Australia (per cent) (Data source: Social Health Atlas, PHIDU, 2022)

Multidimensionality in unemployment and labour force participation

The preceding analysis focused solely on trends in indicators related to engagement in employment and analyses of inequality in these indicators. **Figure A82** presents the unemployment rate by highest level of qualification for people aged between 20 and 64 years from 2015 until 2022. Examining the unemployment rate by education provides some insight into relationships between education and employment. The unemployment rate is much higher for people with education below Year 10 compared with all other levels of education. People with Year 10 or Year 11 as their highest education had the next highest unemployment rate in most years between 2015 and 2022, followed by people with Year 12 as their highest education. People with a graduate diploma or graduate certificate and people with a Bachelor degree had the lowest unemployment rates between 2015 and 2022.[7]

The unemployment rate and labour force participation rate also differs by highest education for recent migrants. In 2021, recent migrants with a higher degree had an unemployment rate of 5.9% and labour force participation rate of 83%. Recent migrants with vocational post-school qualifications had an unemployment rate of 6.1% and labour force participation rate of 78.4%, and recent migrants with secondary education as their highest education had an unemployment rate of 11.5% and labour force participation rate of 53.3%.[89]

In 2021, 85% of Aboriginal and Torres Strait Islander people aged 25-64 who held a Bachelor degree as their highest level of education were employed, compared with 72% of Aboriginal and Torres Strait Islander people with a Certificate III or IV, and 45% of those with Year 10 to Year 12 as their highest level of education, and 24% of those with Year 9 or below.[88] The ABS statistics on the overall

[7] Note that the unemployment rate for people with a postgraduate degree may not be reliable due to the small percentage of Australians who obtain a postgraduate degree.

population and recent migrants and AIHW statistics for Aboriginal and Torres Strait Islander people illustrate the powerful role access to study leading to post-school qualifications can play in increasing the likelihood of employment.

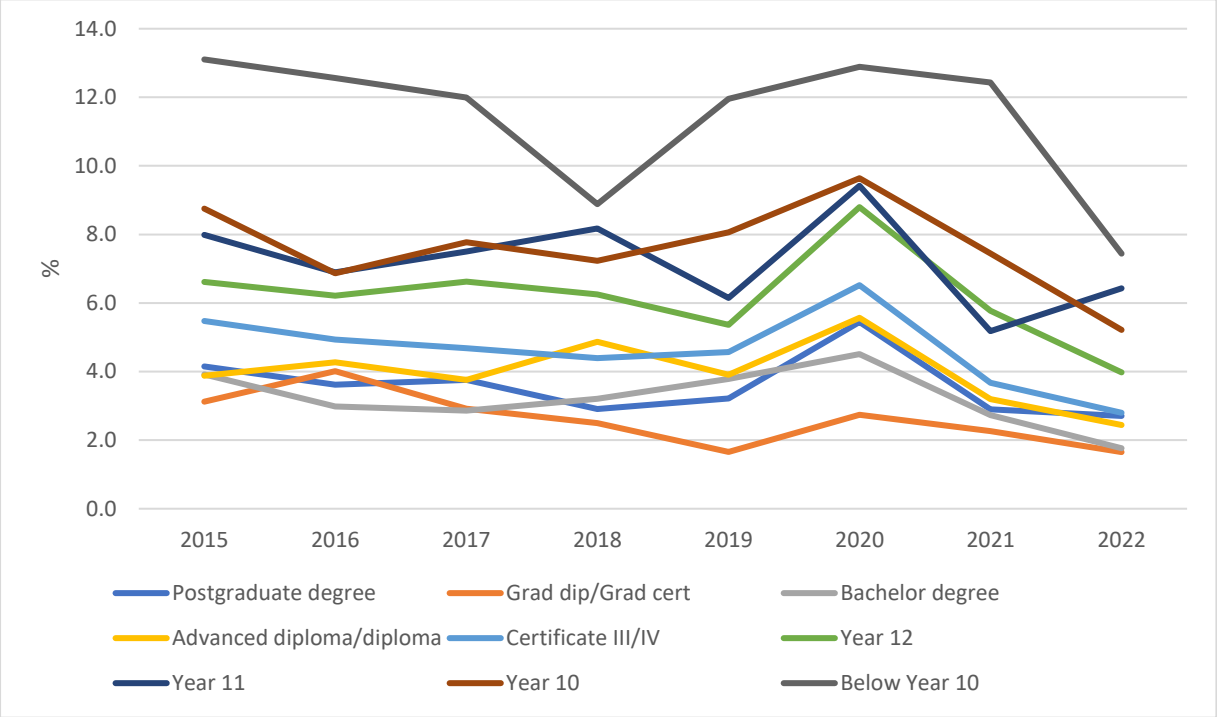


Figure A82: Unemployment rate by level of highest qualification, 20-64 years, Australia, 2015 to 2022 (Data source: ABS Labour Force Survey, Detailed, 2023)[97]

Characteristics of employment

Underemployment

Examining the growth in employment and trends in unemployment and labour force participation provides a partial picture of inequities in employment. Statistics related to labour force status do not provide information on the nature or characteristics of employment. ABS statistics count people as employed if they work one hour or more in the reference week for the Labour Force Survey. **Figure A83** presents the underemployment ratio from 1978 to 2022, which is the number of underemployed people as a percentage of total employed people.[8] Examining underemployment statistics reveals that more than 800,000 workers were underemployed in 2022.[90] The underemployment ratio is higher for women than for men. In 1978, the underemployment ratio was 1.9% for men and 4.5% for women. The underemployment ratio rose over the past four decades, and in 2019 prior to the pandemic it was 6.9% for men and 10.2% for women. Underemployment increased sharply with the onset of the pandemic, to 10.9% for men and 12.4% for women, but then fell in 2021 and again in 2022 to the lowest underemployment ratio since before the Global Financial Crisis.

[8] Underemployment includes part time workers who preferred and were available to work more hours plus full-time employed workers who work part time due to insufficient work, no work being available, reduced hours or being stood down.

The underemployment ratio differs by age as well as by sex as with other employment related measures. The underemployment ratio is much higher for 15-24 year olds compared with all other aged groups. Figure A84 presents the underemployment ratio for people aged 15-24 compared with the overall unemployment ratio. There was only a small difference between the underemployment ratio for 15-24 year olds and the overall underemployment ratio in the late 1970s. The difference between the overall underemployment ratio and the underemployment ratio for 15-24 year olds widened over the past four decades. In 2019, the underemployment ratio for 15-24 year olds was double the overall underemployment ratio. The underemployment ratio for 15-24 year olds increased from 16.8% in 2019 to 17.9% in 2020 with the onset of the pandemic, but the increase in underemployment for 15-24 year olds was lower than the increase in the overall underemployment rate. Underemployment fell for 15-24 year olds in 2021 and 2022, following the overall trend, but the underemployment ratio for 15-24 year olds was still more than double the overall underemployment ratio in 2022.

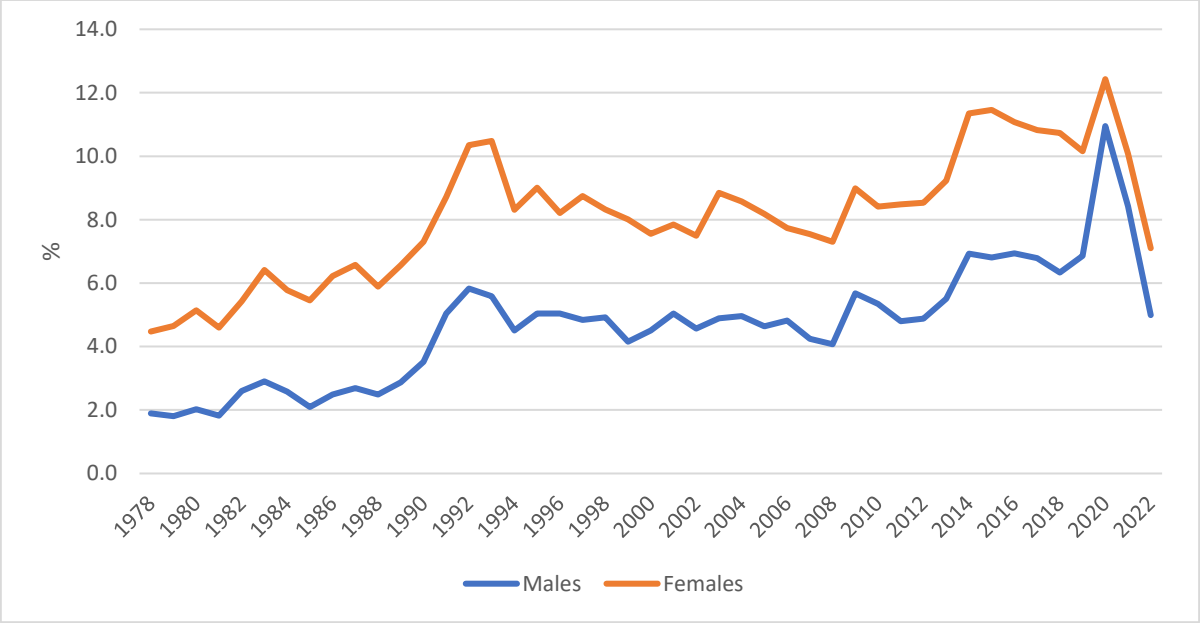


Figure A83: Underemployment ratio, Australia, 1978 to 2022 (per cent) (Data source: Underutilised Persons, ABS, 2023)[90]

The underutilisation rate provides a measure of the percentage of the labour force that is underutilised by adding unemployment and underemployment together. **Figure 31** presents the underutilisation rate in Australia from 1978 to 2022. The underutilisation rate is higher for women than for men and this reflects higher underemployment for women. The unemployment rate decreased over the past four decades but the increase in the underemployment ratio was larger than the decrease in employment therefore the underutilisation rate increased over the past four decades. The difference by sex in the underutilisation rate remained about the same from the late 1970s through to 2019. With the onset of the pandemic the underutilisation rate increased by more for men than for women, and the difference in the underutilisation rate by sex was smaller in 2020, 2021 and 2022. The underutilisation rate for women in 2022 was the lowest since at least 1978, and the underutilisation rate for men in 2022 was the lowest since prior to the Global Financial Crisis.

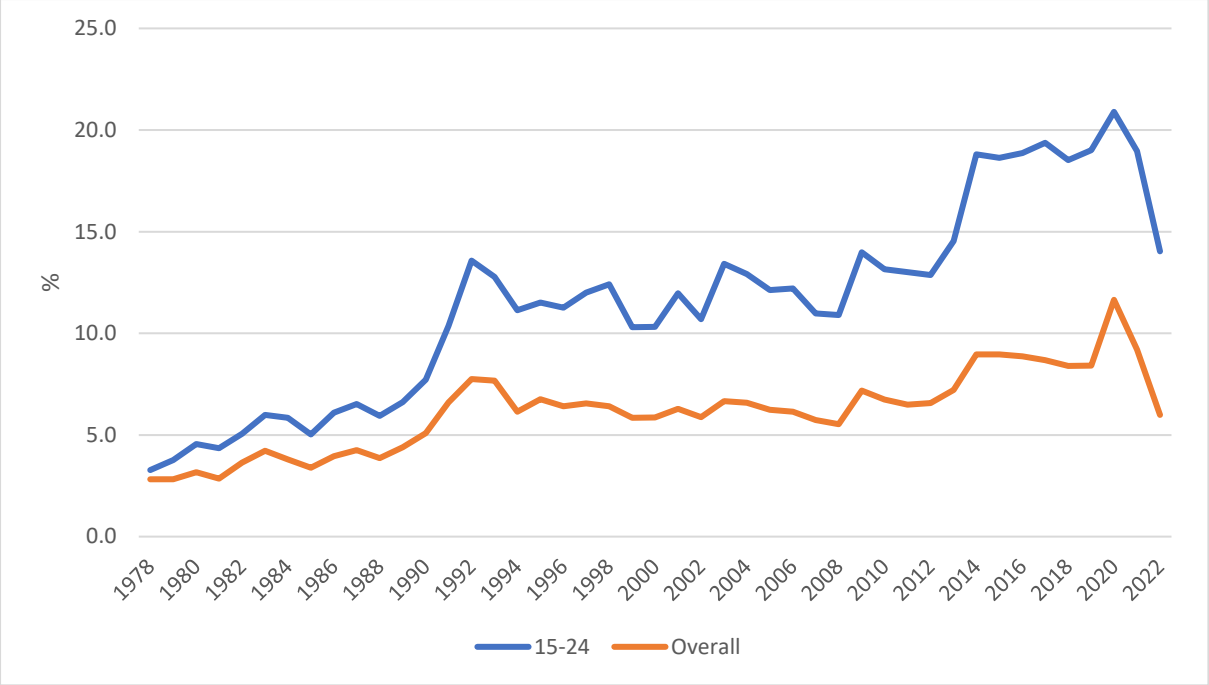


Figure A84: Underemployment ratio, 15-24 years olds and overall, Australia, 1986 to 2022 (Per cent) (Data source: Underutilised persons, ABS, 2023)[90]

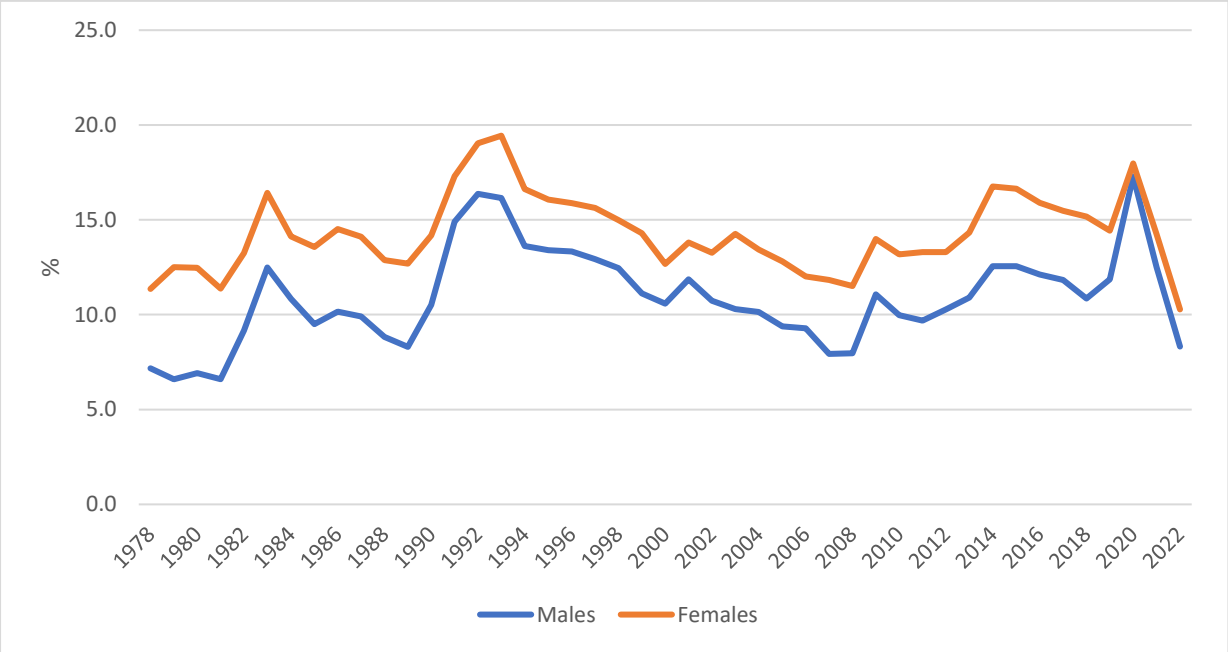


Figure 31: Underutilisation rate, Australia, 1978 to 2022 (per cent) (Data source: Underutilised persons, ABS, 2023)[90]

Table A19 presents the prevalence of underemployment by occupation in 2022 and 2023. Underemployment was highest for occupations that do not generally require higher education and are already lower paying jobs. More than a fifth of labourers were underemployed in 2022 and 2023, and almost a fifth of community and personal service workers were underemployed in 2023. These

occupations represent a higher share of employment for women therefore underemployment in these occupations would have a larger impact on women.

The industries with the highest percentages of underemployment are also those that represent a higher share of employment for women (Table A20). Five out of the top six industries in terms of underemployment are industries representing a higher share of employment for women compared with men. The higher percentage of underemployment in accommodation and food services, retail trade, and health care and social assistance in particular are likely to impact more on women, resulting in lower incomes.

Table A19: Underemployment ratio by occupation (Data source: ABS Underemployed Workers, 2023)[98]

	May 2022	May 2023
Labourers	21.3	21.9
Community and Personal Service Workers	16.7	19.6
Sales Workers	17.8	17.7
Machinery Operators and Drivers	15.6	17.1
Technicians and Trades Workers	11.4	10.7
Clerical and Administrative Workers	7.3	7.7
Professionals	6.3	6.4
Managers	4.5	4.4

Table A20: Underemployment ratio by industry (Data source: ABS Underemployed Workers, 2023)[98]

	May 2022	My 2023
Accommodation and Food Services	20.0	21.2
Retail Trade	16.6	17.5
Administrative and Support Services	11.7	16.4
Arts and Recreation Services	17.3	14.7
Transport, Postal and Warehousing	12.6	14.4
Health Care and Social Assistance	10.3	12.2
Construction	11.2	11.4
Manufacturing	10.7	10.7
Information Media and Telecommunications	10.4	10.3
Other Services	11.5	10.3
Education and Training	8.7	9.4
Wholesale Trade	9.4	9.3
Electricity, Gas, Water and Waste Services	9.0	8.1
Rental, Hiring and Real Estate Services	5.9	7.1
Professional, Scientific and Technical Services	7.5	6.5
Agriculture, Forestry and Fishing	7.2	6.3
Public Administration and Safety	6.7	6.3
Financial and Insurance Services	5.2	4.3
Mining	5.9	3.4

Full time employment and part time employment

The next figures present ABS statistics on terms of employment. **Figure A86** presents the percentage of Australians in full time employment by sex from 1991 until 2022. Full time employment used to be considered the norm, and this is reflected in the very high percentage of men who were in full time employment in 1991, just over 90%. The percentage of women in full time employment is lower than that for men, with 59% of working women in full time employment in 1991. Employment growth was strong over the period included in **Figure A86**, but there was a decline in full time employment for both men and women. Full time employment for women decreased to 52.8% in 2016 before increasing again to 56.6% in 2022. Full time employment for men reached a low of 80.1% in 2020 and was 81% in 2022. The decrease in the percentage of men in full time employment is larger than the decrease for women. Calculations using Census data suggest full time employment grew by 37% between 1996 and 2021, lower than the 49% growth in the population over this period and much lower than the 58% growth in overall employment. For men, full time employment only grew by 27% between 1996 and 2021. This slower growth compared with population growth and overall employment has resulted in a decline in the percentage of people employed on a full-time basis.

Figure A87 presents the percentage of Australians in part time employment by sex from 1991 until 2022. The trend in part time employment is the opposite of the trend in full time employment, with part time employment growing strongly over the past three decades particularly for men. Calculations using Census data indicate that the number of people in part time employment grew by 94% between 1996 and 2021. The number of women in part time employment grew by 81%, and the number of men in part time employment grew by 122%.

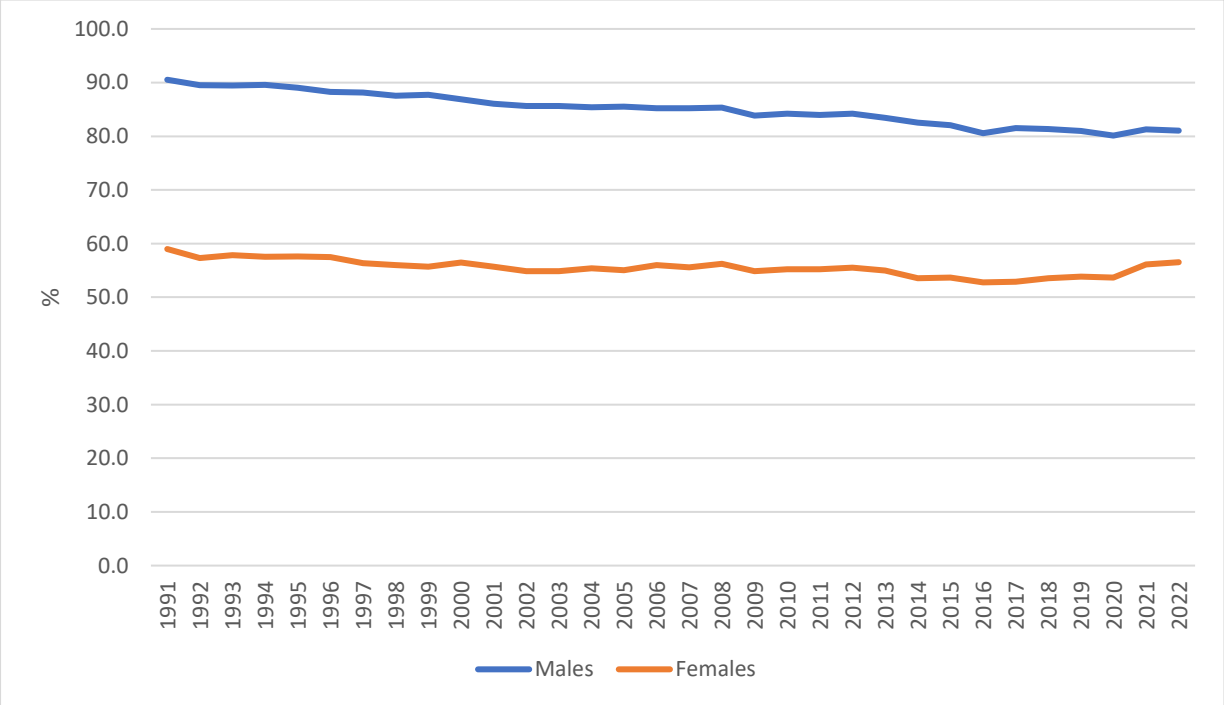


Figure A86: Full-time employment, by Sex, Australia, 1991 to 2022 (per cent) (Data source: ABS Labour Force, Detailed, 2023)[97]

A much higher percentage of women worked part-time, 41% in 1991 compared with just 9.5% for men. The percentage of men employed part time increased a lot (albeit from a lower base) between

1991 and 2022, reaching a high of 19.9% in 2020. The increase in part time employment for women was smaller, with the percentage of women employed part time reaching 47.2% in 2016 before decreasing to 43.4% in 2022. Even though the percentage of women employed part time grew by less compared with men, the much higher percentage of women employed part time adversely impacts women's employment income, superannuation balances and retirement incomes.

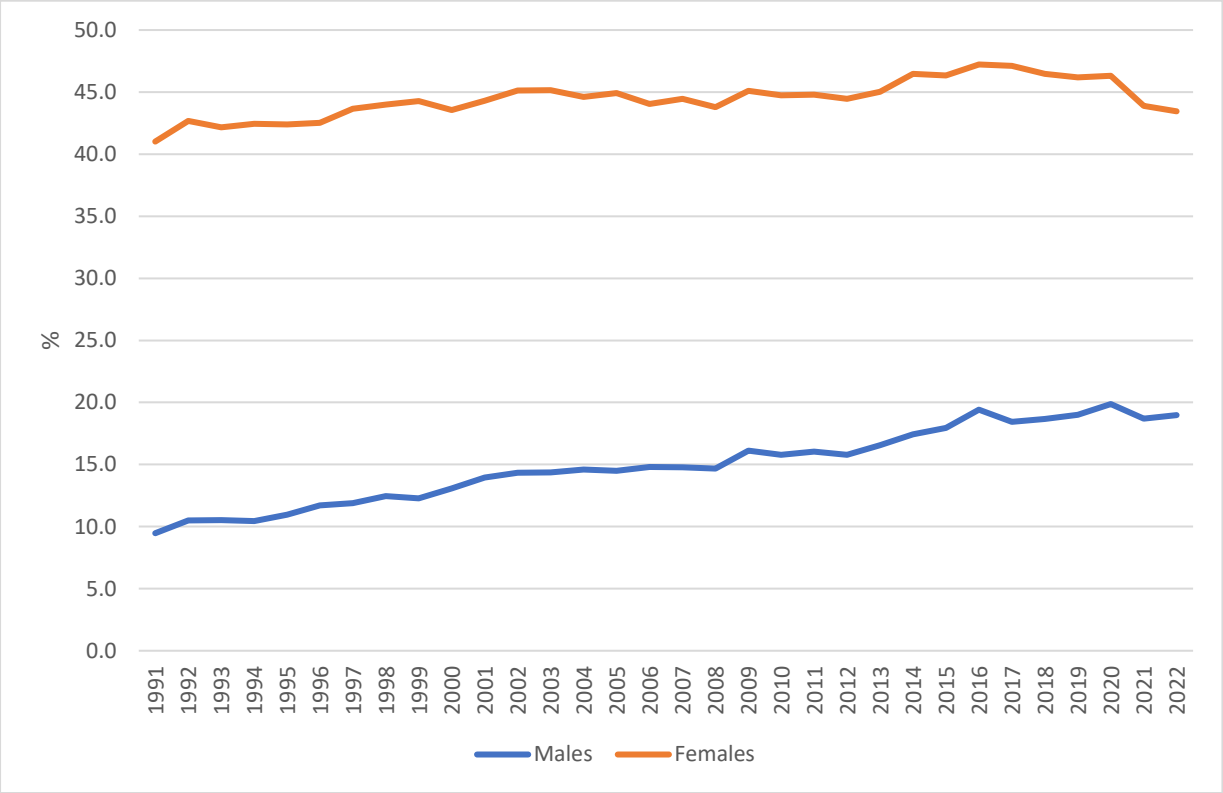


Figure A87: Part-time employment, by Sex, Australia, 1991 to 2022 (per cent) (Data source: ABS Labour Force, Detailed, 2023)[97]

In 2021, an estimated 62.7% of Aboriginal and Torres Strait Islander people who were employed were employed full time, and 37.3% were employed part time.[88] Lower employment rates for Aboriginal and Torres Strait Islander people and a high percentage in part-time employment adversely affects income for Aboriginal and Torres Strait Islander people.

Casual employment

Figure A88 presents ABS statistics on the percentage of workers who were in casual employment by sex from 1984 to 2022. Casual employment grew strongly in the 1980s and 1990s. The percentage of women in casual employment reached a high of 30.6% in 1998 and remained around 30% through to 2003 before declining. In 2022, just over a quarter of women were casually employed. Casual employment for men grew over a much longer period than for women, increasing from just 9% in 1984 to just over 20% in 2001, and after some fluctuations in the early 2000s increasing to 23.3% in 2016 and 2017. Casual employment for men decreased in 2020 and was 21.4% of employment for men in 2022.

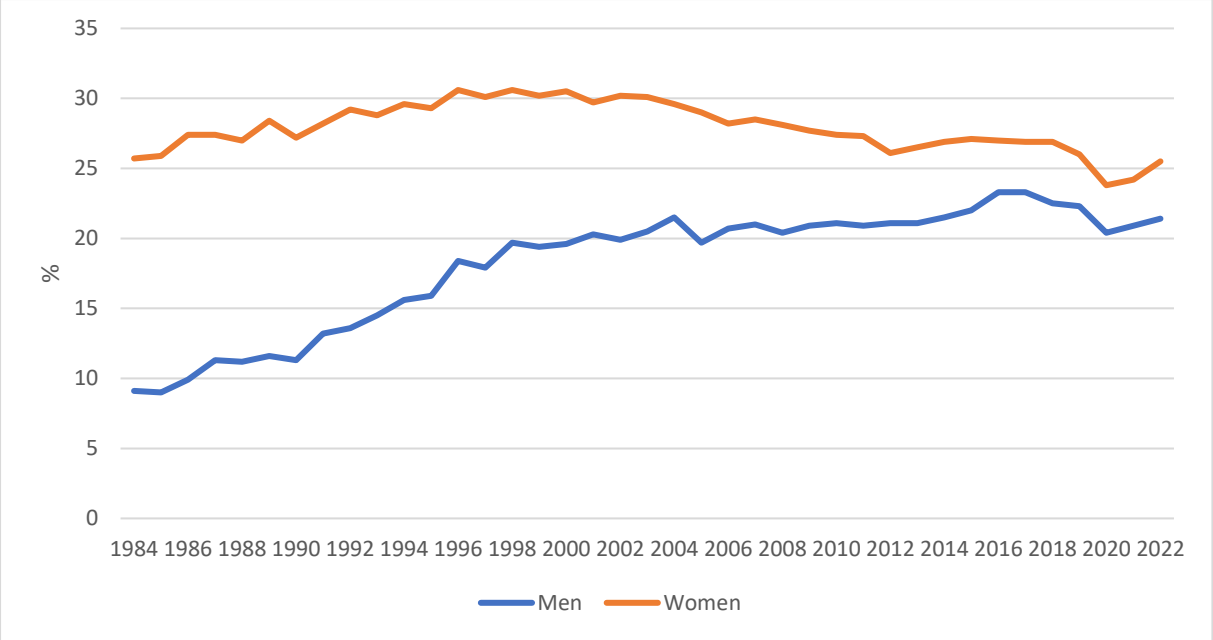


Figure A88: Casual employment, by Sex, Australia, 1984 to 2022 (per cent) (Data source: ABS Working Arrangements, 2023)[99]

The percentage of employees working in casual employment differs by age as with other measures of engagement in employment (**Figure 32**). More than half of people aged 15-24 were in casual employment from 2015 to 2022, a far higher percentage compared with all other age groups. Young people have a higher unemployment rate, a higher unemployment ratio, and a much higher percentage are working in casual jobs. **Figure** presents the percentage of workers with paid leave entitlements by higher and lower income (the ABS definition of casual employment is a lack of leave entitlements). Casual employees are concentrated among the lowest income earners, representing around 80% of the lowest 10% of earners and almost 60% of the lowest 25% of earners.

Table A21 presents casual employment by occupation from 2014 to 2022. The percentage of workers in casual employment differs substantially between occupations. In 2022, the prevalence of casual employment was very high for sales workers (45%), labourers (42%), and community and personal service workers (37%). More than a quarter of machinery operators and drivers were also casually employed. Higher skilled and better paying occupations such as managers and professionals had a much lower prevalence of casual employment, 5% and 9% respectively.

The percentage of employees in casual employment decreased for professionals between 2014 and 2022 and increased for machinery operators and drivers and sales workers. The percentage of casual employees in all other occupations was little changed. Lower paid jobs that do not require higher education have a higher prevalence of casual employment, and the occupations where there was an increase in casual employment are lower skilled occupations. Two of the occupations with a very high prevalence of casual employment also represent a higher share of employment for women compared with men, namely community and personal service workers and sales workers.

The prevalence of casual employment also differs substantially by industry (see Table A22). Almost 60% of workers in accommodation and food services were casually employed in 2022, which is by far the highest prevalence of casual employment in any industry. The next highest prevalence of casual employment was in retail trade (35%), followed by arts and recreation (32%), administrative and support services (26%), transport, postal and warehousing (21%), and health care and social

assistance (19%). The percentage of workers in casual employment in accommodation and food services, retail trade, administrative and support services, transport, postal, and warehousing, and health care and social assistance increased between 2014 and 2022.

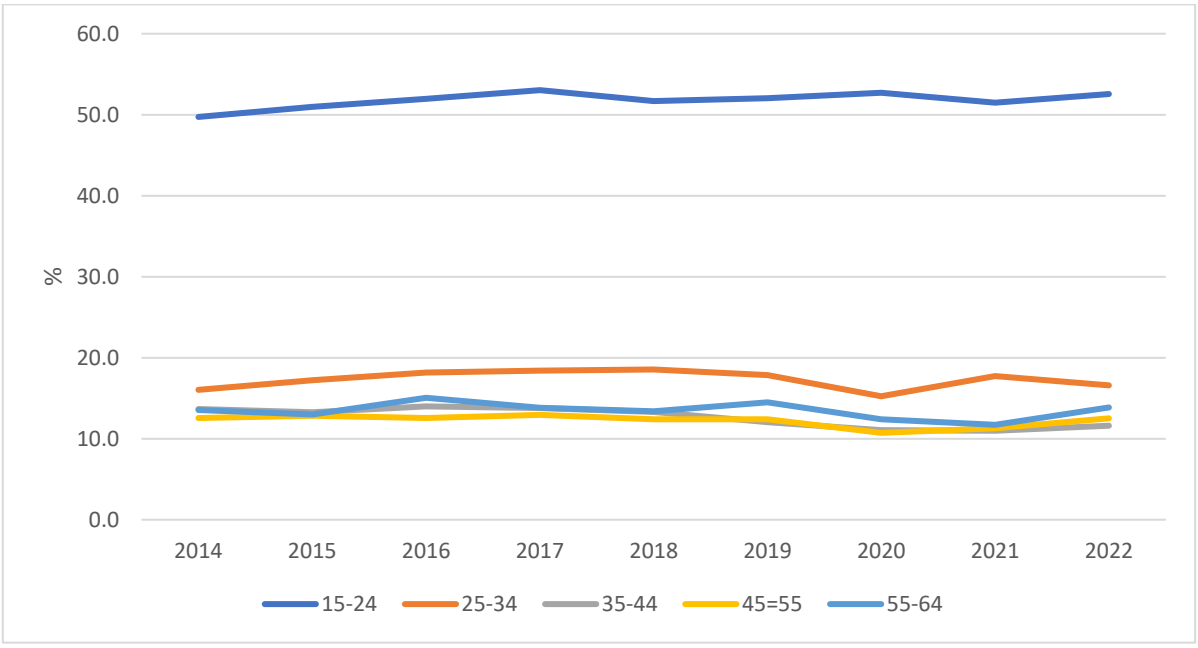


Figure 329: Casual employment, by Age, Australia, 2014 to 2022 (per cent) (Data source: ABS Tablebuilder, Working Arrangements, 2023)[100]

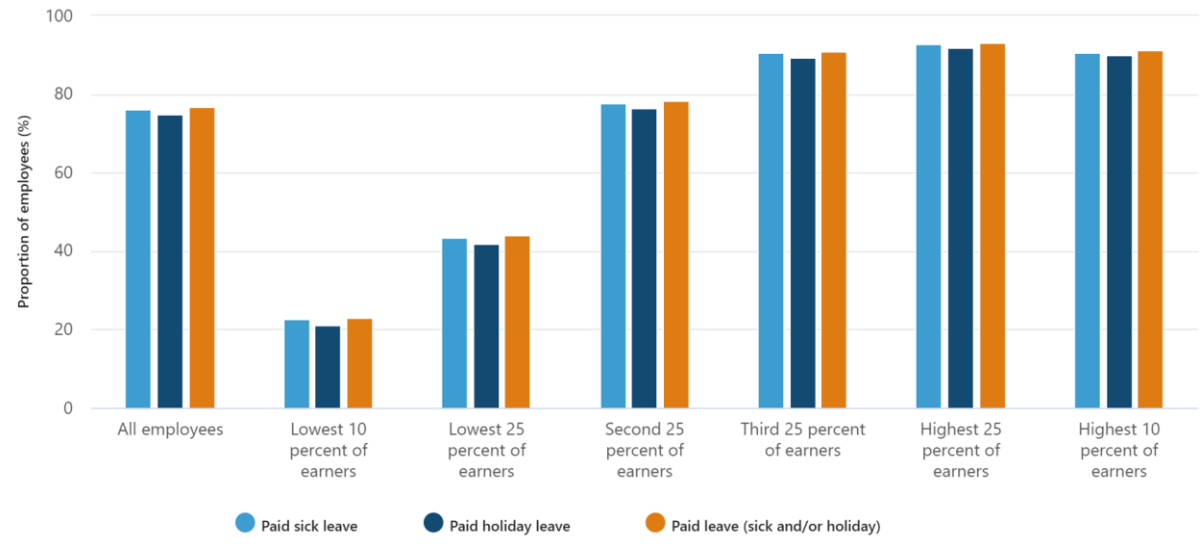


Figure A90: Paid leave entitlements by lower and higher paid workers, Australia, August 2022 (Data source: ABS Working Arrangements, 2023)[99]

Industries with a low prevalence of casual employment were financial and insurance services, professional, scientific, and technical services, public administration and safety, electricity, gas, water and waste services, information media and telecommunication, rental, hiring and real estate services, wholesale trade, construction, and mining. The two industries with the highest percentage of casual employment are those with lower pay, as was the case with casual employment by occupation, and those two industries represent 18% of women's jobs.

Table A21: Casual employment by occupation, 2014 to 2022 (Data source: ABS Tablebuilder, Characteristics of Employment)[100]

	2014	2015	2016	2017	2018	2019	2020	2021	2022
Managers	4.9	5.3	4.8	5.0	4.1	4.8	4.4	4.8	5.0
Professionals	10.5	11.1	10.2	10.0	10.6	9.9	8.4	9.1	9.2
Technicians and trades workers	13.1	13.8	14.7	14.6	15.9	15.3	12.0	13.6	12.8
Community and Personal Service Workers	36.6	37.1	38.0	39.7	37.5	38.1	35.3	35.6	36.9
Clerical and Administrative Workers	14.6	14.8	16.3	14.5	14.7	14.0	12.6	13.1	14.3
Sales Workers	41.0	41.5	40.9	41.2	41.5	40.3	41.2	39.0	44.9
Machinery Operators and Drivers	21.1	21.7	25.1	24.9	24.6	25.8	25.3	24.9	27.2
Labourers	40.6	38.1	42.0	42.5	41.1	38.7	41.0	40.8	42.4

Table A22: Casual employment by industry, 2014 to 2022 (Data source: ABS Tablebuilder, Characteristics of Employment)[100]

	2014	2015	2016	2017	2018	2019	2020	2021	2022
Agriculture, Forestry and Fishing	17.5	18.9	21.5	25.1	18.8	17.1	20.7	16.7	18.2
Mining	9.9	13.0	14.8	13.3	16.5	15.9	16.0	11.7	13.0
Manufacturing	16.5	15.1	16.7	18.8	15.1	17.1	13.8	14.4	14.5
Electricity, Gas, Water and Waste Services	8.1	5.9	7.3	6.7	7.5	10.1	8.3	12.8	10.8
Construction	14.3	13.5	15.5	15.1	16.0	16.4	13.0	12.3	12.8
Wholesale Trade	11.6	15.7	14.3	12.2	12.4	14.1	12.4	14.6	12.5
Retail Trade	32.7	32.2	31.9	32.1	33.8	33.4	33.5	31.8	34.7
Accommodation and Food Services	55.1	58.2	57.8	58.4	55.5	55.2	53.5	57.8	59.4
Transport, Postal and Warehousing	18.5	17.6	20.6	19.8	20.2	18.4	18.3	19.9	21.3
Information Media and Telecommunications	16.0	14.8	17.3	13.3	14.7	16.8	9.4	10.0	11.9
Financial and Insurance Services	5.0	7.3	6.3	6.6	6.9	6.9	5.7	5.3	5.4
Rental, Hiring and Real Estate Services	11.8	14.6	15.1	17.1	14.5	13.8	9.3	9.8	11.9
Professional, Scientific and Technical Services	9.3	10.7	10.6	8.5	10.4	9.0	8.4	9.9	8.1
Administrative and Support Services	22.3	25.7	23.8	25.5	23.7	24.2	24.4	24.8	25.8
Public Administration and Safety	9.7	9.5	9.4	10.7	9.9	9.2	8.3	9.9	8.6
Education and Training	19.3	18.8	17.3	17.4	18.2	16.8	14.2	15.6	14.6
Health Care and Social Assistance	16.9	16.6	19.1	18.1	18.4	17.8	17.6	17.7	18.8
Arts and Recreation Services	38.3	33.2	33.0	36.0	36.3	32.9	27.9	32.3	32.1
Other Services	16.5	14.5	18.7	16.7	18.0	18.3	16.0	12.7	17.9

Changes to industrial relations laws and impacts

The changes to industrial relations laws in the 1980s and 1990s weakened the bargaining power of employees, and union membership declined from 2.5 million workers in 1976 (51% of total employment) to 1.5 million workers in 2016 (14% of total employment).[101] Figure A91 presents the number of industrial disputes, working days lost and employees involved in industrial disputes between 1985 and 2023. All measures fell dramatically in the 1990s and declined further in the late 2000s and the 2010s. The changes to industrial relations laws in the 1980s and 1990s, and changes made subsequently by Coalition governments increased the precarious nature of work. The weakening of bargaining power of employees has also contributed to the decline in the wages share of GDP discussed in the income section of this appendix.

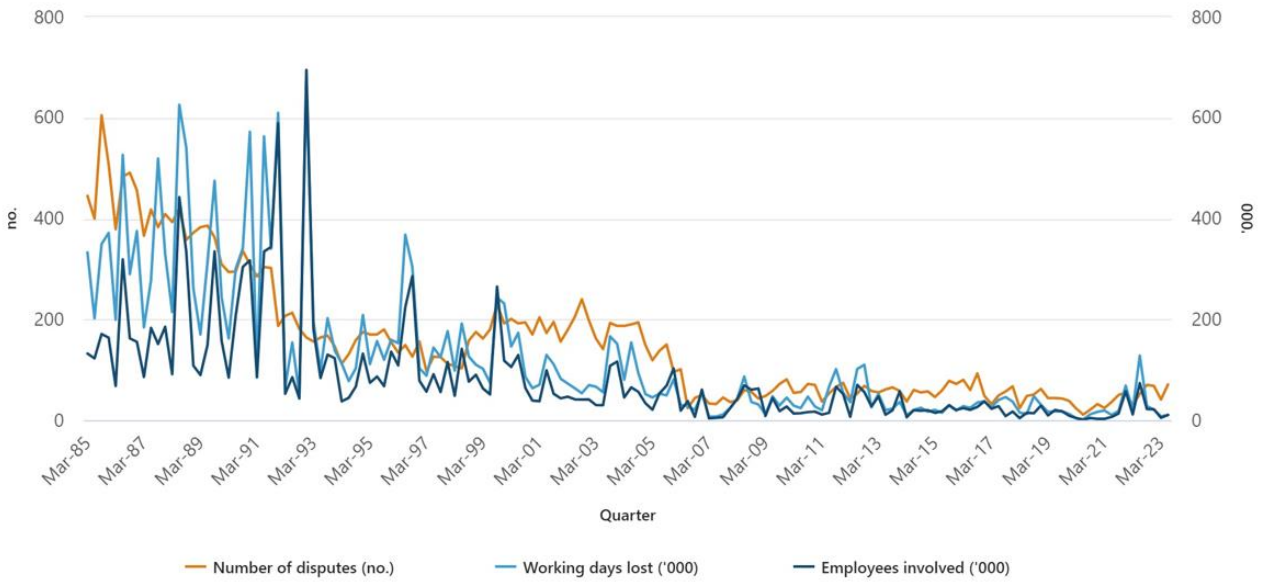


Figure A91: Industrial disputes historical series, Australia (Australian Bureau of Statistics, Industrial Disputes, June 2023)[102]

Employment by occupation

In 1996, the largest occupation category for men was technicians and trade workers, followed by managers (Table A23). The smallest occupation categories were community and personal service workers and sales workers. Jobs growth by occupation between 1996 and 2021 was highest for community and personal support workers (an increase of 98%), then professionals (an increase of 90%). Over this 25 year period, almost 500,000 more men were employed as professionals, and almost 200,000 as community and personal service workers. Growth in employment for men in all other occupations was lower than overall growth in employment, resulting in reductions in the percentage share of all other occupations except for labourers which retained an 11.2% share of employment for men. In 2021, the largest occupation category for men was still technicians and trades workers but professionals were the second largest occupation and if trends persist professionals will soon be the largest occupation category for men. There were reductions in percentage share of employment for lower skilled occupations which may partially explain increasing inequality in labour force participation.

The largest occupation category for women in 1996 was clerical and administrative workers, followed by professionals (Table A24). The smallest occupation categories were machinery operators and drivers, and technicians and trades workers. The highest percentage increases in jobs by occupation for women were community and personal service workers (159%), then professionals (145%), then managers (98%). The increase in jobs for these occupations between 1996 and 2021 was 313,000 for managers, 603,000 for community and personal support workers, and 960,000 for professionals. Growth in all other occupations was lower than overall growth, and there were reductions in the percentage share of employment in lower skilled occupations as was the

case for men. In 2021, the largest occupation for women was professionals, then clerical and administrative workers, followed by community and personal service workers.

Table A23: Occupation, Males, Australia, Employed People Aged 15 and Over, 1996 to 2021 (per cent) (Data Source: Census of Population and Housing, ABS, various years)

Males	1996	2001	2006	2011	2016	2021
Managers	16.7	16.4	16.1	15.6	15.6	16.0
Professionals	15.5	16.7	17.3	18.4	18.9	20.4
Technicians and trades workers	23.5	22.6	22.7	22.6	21.8	20.9
Community and personal service workers	4.7	5.1	5.1	5.6	6.2	6.4
Clerical and administrative workers	6.8	6.5	6.5	6.5	6.2	6.1
Sales workers	6.7	7.2	7.0	6.7	6.9	6.2
Machinery operators and drivers	12.1	11.7	11.0	11.1	10.7	10.7
Labourers	11.2	11.8	12.3	11.4	11.7	11.2
Missing	2.8	2.1	2.0	2.1	2.0	2.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

In 2021, 18% of Aboriginal and Torres Strait Islander people aged 25-64 who were employed worked in the community and personal service workers occupation, 17% were employed as professionals, 13% were clerical and administrative workers, 13% were technicians and trade workers, and 13% were labourers. A higher proportion of Aboriginal and Torres Strait Islander people aged 25-64 were employed as community and personal service workers compared with non-Indigenous people, and a lower proportion of Aboriginal and Torres Strait Islander people were employed as professionals.[88]

Table A24: Occupation, Females, Australia, Employed People Aged 15 and Over, 1996 to 2021 (per cent) (Data Source: Census of Population and Housing, ABS, various years)

Female	1996	2001	2006	2011	2016	2021
Managers	9.8	9.6	9.9	9.8	10.1	11.2
Professionals	19.7	21.2	22.8	24.6	25.9	27.8
Technicians and trades workers	4.7	4.5	4.6	4.5	4.5	4.4
Community and personal service workers	11.3	12.0	13.2	14.3	15.9	16.8
Clerical and administrative workers	27.5	26.6	25.0	24.2	21.7	19.6
Sales workers	12.9	13.6	13.2	12.4	12.1	10.2
Machinery operators and drivers	2.8	2.2	1.5	1.4	1.3	1.6
Labourers	9.0	8.4	8.3	7.1	7.0	6.7
Missing	2.4	1.9	1.6	1.6	1.5	1.6
Total	100.0	100.0	100.0	100.0	100.0	100.0

Employment by industry

The largest industries for employment for men in 1996 were manufacturing, construction, retail trade, public administration and safety, and wholesale trade (Table A25 and Table A26). The percentage increase in the number of jobs by industry was highest for men for health care and social assistance (146%), mining (131%), construction

(123%), professional, scientific, and technical services (98%), administrative and support services (89%), financial and insurance services (73%), accommodation and food services (72%), arts and recreation services (71%) and electricity, gas, water, and waste services (71%). The largest increases in number of jobs by industry were more than 500,000 in construction, more than 250,000 in professional, scientific and technical services, more than 230,000 in health care and social assistance, almost 150,000 in accommodation and food services, 140,000 in retail trade, 138,000 in transport, postal and warehousing, and 121,000 in public administration and safety. Mining, administrative and support services, and arts and recreation services were amongst the smallest industries for employment for men in 1996 therefore the increase in the number of jobs in these industries is not as large as for larger industries that had strong growth in employment.

There were reductions in employment for men in some industries between 1996 and 2021. Employment in wholesale trade declined by 29%, manufacturing by 25%, agriculture, forestry and fishing by 15%, and information media and telecommunications by 12%. For manufacturing the 25% decline equalled a loss of more than 160,000 jobs, jobs in wholesale trade declined by almost 85,000, agriculture, forestry and fishing declined by 34,000 jobs, and information and media communications declined by almost 14,000 jobs.

The largest industries for employment for men in 2021 were construction, followed by manufacturing, professional, scientific and technical services, retail trade, and public administration and safety.

Table A25: Industry, Males, Australia, Employed People Aged 15 and Over, 1996 to 2021 (per cent) (Data Source: Census of Population and Housing, ABS, various years)

Males	1996	2001	2006	2011	2016	2021
Agriculture, Forestry and Fishing	5.3	5.1	4.0	3.3	3.3	3.1
Mining	1.8	1.4	1.8	2.7	2.7	2.8
Manufacturing	15.6	15.7	14.4	12.4	8.8	8.1
Electricity, Gas, Water and Waste Services	1.4	1.4	1.4	1.6	1.6	1.6
Construction	9.6	10.4	12.5	13.4	14.1	14.7
Wholesale Trade	6.8	6.2	5.3	4.9	3.6	3.3
Retail Trade	8.0	8.9	9.0	8.3	8.1	7.8
Accommodation and Food Services	4.9	5.1	5.0	5.3	6.0	5.8
Transport, Postal and Warehousing	6.5	6.5	6.7	6.9	6.8	6.7
Information Media and Telecommunications	2.7	2.6	2.1	1.9	1.9	1.6
Financial and Insurance Services	3.0	3.0	3.2	3.3	3.3	3.5
Rental, Hiring and Real Estate Services	1.5	1.6	1.5	1.5	1.6	1.5
Professional, Scientific and Technical Services	6.1	6.6	6.7	7.5	7.6	8.3
Administrative and Support Services	2.3	2.9	2.8	2.9	3.1	3.0
Public Administration and Safety	7.0	6.4	7.0	6.9	6.8	6.8
Education and Training	4.6	4.5	4.3	4.5	4.7	4.7
Health Care and Social Assistance	3.7	3.7	4.2	4.6	5.2	6.3
Arts and Recreation Services	1.3	1.4	1.4	1.5	1.7	1.5
Other Services	4.7	4.4	3.9	3.9	3.8	3.7
Missing	3.4	2.3	2.9	2.6	5.3	5.2

Total	100.0	100.0	100.0	100.0	100.0	100.0

Table A26: Industry, Males, Australia, Employed People Aged 15 and Over, 1996 to 2021, Number and % Change between 1996 and 2021 (Data Source: Census of Population and Housing, ABS, various years)

Males	1996	2001	2006	2011	2016	2021	%
Agriculture, Forestry and Fishing	225,679	230,610	195,007	174,774	185,209	191,574	-15.1
Mining	75,497	64,947	90,835	145,768	149,064	174,695	131.4
Manufacturing	667,346	714,738	704,855	668,017	493,122	503,739	-24.5
Electricity, Gas, Water and Waste Services	58,273	61,741	69,855	87,955	88,111	99,798	71.3
Construction	408,610	471,707	613,957	719,209	793,045	910,676	122.9
Wholesale Trade	289,439	282,565	258,845	264,640	202,329	204,844	-29.2
Retail Trade	340,686	406,544	441,971	446,000	453,247	481,042	41.2
Accommodation and Food Services	209,169	234,127	247,689	284,819	335,867	358,848	71.6
Transport, Postal and Warehousing	278,637	295,043	328,753	368,051	382,262	417,438	49.8
Information Media and Telecommunications	114,344	117,910	101,921	103,637	108,322	100,578	-12.0
Financial and Insurance Services	127,364	136,474	158,753	176,631	186,496	219,849	72.6
Rental, Hiring and Real Estate Services	64,494	72,557	75,843	78,006	88,668	91,528	41.9
Professional, Scientific and Technical Services	260,558	301,290	328,187	404,356	426,416	515,326	97.8
Administrative and Support Services	99,299	131,252	137,244	156,923	173,309	187,252	88.6
Public Administration and Safety	297,986	289,015	341,902	372,303	380,771	419,100	40.6
Education and Training	194,989	203,162	212,812	240,824	266,094	290,405	48.9
Health Care and Social Assistance	158,753	169,673	204,496	245,319	289,966	390,529	146.0
Arts and Recreation Services	55,205	61,568	66,486	79,356	92,659	94,655	71.5
Other Services	201,035	198,661	191,117	211,297	215,407	227,859	13.3
Missing	144,688	103,199	140,603	138,798	297,403	320,475	121.5
Total	4,272,051	4,546,783	4,911,131	5,366,663	5,607,777	6,200,207	45.1

In 1996, the largest industries for employment for women were health care and social assistance, retail trade, education and training, and accommodation and food services (Tables A27 and A28). The highest percentage increases in employment by industry between 1996 and 2021 were in mining (272%), electricity, gas, water and waste services (209%), construction (151%), health care and social assistance (144%), public administration and

safety (124%), education and training (112%), professional, scientific and technical services (108%). Mining, electricity, gas, water and waste services, and construction were relatively small employers for women in 1996 therefore these very high percentage increases did not equate to the largest increases in numbers employed by industry. The largest increases in numbers employed were more than 800,000 in health care and social assistance, more than 400,000 in education and training, 223,000 in professional, scientific and technical services, 209,000 in public administration and safety, 181,000 in retail trade and 157000 in accommodation and food services.

Table A27: Industry, Females, Australia, Employed People Aged 15 and Over, 1996 to 2021 (per cent) (Data Source: Census of Population and Housing, ABS, various years)

Females	1996	2001	2006	2011	2016	2021
Agriculture, Forestry and Fishing	2.9	2.7	2.0	1.6	1.6	1.5
Mining	0.3	0.3	0.4	0.7	0.6	0.7
Manufacturing	7.6	7.1	5.9	5.0	3.8	3.6
Electricity, Gas, Water and Waste Services	0.3	0.4	0.5	0.6	0.5	0.6
Construction	1.9	1.9	2.3	2.3	2.3	2.7
Wholesale Trade	4.0	3.6	3.3	3.0	2.1	1.8
Retail Trade	13.0	13.8	14.1	13.0	11.8	10.6
Accommodation and Food Services	8.0	8.2	7.8	7.8	7.9	7.3
Transport, Postal and Warehousing	2.4	2.4	2.4	2.4	2.3	2.2
Information Media and Telecommunications	2.3	2.3	1.8	1.6	1.4	1.1
Financial and Insurance Services	5.0	4.7	4.5	4.3	3.9	3.9
Rental, Hiring and Real Estate Services	1.6	1.8	1.9	1.7	1.8	1.6
Professional, Scientific and Technical Services	6.1	6.6	6.5	6.9	6.9	7.3
Administrative and Support Services	3.3	3.9	3.6	3.6	3.8	3.4
Public Administration and Safety	5.0	5.2	6.4	6.8	6.5	6.5
Education and Training	10.8	11.3	11.6	12.0	13.0	13.2
Health Care and Social Assistance	16.6	16.6	17.9	19.7	20.9	23.3
Arts and Recreation Services	1.6	1.4	1.5	1.5	1.7	1.6
Other Services	4.0	3.5	3.5	3.6	3.6	3.5
Missing	3.3	2.4	2.3	2.0	3.5	3.5
Total	100.0	100.0	100.0	100.0	100.0	100.0

Table A28: Industry, Females, Australia, Employed People Aged 15 and Over, 1996 to 2021, Number and % Change between 1996 and 2021 (Data Source: Census of Population and Housing, ABS, various years)

Females	1996	2001	2006	2011	2016	2021	%
Agriculture, Forestry and Fishing	98,651	100,172	85,911	75,052	81,736	90,651	-8.1
Mining	10,764	10,231	16,059	30,795	28,583	40,064	272.2
Manufacturing	255,553	266,212	247,160	234,812	190,564	211,021	-17.4

Electricity, Gas, Water and Waste Services	11,168	15,289	19,596	27,657	27,640	34,567	209.5
Construction	62,525	71,532	95,886	109,702	118,009	156,968	151.0
Wholesale Trade	133,244	135,363	137,523	139,159	105,411	107,022	-19.7
Retail Trade	437,319	516,023	591,220	611,313	600,565	618,571	41.4
Accommodation and Food Services	267,503	306,554	327,422	365,580	402,360	424,891	58.8
Transport, Postal and Warehousing	80,520	90,227	99,036	111,126	117,225	128,926	60.1
Information Media and Telecommunications	78,570	86,370	74,902	74,553	71,200	66,291	-15.6
Financial and Insurance Services	169,092	175,922	189,833	200,725	198,108	225,280	33.2
Rental, Hiring and Real Estate Services	54,060	68,498	78,064	80,850	93,483	96,089	77.7
Professional, Scientific and Technical Services	206,612	247,201	273,830	325,709	349,566	429,767	108.0
Administrative and Support Services	112,437	145,282	149,378	166,853	192,417	201,179	78.9
Public Administration and Safety	168,541	194,675	266,703	317,628	332,366	377,933	124.2
Education and Training	364,223	423,804	484,993	563,594	659,790	770,920	111.7
Health Care and Social Assistance	557,410	623,718	751,648	922,318	1,061,053	1,361,188	144.2
Arts and Recreation Services	52,486	53,456	60,910	72,218	83,998	93,826	78.8
Other Services	133,397	131,974	147,095	166,920	184,228	207,598	55.6
Missing	110,193	89,320	95,884	95,088	177,741	206,455	87.4
Total	3,364,268	3,751,823	4,193,053	4,691,661	5,076,066	5,849,207	73.9

There were reductions in employment for women in wholesale trade (20%), manufacturing (17%), information media and telecommunications (16%) and agriculture, forestry and fishing (8%). These reductions equated to a loss of 44,000 jobs in manufacturing, 26,000 in wholesale trade, 12,000 in information media and telecommunications, and 8,000 in agriculture, forestry and fishing. The largest industries for employment for women in 2021 were health care and social assistance, followed by education and training, then retail trade, with accommodation and food services and professional, scientific and technical services having an equal fourth highest share of employment for women.

In 2021, the main industries of employment for Aboriginal and Torres Strait Islander people aged 25-64 were health care and social assistance (19%), public administration and safety (13%), education and training (11%), and construction (10%). Aboriginal and Torres Strait Islander people working in health care and social assistance were mostly women (78%), and those working in construction were mostly men (88%).[88]

Employment sector and employment type

Public agencies play a key role in health care and education which are two of the largest industries for employment of women, and the public sector also includes public administration and safety.[91] Women comprised 63.7% of public sector jobs in May 2023, up from 59% in 2014.[97] In 2023, 18.6% of women were employed in the public sector. Public sector jobs are more likely to be full-time and offer higher wages compared with jobs women typically work in the private sector[91] (particularly in retail, hospitality which are among the biggest private-sector employers of women). The public sector is important as a source of high-quality jobs for women. However, more than 80% of women work in the private sector.[91]

The analysis in this section has shown that a much higher percentage of women work part time compared with men, that a higher percentage of women are casually employed, and a higher percentage of women are underemployed. While it is possible for part time jobs to be well paid, most are not and about half of part time jobs are casual and do not offer leave entitlements that are important to working parents.[91] In 2018, 12% of women were self-employed compared with 20% of men, and most self employed women were in lower wage businesses that were not incorporated and had no employees (they were the only employee), and were part time.[91] Women also switch jobs more often than men due to their precarious employment, and are more likely to have held a job for less than 5 years compared with men and less likely to have kept their position for 10 or more years.[91]

Figure presents employment type for women and men in 2018. Only 43% of women worked in a full time permanent job with leave entitlements. More than half of women are in some kind of precarious employment whether it be casual, self-employed, or part-time with many of these jobs not providing adequate income. Precarious work has also become more common for men, but 57% still have permanent, full-time employment with leave entitlements and the 20% that are self employed are much more likely to work full time than women, much more likely to be in an incorporated business and to have employees.[91]

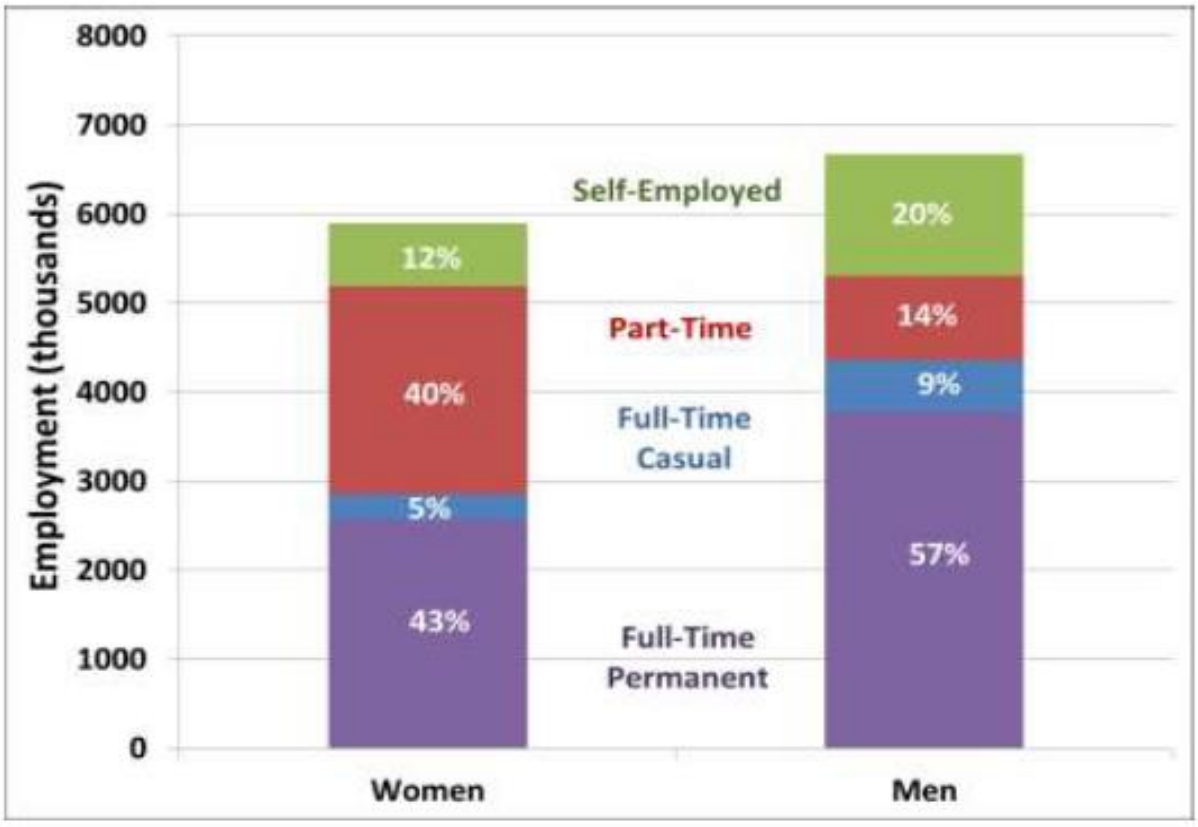


Figure A92: Employment Type by Gender, 2018 (Data source: Pennington & Stanford, 2020)[91]

Overall, women employees earned almost a third less than men prior to the pandemic, and the gender pay gap is even larger for the self-employed. The concentration of women in part-time work is the biggest contributor to the gender pay gap, but other contributors include the concentration of payments of bonuses and overtime pay among traditionally 'male' jobs like executives, financial professionals, construction and mining, and the concentration of jobs for women in occupations which have traditionally been considered 'women's work' which are underpaid and undervalued and offer lower quality jobs.[91]

Jurisdiction analysis: Unemployment and labour force participation

Jurisdiction analysis: Unemployment

Overall, the unemployment rate was highest in 2021 in Queensland, followed by SA, then WA, then Tasmania. The ACT had the lowest overall unemployment rate.[14] **Figure** presents the unemployment rate in each jurisdiction and in Australia for the least disadvantaged quintile (Q1) and the most disadvantaged quintile (Q5) in 1986 and 2021. NSW, the ACT, and Victoria followed the national trend of larger reductions in unemployment in more disadvantaged quintiles compared to less disadvantaged quintiles and a reduction in inequality and this can be seen in **Figure** by comparing the unemployment rate in 1986 with that in 2021 for the least disadvantaged quintile and most disadvantaged quintile. In the NT there were larger reductions in unemployment in all quintiles compared with other jurisdictions, with the unemployment rate for the least disadvantaged quintile in 2021 around half what it was in 1986, and a 63% reduction in unemployment for the most disadvantaged quintile. The reduction in inequality in unemployment was largest in NSW, followed by the NT, ACT, then Victoria (based on the percentage decrease in the rate ratio).

In Queensland, SA, WA, and Tasmania the decrease in unemployment was larger in less disadvantaged quintiles and inequality in unemployment increased between 1986 and 2021. The jurisdictions where socio-economic inequality increased are the four jurisdictions with the highest unemployment rates for the most disadvantaged quintile in 2021. The largest increases in socio-economic inequality in unemployment were in Tasmania, followed by WA, then SA, then Queensland (based on the percentage increase in the rate ratio). In 2021, the jurisdictions with the highest socio-economic inequality in distribution of unemployment were Tasmania (rate ratio of 3.38), then SA (2.88), WA (2.77), Queensland (2.64), then the NT (2.32). The jurisdictions with the lowest inequality were the ACT (1.64), then Victoria (2.22), then NSW (2.27).

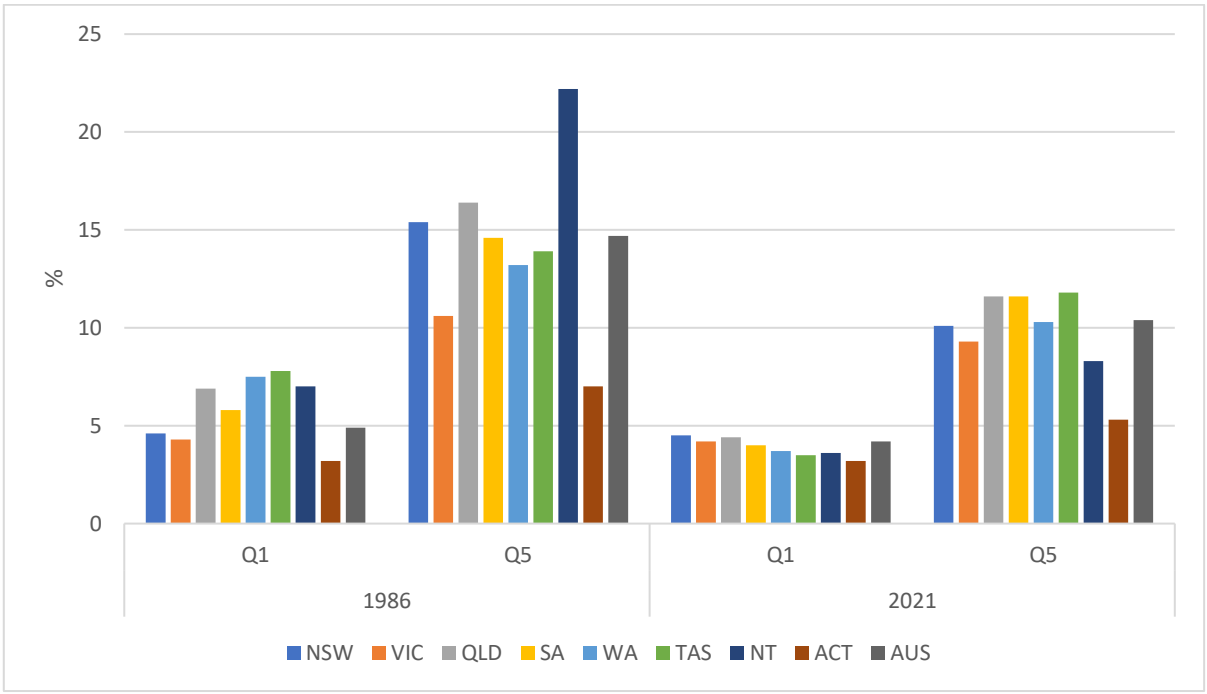


Figure A93: Rates of unemployment in each State in Australia, by quintile 1 (Q1, least disadvantaged) and quintile 5 (Q5, most disadvantaged) 1986 and 2021, Australia (Data source: Social Health Atlas, PHIDU, 2022)

Jurisdiction analysis: Labour force participation rate

In 2021, the NT had the highest overall labour force participation rate (69.8%) followed by the ACT (67%). Tasmania had a much lower overall labour force participation rate compared with all other jurisdictions (58.1%), followed by SA (61.1%).[14] **Figure** presents the labour force participation rate by jurisdiction and in Australia for the least disadvantaged quintile (Q1) and the most disadvantaged quintile (Q5) in 1986 and 2021. NSW, Victoria, Queensland, and WA followed the national trend of a much smaller increase in labour force participation for the most disadvantaged quintile compared with the least disadvantaged and an increase in inequality. In the NT, the increase in the labour force participation rate was much larger for the most disadvantaged quintile, resulting in a decrease in inequality in labour force participation.

In SA, Tasmania, and the ACT the labour force participation rate for the most disadvantaged quintile was lower in 2021 compared with 1986. The decrease in labour force participation for quintile 5 in the ACT was small, only 0.3 percentage points, and inequality in labour force participation actually decreased in the ACT because labour force participation was lower in all quintiles in 2021 and the decrease was larger for the least disadvantaged quintile. In SA, labour force participation for quintile 5 decreased by 1.4 percentage points, and in Tasmania labour force participation for quintile 5 decreased by 6.2 percentage points, a large decrease. The labour force participation rates for the least disadvantaged quintile in SA and Tasmania increased therefore in gap between the labour force participation rate for the most and least disadvantaged quintiles was much larger in 2021 compared with 1986, and there was a very large increase in inequality in Tasmania (a large change given Tasmania was the jurisdiction with the lowest inequality in 1986), and a large increase in inequality in SA.

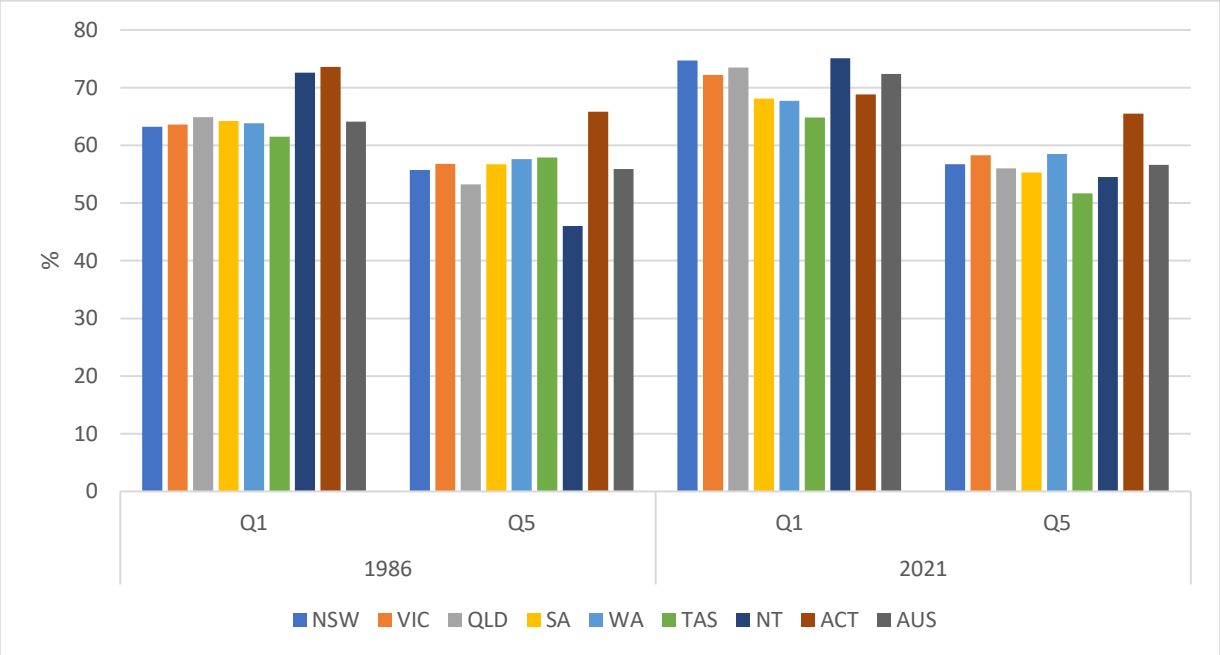


Figure A94: Rates of labour force participation in each State in Australia, by quintile 1 (Q1, least disadvantaged) and quintile 5 (Q5, most disadvantaged) 1986 and 2021, Australia (Data source: Social Health Atlas, PHIDU, 2022)

The ACT had the highest labour force participation rate for quintile 5, fourth lowest labour force participation for quintile 1 and had the lowest inequality in labour force participation in 2021 (rate ratio of 0.95). WA had the

second highest labour force participation rate for quintile 5, the second lowest labour force participation rate for quintile 1 and second lowest inequality in labour force participation (rate ratio of 0.86) The NT had the highest labour force participation rate for quintile 1 but had the second lowest labour force participation rate for quintile 5 and had the highest inequality in 2021 (rate ratio of 0.73). NSW had the second highest labour force participation rate for quintile 1, and the second highest inequality (rate ratio of 0.76). Inequality in NSW was equal with inequality in Queensland which had the third highest labour force participation rate for quintile 1 but the fourth lowest labour force participation rate for quintile 5.

The highest increase in inequality was in Tasmania (rate ratio declining from 0.94 to 0.80), followed by NSW (rate ratio of 0.88 in 1986 and 0.76 in 2021), then Victoria (from rate ratio of 0.89 to 0.81), then SA (from a rate ratio of 0.88 to 0.81). Of the two jurisdictions where inequality decreased, the largest decrease in inequality was in the NT (from a rate ratio of 0.63 to 0.73), with the ACT having a smaller decrease in inequality.

Jurisdiction analysis: Female labour force participation rate

In 2021, the ACT had the highest female labour force participation rate (67.1%), followed by the NT (61.3%) then WA (60.4%). Tasmania had the lowest female labour force participation rate (55.5%), followed by NSW (55.6%), then SA (56.8%).[14] NSW, Queensland, WA, the NT, the ACT, and Tasmania all followed the national trend of larger increases in female labour force participation for the least disadvantaged compared with the most disadvantaged and increasing inequality between 2006 and 2021 (**Figure 33**). Female labour force participation was lower for the most disadvantaged quintile in 2021 compared with 2006 in NSW and WA. In Victoria, the increase in labour force participation for the most disadvantaged quintile was of equal proportion to the increase for the least disadvantaged quintile, leaving inequality unchanged. Inequality in female labour force participation decreased in SA due to a higher increase in female labour force participation for the most disadvantaged quintile compared with the least disadvantaged quintile.

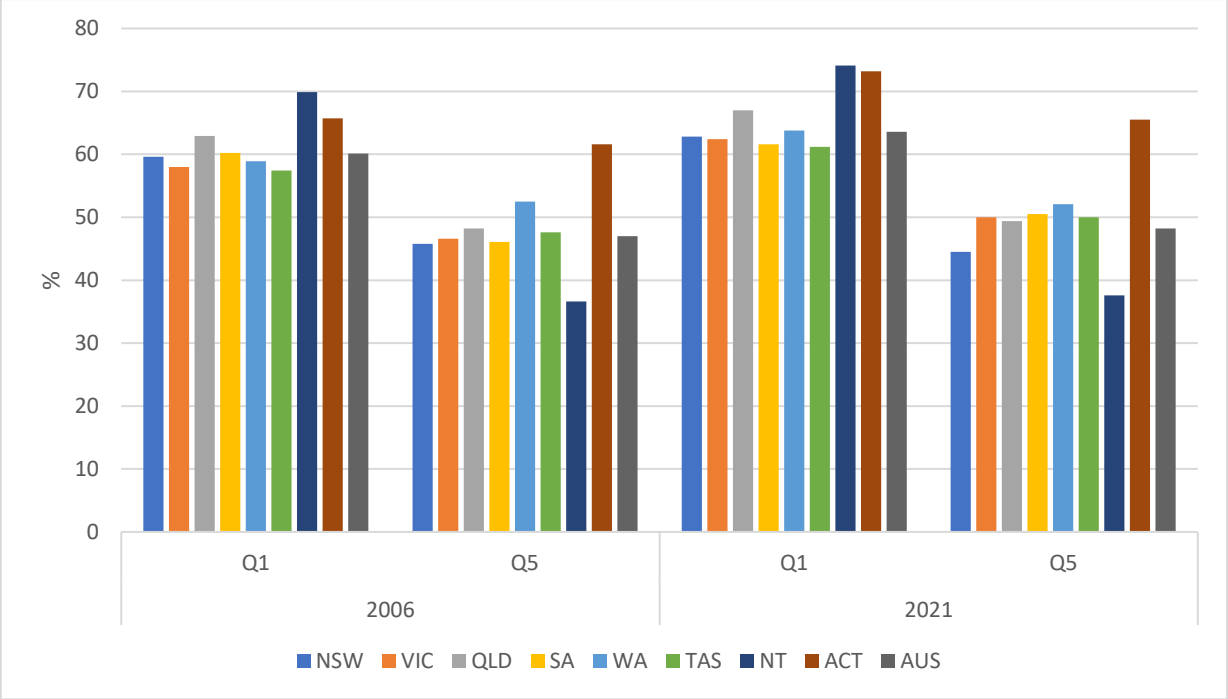


Figure 33: Rates of female labour force participation in each State in Australia, by quintile 1 (Q1, least disadvantaged) and quintile 5 (Q5, most disadvantaged) 2006 and 2021, Australia (Data source: Social Health Atlas, PHIDU, 2022)

In 2021, the highest inequality in female labour force participation was in the NT where the labour force participation rate for the least disadvantaged quintile was double that of the most disadvantaged quintile (a rate

ratio of 0.51). NSW had the second highest inequality (a rate ratio of 0.71), followed by Queensland (rate ratio of 0.74). The ACT had the lowest inequality in female labour force participation (a rate ratio of 0.89), and SA, WA, and Tasmania all had a rate ratio of 0.82, followed by Victoria with a rate ratio of 0.80.

In 2006, SA had the second highest inequality in female labour force participation but the decrease in inequality between 2006 and 2021 changed this, with SA having the equal second highest rate ratio (albeit there is still substantial inequality when the labour force participation rate for the most disadvantaged is 0.82 times that of the least disadvantaged). The highest increase in inequality was in WA, followed by NSW, then the ACT.

Jurisdiction analysis: Aboriginal and Torres Strait Islander employment rate

Figure A96 presents the employment rate for Aboriginal and Torres Strait Islander people by jurisdiction in 2021. The employment rate is the percentage of Aboriginal and Torres Islander people aged 15-64 who were employed. While this does not provide information on the socioeconomic distribution of employment for Aboriginal and Torres Strait Islander people within jurisdictions, it does provide an indication as to which jurisdiction had a higher rate of employment. The ACT had the highest employment rate of Aboriginal and Torres Strait Islander people (69%), followed by Tasmania (59%), Victoria (58%), and NSW (56%). The NT had a very low employment rate, only 31%, with the next lowest in WA (46%), then SA (47%).

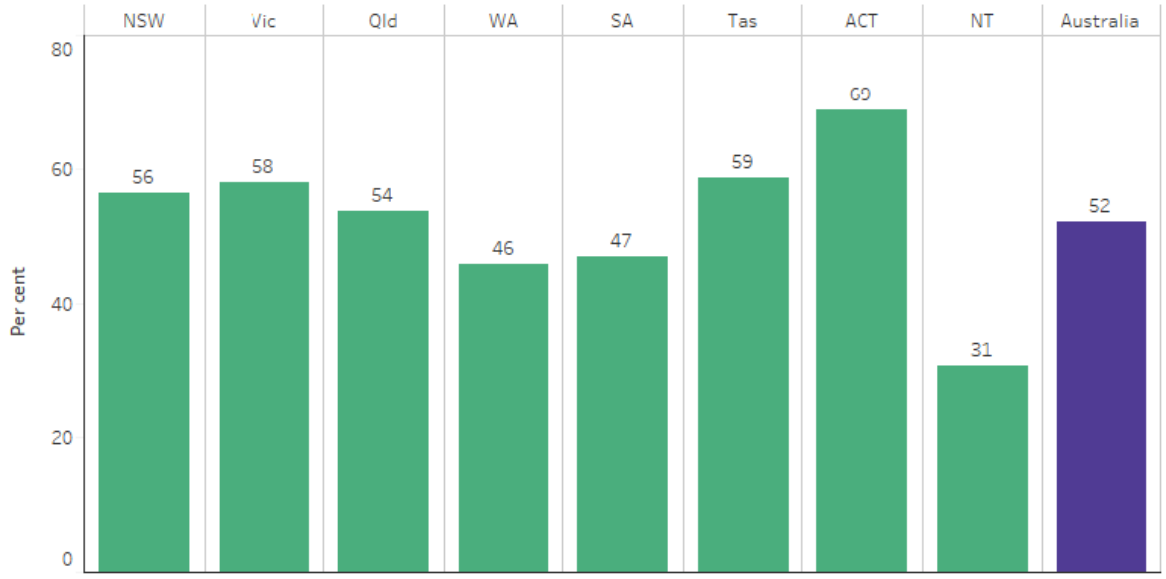


Figure A96: Employment rate for Aboriginal and Torres Strait Islander people by jurisdiction, 2021 (Data source: AIHW Indigenous Health Performance Framework, 2023)[88]

Jurisdiction analysis: Jobless families

Every jurisdiction except for the ACT followed the national trend of a much larger decrease in the percentage of jobless families in the least disadvantaged quintile compared with the most disadvantaged quintile between 2001 and 2021 (see **Figure A9**). In the ACT there was a larger decrease in the percentage of jobless families in the most disadvantaged quintile (a reduction by more than half) compared with the least disadvantaged quintile (a reduction of just under a third). Socio-economic inequality in the distribution of jobless families decreased in the ACT between 2001 and 2021, but there were large increases in inequality in all other jurisdictions.

The largest increase in inequality was in Tasmania where the rate ratio more than doubled, followed by the NT, then WA. The lowest increase in inequality was in Victoria, followed by SA. In 2021, the jurisdictions with the lowest inequality in the distribution of jobless families were the ACT (rate ratio of 1.72), followed by Victoria where the rate ratio was still quite high at 3.48. The jurisdictions with the highest inequality were the NT (rate ratio of 10.4), followed by SA (rate ratio of 4.6), then Tasmania (rate ratio of 4.5),

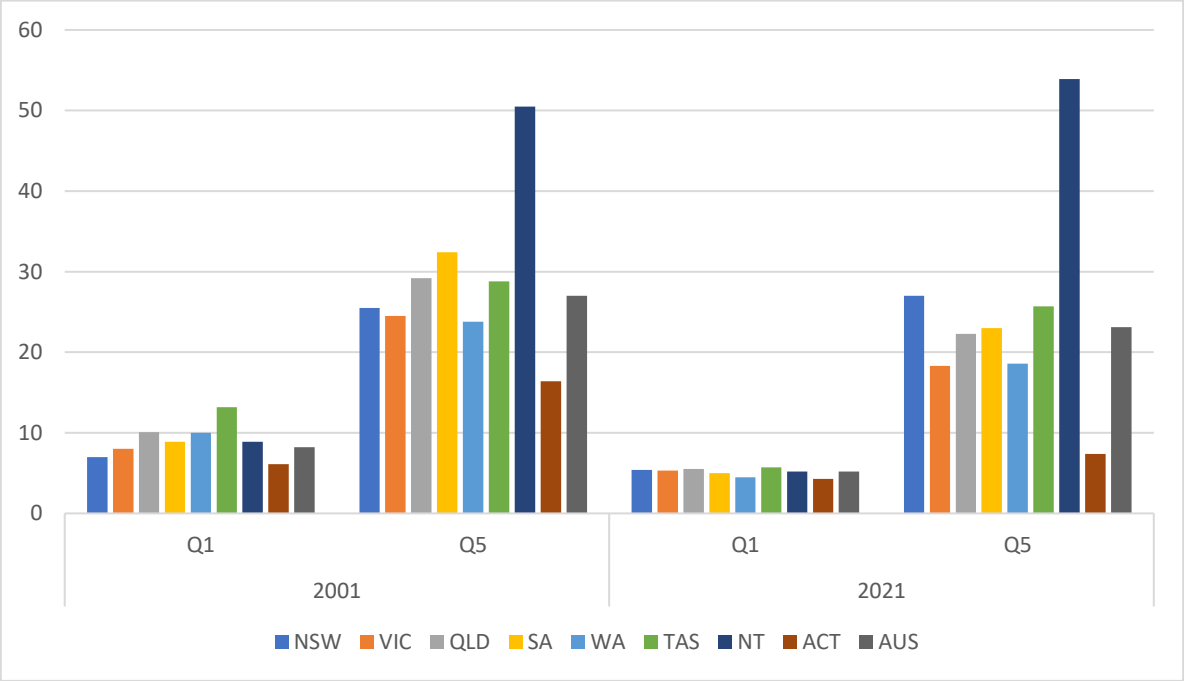


Figure A97: Jobless families with children aged less than 15 years in each State in Australia, by quintile 1 (Q1, least disadvantaged) and quintile 5 (Q5, most disadvantaged) 2001 and 2021, Australia (per cent) (Data source: Social Health Atlas, PHIDU, 2022)

Jurisdiction analysis: Characteristics of employment

Jurisdiction analysis: Part time employment and underemployment

The preceding figures focused on engagement in employment by jurisdiction, identifying trends by jurisdiction, where inequality has increased the most (or decreased) and which jurisdictions have the highest inequality according to the most recently available data. The next figures focus on the characteristics of employment by jurisdiction to determine any differences by jurisdiction in trends and differences in terms of employment according to the most recently available data.

Figure presents the percentage of people in part time employment by jurisdiction from 1991 to 2022. The trend for all jurisdictions was an increase in part time employment over this period (and decrease in full time employment). The jurisdiction with the lowest percentage of people in part time employment (and hence the highest percentage in full time employment) was the NT for almost every year over the period where data was available. From the early 2000s until just prior to the pandemic the NT had a much lower percentage of people in part time employment compared with the other jurisdictions, however the NT had the largest increase in part time employment. The ACT had the second lowest percentage of people in part time employment for most of the period in **Figure** , particularly from the early 2000s onwards, and the lowest increase in part time employment. The jurisdiction with the highest percentage of people in part time employment was Tasmania for most years between 1991 and 2022, followed closely by SA. The increase in part time employment in Tasmania and SA was also higher than the national average.

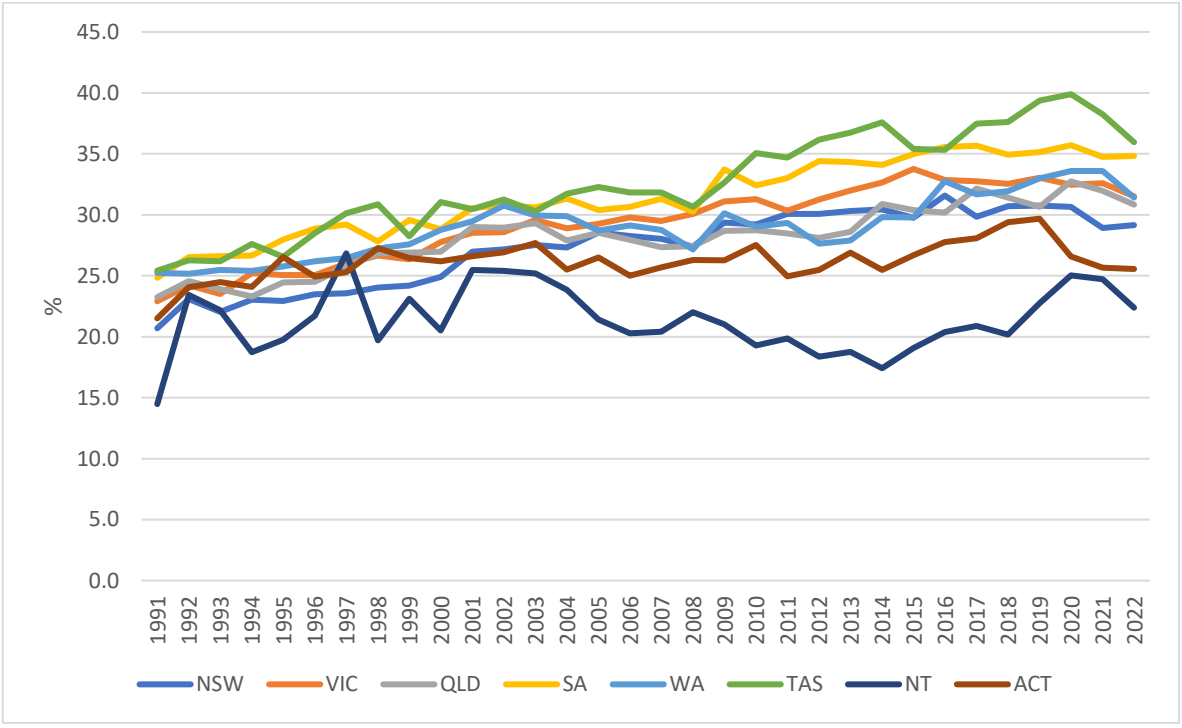


Figure A98: Percentage of part time employment by jurisdiction, 1991 to 2022 (Data source: ABS Labour Force Survey, 2023)[90]

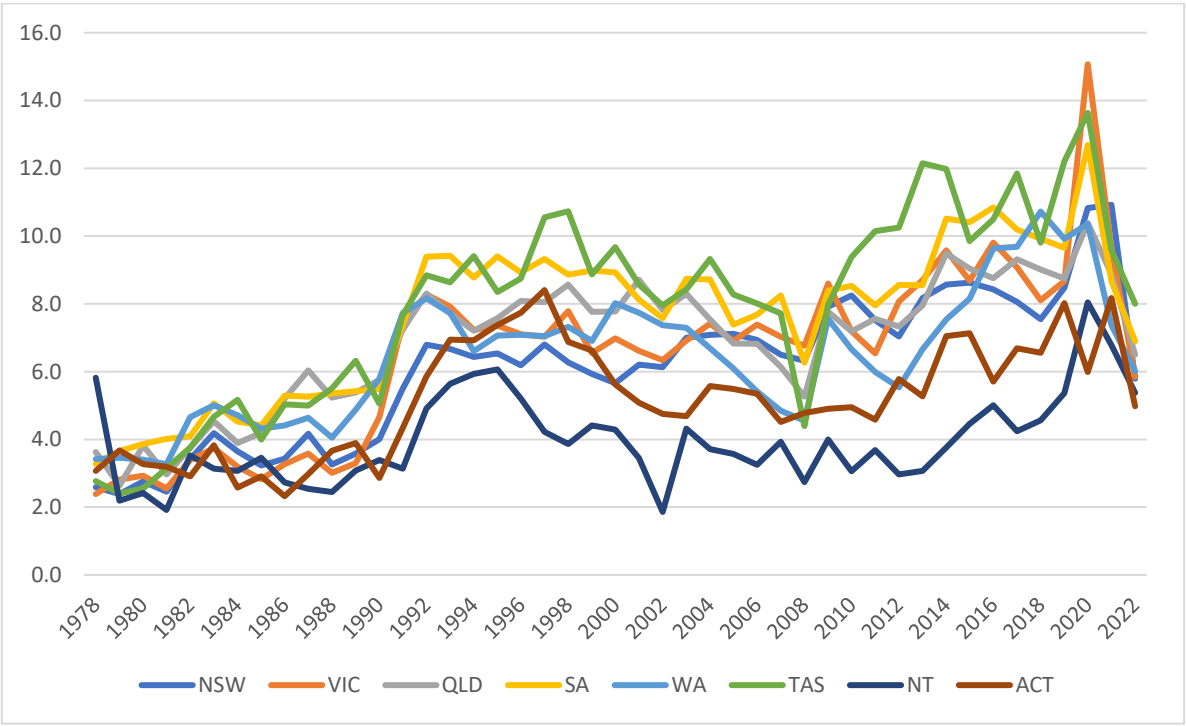


Figure A99: Underemployment ratio by jurisdiction, 1978 to 2022 (Data source: ABS Underutilised Persons, ABS, 2023)[90]

Figure A99 presents the underemployment ratio by jurisdiction from 1978 to 2022. The jurisdictions with the highest underemployment ratios are SA and Tasmania, the same jurisdictions that had the highest percentage of people who were employed part time. The jurisdictions with the lowest underemployment ratio was the NT, followed by the ACT. Again, these are the jurisdictions with the lowest percentage of people who are employed

part time. Not all part time employees are underemployed, only those employees who want to work more hours. The jurisdictions with a higher percentage of people employed part time have a higher percentage of underutilised persons.

Jurisdiction analysis: casual employment

Table A29 presents the percentage of employees who were casually employed by jurisdiction between 2014 and 2022. Tasmania had the highest percentage of casual employment from 2019 to 2021 and had a relatively higher percentage of casual employment in most years in **Table**. SA and Queensland also had higher percentages of casual employment compared with other jurisdictions, but the prevalence was little changed in Queensland and SA from 2014 to 2022. The NT had the lowest percentage of casual employment of all jurisdictions from 2014 to 2017. The percentage of employees in casual employment increased in the NT between 2014 and 2021, but NT had the lowest percentage of casual employment in 2022. The ACT had a relatively lower prevalence of casual employment than most jurisdictions in each year from 2014 to 2022, as did Victoria where there was a decrease in casual employment. Casual employment was relatively lower in NSW than in most jurisdictions particularly from 2020 onwards.

Table A29: Percentage of employees in casual employment by jurisdiction, 2014 to 2022 (Data source: ABS TableBuilder, Working Arrangements, 2023)[100]

	2014	2015	2016	2017	2018	2019	2020	2021	2022
NSW	19.1	19.9	20.2	19.7	21.0	19.8	17.5	17.2	18.7
VIC	18.6	18.7	19.4	19.3	17.4	19.0	15.6	17.5	17.7
QLD	21.4	22.1	22.9	24.1	23.0	21.1	20.6	20.9	22.2
SA	22.1	21.7	23.3	22.9	23.5	21.9	20.9	21.2	21.7
WA	19.9	19.7	21.4	20.4	19.8	19.8	20.5	19.3	21.0
TAS	20.3	20.0	21.0	20.1	20.5	23.4	22.0	22.5	19.4
NT	14.8	16.8	16.0	17.4	19.3	18.4	18.4	19.0	16.9
ACT	18.2	17.1	17.2	17.9	19.7	18.7	16.5	18.3	18.3

Jurisdiction analysis: employment by occupation

Table A30 and Table A31 present the percentage employed by occupation in each jurisdiction in 1996 and 2021. The trend in growth in employment by jurisdiction follows the national trend of a reduction in technicians and trades workers, clerical and administrative workers, sales workers, machinery operators and drivers and managers, and growth in community and personal service workers and professionals. The growth in employment of labourers in SA was one exception, as was the increase in employment of managers in the NT and ACT. There was very strong growth in community and personal service workers and professionals in all jurisdictions.

There were some differences in the distribution of employment by occupation between jurisdictions in 2021: a much higher percentage of managers and professionals in the ACT compared to other jurisdictions and a lower percentage of technicians and trades workers, sales workers, machinery operators and drivers, and labourers. WA had the highest percentage of jobs in technicians and trades workers of all jurisdictions in 2021. The NT had highest percentage of jobs in community and personal service workers and there was a much higher percentage of labourers in SA.

Table A30: Percentage employed in each occupation by jurisdiction, 1996 (Data source: ABS Census Time Series Profiles)[54]

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT
Managers	13.5	13.9	13.3	13.9	13.5	13.6	11.9	14.9
Professionals	18.2	18.0	15.3	16.7	16.4	16.4	17.0	25.7

Technicians and trades workers	14.9	15.1	15.6	15.1	16.6	15.4	16.1	11.2
Community and Personal Service Workers	7.4	7.1	8.1	8.0	7.6	8.4	10.2	8.2
Clerical and Administrative Workers	16.7	15.8	15.3	15.0	15.3	13.9	14.9	19.2
Sales Workers	9.3	9.5	10.2	9.2	9.2	9.2	7.3	8.1
Machinery Operators and Drivers	7.8	8.2	8.3	8.0	8.3	8.5	6.7	3.7
Labourers	9.6	9.7	11.4	11.6	10.6	11.6	12.6	5.2

Table A31: Percentage employed in each occupation by jurisdiction, 2021 (Data source: ABS Census Time Series Profiles)[54]

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT
Managers	14.6	14.0	12.5	13.0	12.3	12.7	12.9	17.9
Professionals	25.8	25.0	21.4	21.5	22.0	20.0	22.0	31.4
Technicians and trades workers	11.9	12.6	13.7	13.2	15.3	13.9	13.8	9.6
Community and Personal Service Workers	10.6	11.0	12.3	13.0	11.8	13.6	15.7	10.9
Clerical and Administrative Workers	13.0	12.4	12.7	12.5	12.1	11.7	13.2	14.5
Sales Workers	8.0	8.3	8.7	8.5	7.8	8.6	6.5	6.1
Machinery Operators and Drivers	6.0	5.9	6.8	6.0	7.7	6.4	5.2	2.4
Labourers	8.2	8.8	10.1	13.0	9.4	11.3	8.5	5.0

The jurisdictions with highest percentage of casual workers (Tasmania, SA, and Queensland) have a higher percentage of jobs in occupations that have a relatively higher prevalence of casual employment: labourers, sales workers, community and personal service workers, and machinery operators and drivers. The reverse is true of the jurisdictions with the lowest percentage of casual workers, particularly for the ACT.

Jurisdiction analysis: employment by industry

Table A32 and Table A33 present the percentage employed in each industry by jurisdiction in 1996 and 2021. The trend in employment by industry for jurisdictions followed the national trend of reductions in the percentage employed in agriculture, forestry and fishing, large reductions in manufacturing in all jurisdictions but particularly in NSW, Victoria and SA where the percentage share of manufacturing was more than halved, reductions in the percentage employed in wholesale trade, and reductions in the percentage employed in information media and telecommunications. Other jurisdiction trends that followed the national trend were large increases in employment in healthcare and social assistance, increases in the percentage employed in construction, increases in the percentage employed in retail trade, professional, scientific and technical services, education and training, administrative and support services, and public administration and safety (with the exception of Queensland and Tasmania for the latter),

Table A32: Percentage employed in each industry by jurisdiction, 1996 (Data source: ABS Census Time Series Profiles)[54]

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT
Agriculture, Forestry and Fishing	3.6	3.9	5.2	5.6	4.9	6.6	2.9	0.4

Mining	0.8	0.3	1.6	0.6	3.7	1.0	3.5	0.1
Manufacturing	11.5	15.7	10.1	14.5	9.5	11.8	4.1	2.9
Electricity, Gas, Water and Waste Services	1.0	0.9	0.9	0.9	1.0	0.6	0.8	0.4
Construction	6.2	5.7	7.0	4.8	7.0	5.8	7.2	4.5
Wholesale Trade	5.9	5.8	5.3	5.3	5.4	4.4	3.4	2.3
Retail Trade	10.1	10.3	10.6	10.1	10.1	10.4	8.2	8.5
Accommodation and Food Services	6.5	5.5	7.2	5.7	5.9	6.2	7.5	6.4
Transport, Postal and Warehousing	5.1	4.4	5.1	4.1	4.3	4.1	4.3	3.3
Information Media and Telecommunications	2.9	2.7	2.1	2.1	1.9	2.2	2.1	2.9
Financial and Insurance Services	4.8	4.1	3.0	3.3	3.3	2.9	2.0	2.6
Rental, Hiring and Real Estate Services	1.6	1.2	2.0	1.4	1.9	1.3	1.6	1.2
Professional, Scientific and Technical Services	6.6	6.6	5.5	4.9	5.9	3.9	4.5	7.5
Administrative and Support Services	2.9	2.7	2.7	2.8	3.0	2.0	2.8	2.2
Public Administration and Safety	5.6	4.9	6.3	5.4	5.5	7.9	16.9	27.0
Education and Training	7.0	7.2	7.5	7.6	7.6	8.1	7.6	9.3
Health Care and Social Assistance	9.2	9.2	9.2	11.2	9.2	10.8	10.9	7.8
Arts and Recreation Services	1.3	1.4	1.5	1.3	1.4	1.6	2.2	1.8
Other Services	4.4	4.4	4.3	4.6	4.6	4.1	3.8	4.2

There were some differences between jurisdictions, with a reduction in the percentage employed in mining in the NT, a reduction in the percentage employed in accommodation and food services in NSW, and a reduction in financial and insurance services in multiple jurisdictions. In 2021, Tasmania and SA had the highest percentages employed in retail trade, Tasmania had the highest percentage employed in accommodation and food services, and Tasmania and SA had the highest percentage employed in health care and social assistance, industries with a higher prevalence of casual employment and underemployment. Queensland had the next highest percentage employed in health care and social assistance, a relatively higher percentage employed in retail trade, and a relatively higher percentage employed in accommodation and food services, consistent with a relatively high percentage of casual employment. Conversely, the ACT had a relatively low percentage employed in retail trade, accommodation and food services, and health care and social assistance, consistent with the lower percentage employed part time, lower underemployment and lower prevalence of casual employment in this jurisdiction.

Table A33: Percentage employed in each industry by jurisdiction, 2021 (Data source: ABS Census Time Series Profiles)[54]

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT
Agriculture, Forestry and Fishing	2.0	2.1	2.6	3.8	2.3	5.3	2.3	0.3
Mining	1.0	0.3	2.3	1.3	7.5	1.0	2.4	0.1
Manufacturing	5.5	7.0	5.7	7.2	5.3	6.4	2.2	1.7
Electricity, Gas, Water and Waste Services	1.0	1.1	1.2	1.3	1.2	1.8	1.5	0.8
Construction	8.6	9.4	9.1	8.3	8.8	8.6	8.0	6.7
Wholesale Trade	2.8	2.8	2.4	2.4	2.5	2.2	1.5	0.8
Retail Trade	9.0	9.4	9.3	9.7	8.8	9.6	7.2	6.5
Accommodation and Food Services	6.2	6.2	7.2	6.6	6.5	7.6	7.4	6.3
Transport, Postal and Warehousing	4.6	4.7	4.7	4.1	4.5	4.1	4.0	2.1
Information Media and Telecommunications	1.8	1.6	1.0	1.0	0.8	1.0	0.7	1.5
Financial and Insurance Services	5.3	4.1	2.6	2.8	2.2	1.9	0.9	1.4

Rental, Hiring and Real Estate Services	1.7	1.5	1.8	1.2	1.4	1.1	1.1	1.2
Professional, Scientific and Technical Services	8.9	8.4	6.7	6.2	6.9	5.1	4.9	10.9
Administrative and Support Services	3.2	3.1	3.4	3.8	3.1	2.9	2.9	2.6
Public Administration and Safety	6.1	5.6	6.2	6.7	5.9	7.3	18.2	29.8
Education and Training	8.7	8.8	8.8	8.8	8.8	9.4	9.4	9.4
Health Care and Social Assistance	14.4	14.1	15.4	16.4	13.6	16.4	14.9	11.5
Arts and Recreation Services	1.4	1.7	1.5	1.4	1.6	1.8	2.3	1.8
Other Services	3.4	3.5	3.9	3.9	3.9	3.8	3.9	2.9

Social Inclusion

There are many elements to social inclusion. The Social Exclusion Monitor developed by the Brotherhood of St Laurence and the Melbourne Institute of Applied Economic and Social Research includes 30 components of disadvantage.[103] The Inclusive Australia Social Inclusion Index includes different measures and was developed via a survey that included five aspects of social exclusion: individual levels of belonging and wellbeing, contact and friendship with minority groups, prejudicial attitudes and experiences of discrimination, willingness to volunteer for social inclusion, and willingness to advocate for social inclusion.[104] The Social Exclusion Monitor estimated that more than 1.2 million people (almost 5%) in Australia were experiencing deep social exclusion in 2018, defined as at least four different types of disadvantage, and 25% of all Australians experienced social exclusion.[103] The Inclusive Australia Social Inclusion Index reports that 6.7 million Australians (approximately 25%) experience social exclusion at a cost to the economy of $45 billion a year.[104]

The Social Exclusion Monitor uses a definition that acknowledges that social exclusion arises from multiple overlapping disadvantages, and that poor health is one of these disadvantages.[103] Respondents who live in countries with higher social inclusion have been found to be more likely to report good health, and social inclusion may affect health through participation in social, economic, and political activities.[105] Social inclusion may also affect health through increased access to resources that promote better health.[105]

This section considers indicators that are strongly associated with social inclusion, or social exclusion.

Homelessness

Social exclusion can contribute to, exacerbate, and maintain experiences of homelessness.[106] Homelessness sharply steepens the slope of the social gradient in health[107] and instability of housing and shelter impacts on other social determinants of health.[108] Homelessness is also an extreme form of social inclusion with both material and social deprivation.[109]

The ABS provides data and analysis on homelessness from the Census. **Figure A34**00 presents Census estimates of the number of people experiencing homelessness from 2006 to 2021. The overall counts of people experiencing homelessness have increased with each Census, from 89,733 in 2006 to an estimate of 122,494 in 2021. The increase in the number of people experiencing homelessness between 2016 and 2021 was 6,067, or 5.2%. A larger number of men were experiencing homelessness than women, 55.9% of people experiencing homelessness in 2021 were male and the number of men experiencing homelessness increased by 1.6% compared with 2016. The number of women experiencing homelessness increased by 10.1% compared with 2016.[110]

Census estimates also report rates of homelessness which provide a measure of homelessness that accounts for population growth. The rate of homelessness for men was 55 per 10,000 in 2021, a decrease compared to the rate in 2016 of 58 per 10,000. The rate of homelessness for women was 42 per 10,000 in 2021, up from 41 per 10,000 in 2016.[110] Rates of homelessness are higher for Aboriginal and Torres Strait Islander people and were an estimated 307 per 10,000 people in 2021. The estimated rate of homelessness for Aboriginal and Torres Strait Islander people has decreased with each Census since 2006, from 571 per 10,000 in 2006, to 487 per 10,000 in 2011, and 361 per 10,000 in 2011.[110]

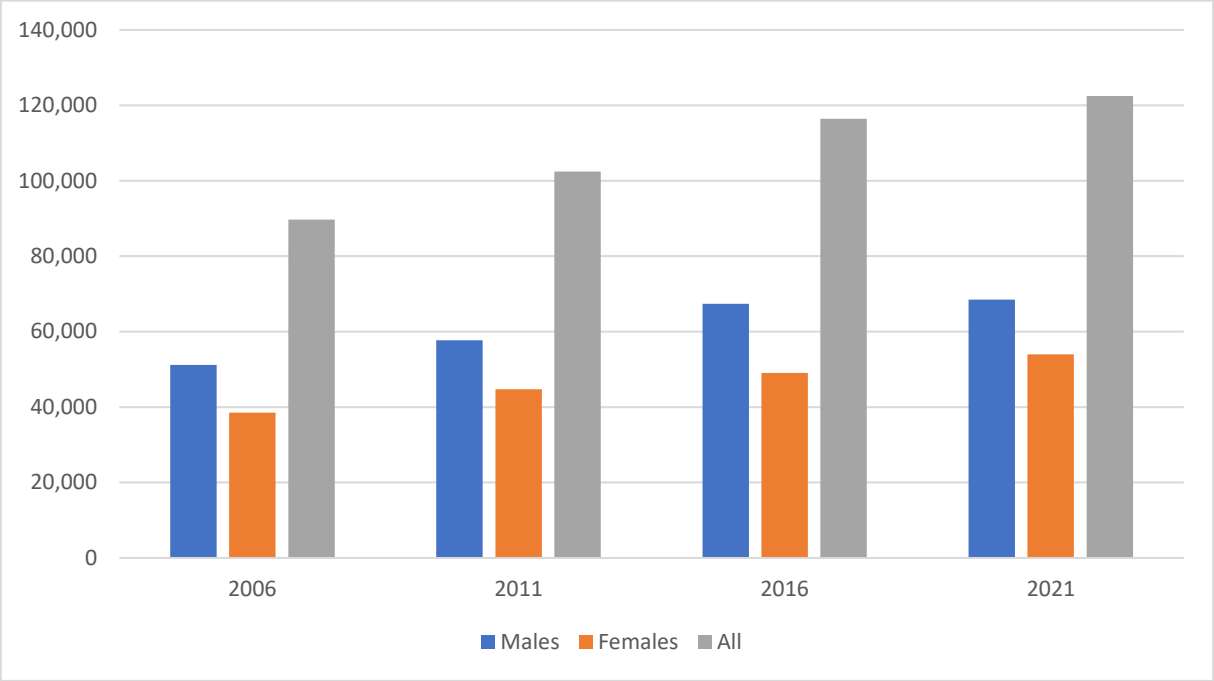


Figure A3400: Counts of people experiencing homelessness, by sex, Australia, 2006 to 2021 (Data source: ABS Estimating Homelessness: Census, 2023[110])

The ABS definition of homelessness includes people living in improvised dwellings, tents, or sleeping out, people in supported accommodation for the homeless, people staying temporarily with other households, people living in boarding houses, people in other temporary lodgings, and people living in severely crowded dwellings (defined as residents in dwellings needing 4 or more extra bedrooms). **Figure A101** presents the estimated number of people experiencing homelessness in each of these homelessness operational groups from 2006 to 2021.

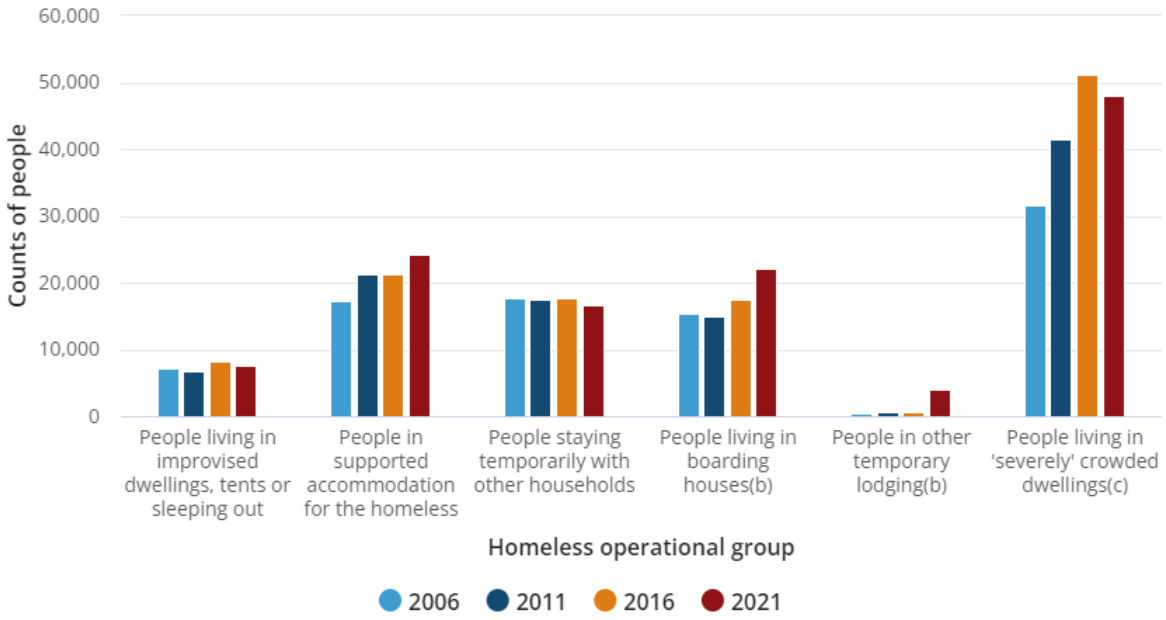


Figure A101: Count of people experiencing homelessness by homeless operational groups, Australia 2021 (Data source: ABS Estimating Homelessness: Census, 2023[110])

In 2021, almost 40% were living in severely crowded dwellings, almost 20% were in supported accommodation for the homeless, and 18% were living in boarding houses. Between 2016 and 2021, there was an estimated 26.5%

increase in people living in boarding houses, a 14.4% increase in people in supported accommodation for the homeless, a 6.9% decrease in people living in improvised dwellings, tents, or sleeping out, and a 6.3% decrease in people living in severely crowded dwellings.[110]

Census statistics include estimates of the number and percentage of people experiencing homelessness for each age group. The estimate for the number of children aged under 12 years experiencing homelessness was 17,646, representing 14.4% of people experiencing homelessness. Twenty three percent of people experiencing homelessness in 2021 were aged between 12 and 24 years. People aged 25 to 34 represented just over a fifth of people experiencing homelessness (20.8%), 13.9% were aged 35 to 44, and 12% were aged 45 to 54. People aged 55 and over represented 15.8% of people experiencing homelessness.[110]

The ABS suggested the decrease in people living in improvised dwellings, tents, or sleeping out may be partly associated with the response to COVID-19 and measures put in place by local and state governments.[110]

The Australian Homelessness Monitor also examines changes in the scale and nature of homelessness in Australia, and how social, economic and policy factors influence changes in homelessness. The Australian Homelessness monitor uses Specialist Homelessness Services data (SHS) and research components such as online surveys and qualitative interviews in addition to Census data and is therefore able to report statistics biannually. The 2022 Australian Homelessness Monitor report is the third, with previous reports in 2020 and 2018. More frequent collection of SHS data and use of multiple data sources allows more in-depth analysis and analysis of changes that may capture effects of economic, social, and policy changes somewhat better than the Census alone which is only conducted every 5 years and cannot capture the multidimensional nature of homelessness.

The 2018 Australian Homelessness Monitor reported that the number of people experiencing homelessness increased by 14% between 2011 and 2016, and the number of people who were sleeping rough increased by 20%.[111] The 2020 Australian Homelessness Monitor reported a 14% increase in the average monthly number of SHS users between 2014-15 and 2018-19, higher than population growth.[112] SHS data does only count people who seek assistance and are provided with assistance, however the research components of the 2022 Australian Homelessness Monitor included an online survey of 70 SHS provider agencies and two thirds of respondents to this survey agreed that excess demands or reduction in service capacity led to turning away of a more service users in 2022 compared to 2019 which suggests increases in homelessness may be even larger than estimated from SHS data, especially for the 2022 report.[112]

The 2022 Australian Homelessness Monitor included the first major analysis spanning the crisis years of COVID-19. The average monthly number of SHS users increased by 8% between 2017-18 and 2021-22, again higher than population growth, and the growth in SHS users in regional Australia was double the rate in capital cities (13% compared with 6%). Housing affordability stress was the most rapidly growing causal factor for homelessness between 2017-18 and 2021-22, with 27% of SHS users citing housing affordability stress as the trigger for their need for aid. The fastest growing groups of SHS users were Aboriginal and Torres Strait Islander people (an increase of 23%) and people with mental ill health (an increase of 20%).[112]

While the ABS indicated that a reduction in rough sleeping in Census data might be attributed to COVID-19 measures to reduce transmission, the 2022 Australian Housing Monitor notes that although the COVID-19 innovations engendered some positive change, they fall well short of changes required to adequately address homelessness and rough sleeping in the long term. These COVID-19 programs related to homelessness were considered to be modest and in some cases time-limited and unlikely to have significant long-term impacts on homelessness.[112]

Digital inclusion

An increasing number of activities are undertaken online, therefore exclusion or barriers to accessing the internet prevent people from experiencing opportunities that cannot be accessed offline.[113] Digital inclusion is strongly connected to social inclusion.[113]

PHIDU provide data on the percentage of dwellings where internet was accessed in 2006 and 2016 by quintile of socio-economic disadvantage (**Figure A102**). The time points in **Figure A102** only capture part of the time period in which digital inclusion has been increasing but the time period covered is a period when digital inclusion became increasingly important. There were substantial socio-economic inequities in internet access in 2006, with less than half of dwellings in the most disadvantaged quintile having internet access compared with almost three quarters of dwellings in the least disadvantaged quintile. There was a fairly large increase in the number of dwellings with internet access in every quintile between 2006 and 2016. Inequality in access to the internet decreased over this period. In 2006 the percentage of dwellings where internet was accessed for the most disadvantaged quintile was only 0.63 times the percentage for the least disadvantaged quintile. In 2016, the percentage for the most disadvantaged quintile was 0.83 times that of the least disadvantaged quintile. There was still substantial inequality in internet access in 2016 but it was improved compared with 2006. Access to the internet decreases with increasing disadvantage, there is clear social gradient in internet access in **Figure A102**.

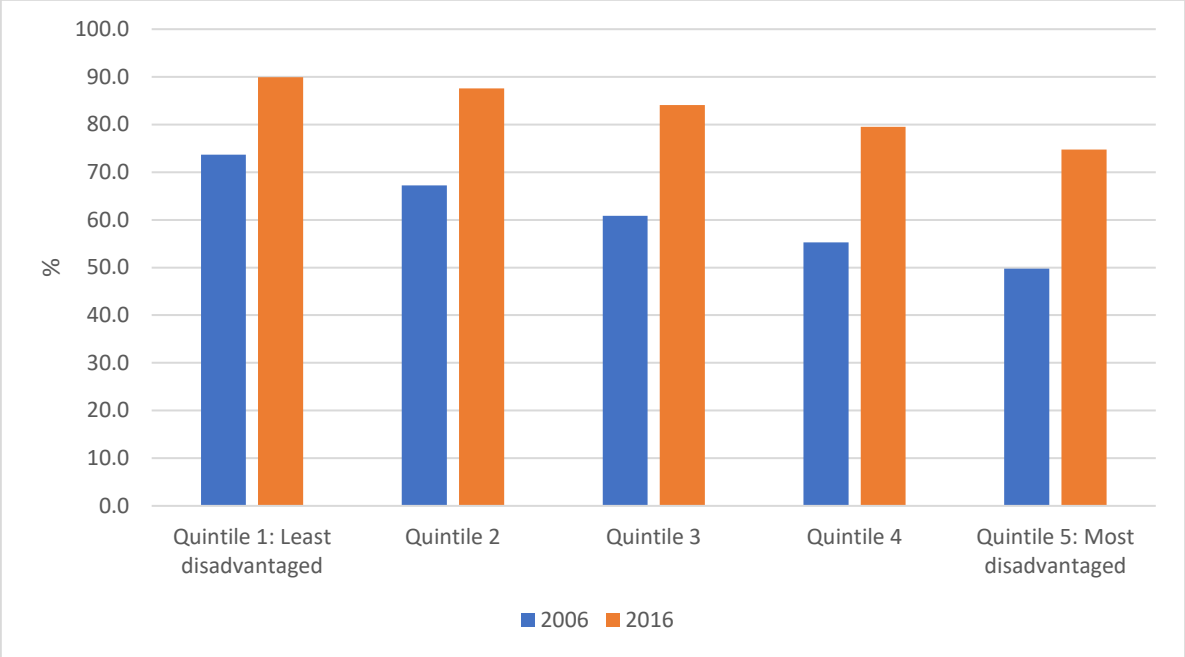


Figure A102: Dwellings where internet was accessed by quintile of socioeconomic disadvantage, 2006 and 2016, Australia (per cent) (Data source: Social Health Atlas, PHIDU, 2022[14])

The reduction in inequality in internet access was due to a higher proportional increase in the percentage of dwellings where internet was accessed in more disadvantaged areas. **Table A34** presents the proportional increase by quintile of socio-economic disadvantage between 2006 and 2016. The least disadvantaged quintile experienced the lowest proportional increase in the number of dwellings, and the proportional increase was higher with increasing disadvantage. The increase for the areas represented in the most disadvantaged quintile was more than double the increase for the least disadvantaged quintile.

Table A34: Table of proportional increase in dwellings where internet was accessed between 2006 and 2016

Quintile 1 (least disadvantaged)	22.0

Quintile 2	30.3
Quintile 3	38.1
Quintile 4	43.8
Quintile 5 (most disadvantaged)	50.1

Australian Digital Inclusion Index

PHIDU data on access to the internet was sourced from the Census. The 2021 Census did not include a question on internet access therefore Census data could only be used to examine the trend in access to the internet between 2006 and 2016. The Australian Digital Inclusion index was developed in 2015 and uses data from the Australian Internet Usage Study to measure digital inclusion by characteristics including age, gender, employment status, income, household type, housing tenure, and remoteness. The Australian Digital Inclusion Index also measures three dimensions of digital inclusion: access, affordability, and digital ability. The Index has been reported annually since 2014. This section analyses Australian Digital Inclusion Index data from 2014 to 2020[9].

Each dimension in the Australian Digital Inclusion Index has multiple components. Access has three components: internet access (frequency, places, number of access points), internet technology (computers, mobile phones, mobile broadband, fixed broadband), and internet data allowance.[114] Affordability has two components: relative expenditure (share of household income spent) and value of expenditure (data allowance per dollar spent).[114] Digital ability has three components: attitudes (e.g. learning, confidence, enthusiasm), basic skills, and digital activities.[114]

Figure A103 presents Australian Digital Inclusion Index scores for access, affordability, digital ability and the overall ADII score from 2014 to 2020. Data for 2020 was collected up to March 2020 therefore data analysed in **Figure A103** and subsequent figures does not capture the effects of the pandemic. Digital inclusion did increase between 2014 and 2022 for all dimensions included in **Figure A103**. The overall increase was very small between 2014 and 2015, with the rate of increase being higher from 2015 to 2019. The rate of increase was small from 2019 to 2020, an increase of only 1.1 points. The small increase from 2014 to 2015 can be attributed to a decrease in the score for affordability in 2015 compared with 2014, and the relatively small increase between 2019 and 2020 can be attributed to a very small increase in the score for access.

There were increases in access to the internet in each year from 2014 to 2020. Likewise, digital ability steadily increased in each year from 2014 to 2020. Affordability was a different matter. The score for affordability decreased in 2015 compared to 2014 and decreased a little again in 2016 compared with 2015. Scores for affordability only began increasing from 2016, and the score for 2017 was still below than in 2014. Affordability improved in each year from 2016 to 2020.

[9] The Australian Digital Inclusion Index was revised, and changes were made to construction of the Index for the 2021 and 2022 reports. Data from the revised Index is not comparable with data from 2014 to 2020.

Figure A103 presented overall scores which mask differences in the distribution by socio-economic status and other factors.

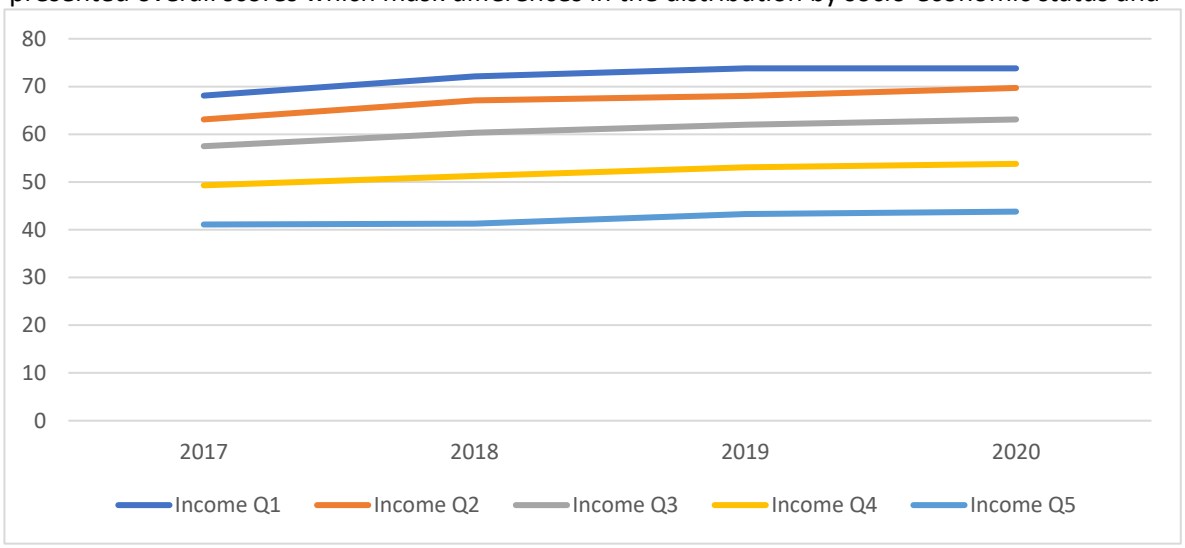


Figure A104 presents the Australian Digital Inclusion Index overall score (ADII score) by income quintile for 2017 to 2020. Australians with lower levels of income were significantly less digitally included in each year for which comparable data are available. There was a clear social gradient in digital inclusion over this period, with digital inclusion decreasing with lower income. There were smaller increases in ADII scores for low-income quintiles compared with higher income quintiles between 2017 and 2020. The rate ratio of the lowest income quintile to the highest was 0.60 in 2017, and was still only 0.59 in 2020, indicating no improvement in inequality.

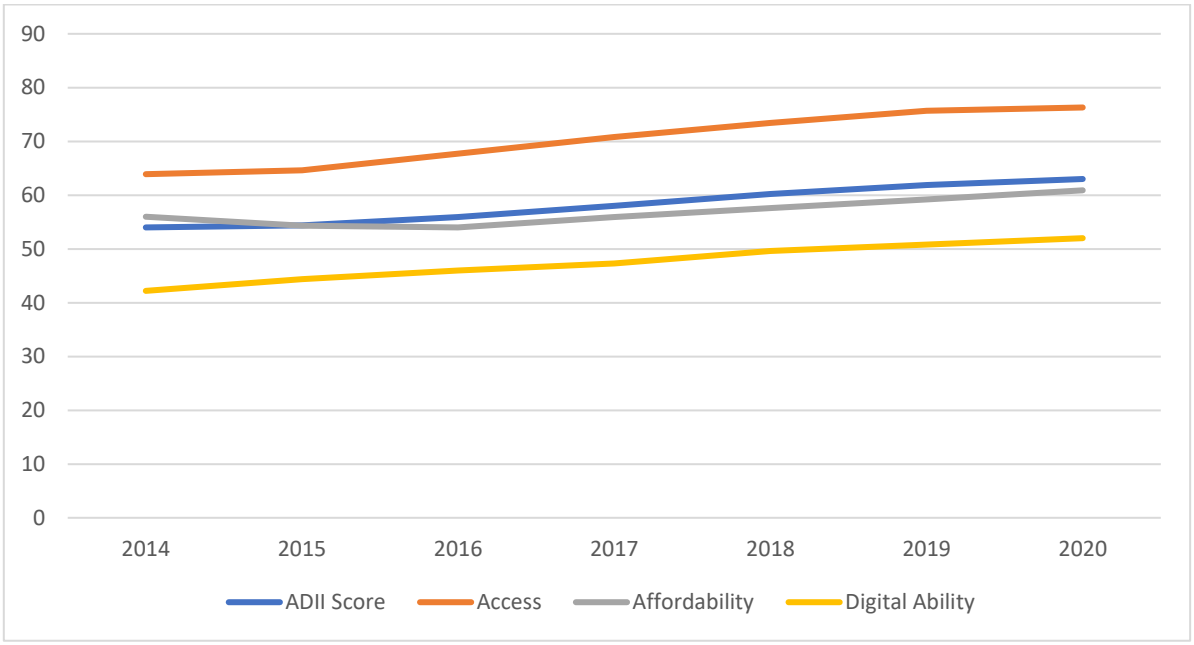


Figure A103: Australian Digital Inclusion Index Scores for Access, Affordability, Digital Ability and Overall Score, 2014 to 2020 (Measuring Australia's Digital Divide, Australian Digital Inclusion Index, various years)

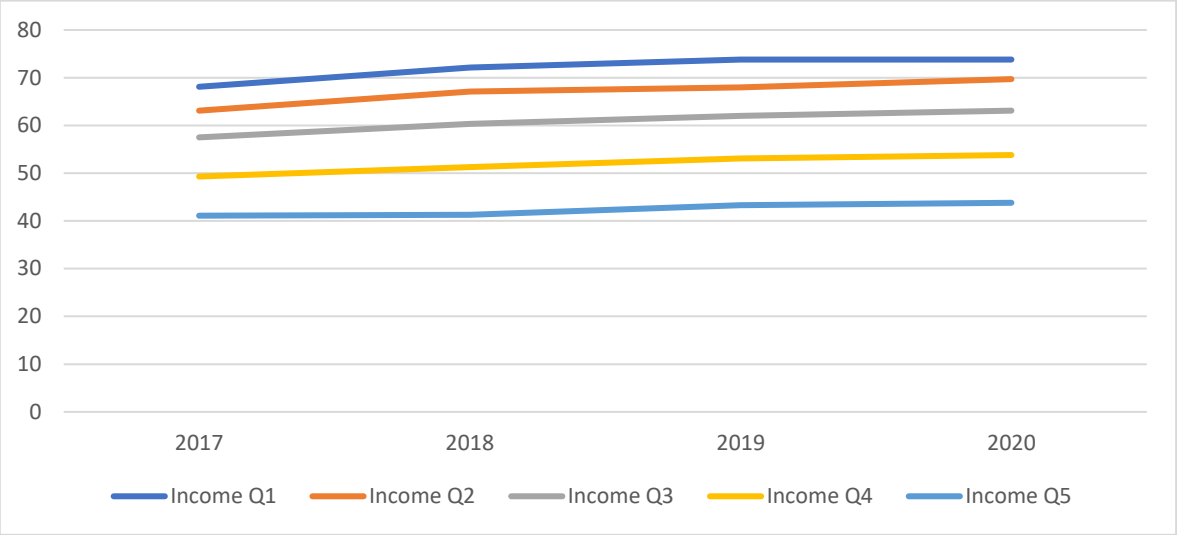


Figure A104: Australian Digital Inclusion Index, Overall Score, by Income Quintile, 2017 to 2020 (Measuring Australia's Digital Divide, Australian Digital Inclusion Index, various years)

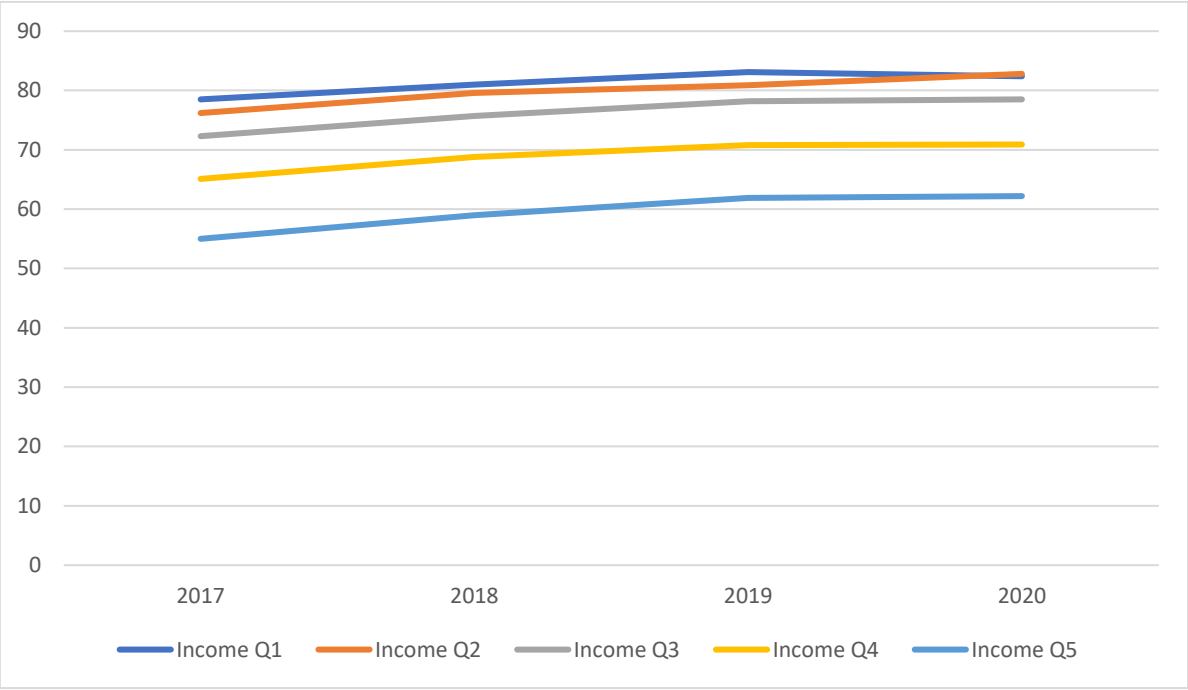


Figure A105 presents the Australian Digital Inclusion Index scores for access by quintile of socioeconomic disadvantage for 2017 to 2020. The gap between access score for the highest income quintile and for the lowest income quintile did decrease between 2017 and 2020, but the gap is still more than 20.2 points. In 2017 the rate ratio of the highest income quintile to the lowest income quintile was 0.70, and it did improve but was still only 0.75 in 2020 (equality is a rate ratio of 1). With the exception of similar scores for access for quintile 1 and quintile 2, access decreases with lower income.

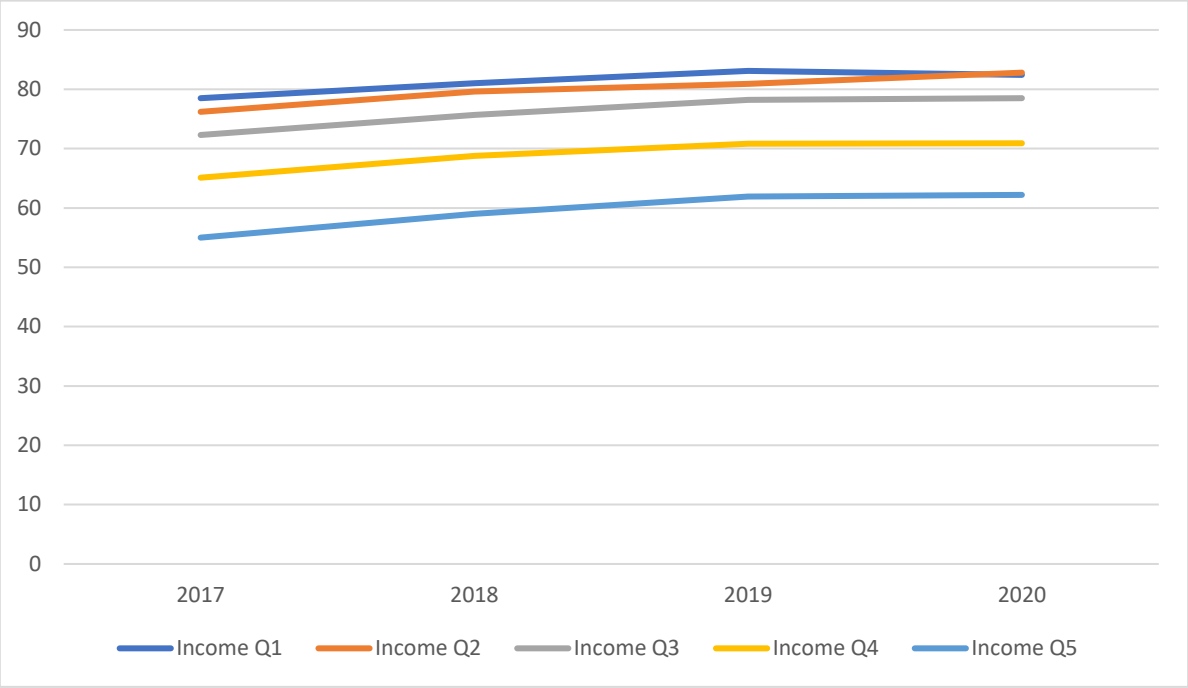


Figure A105: Australian Digital Inclusion Index, Access, by Income Quintile, 2017 to 2020 (Measuring Australia's Digital Divide, Australian Digital Inclusion Index, various years)

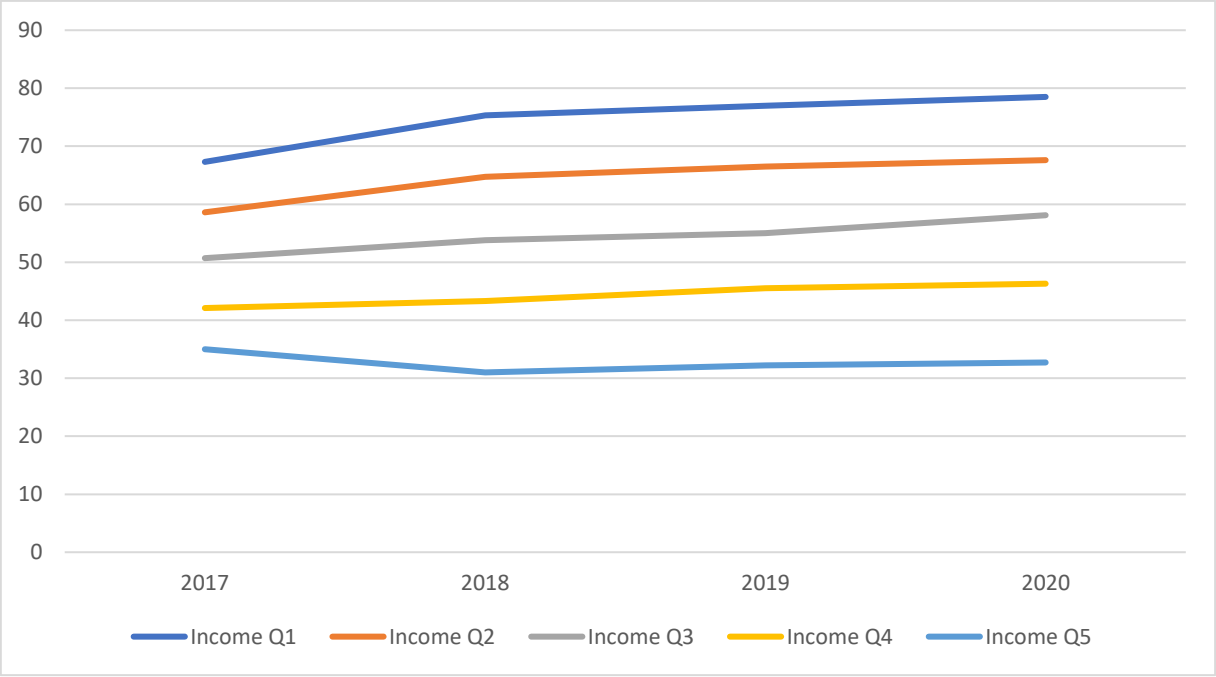


Figure A106 presents the Australian Digital Inclusion Index scores for affordability from 2017 to 2020. The scores for affordability for higher income quintiles increased each year. This was not the case for lower income quintiles for whom affordability scores decreased from 2017 to 2018 and the affordability score in 2020 remained lower than the score in 2017. Inequality in affordability increased over time through a steepening of the social gradient where affordability decreased even more with lower income in 2020 compared with 2017, and through a widening of the gap between the lowest income quintile and the highest income quintile. The rate ratio was 0.52 in 2017 and worsened to 0.42 in 2020.

The third dimension of digital inclusion included in the Australian Digital Inclusion Index is digital ability.

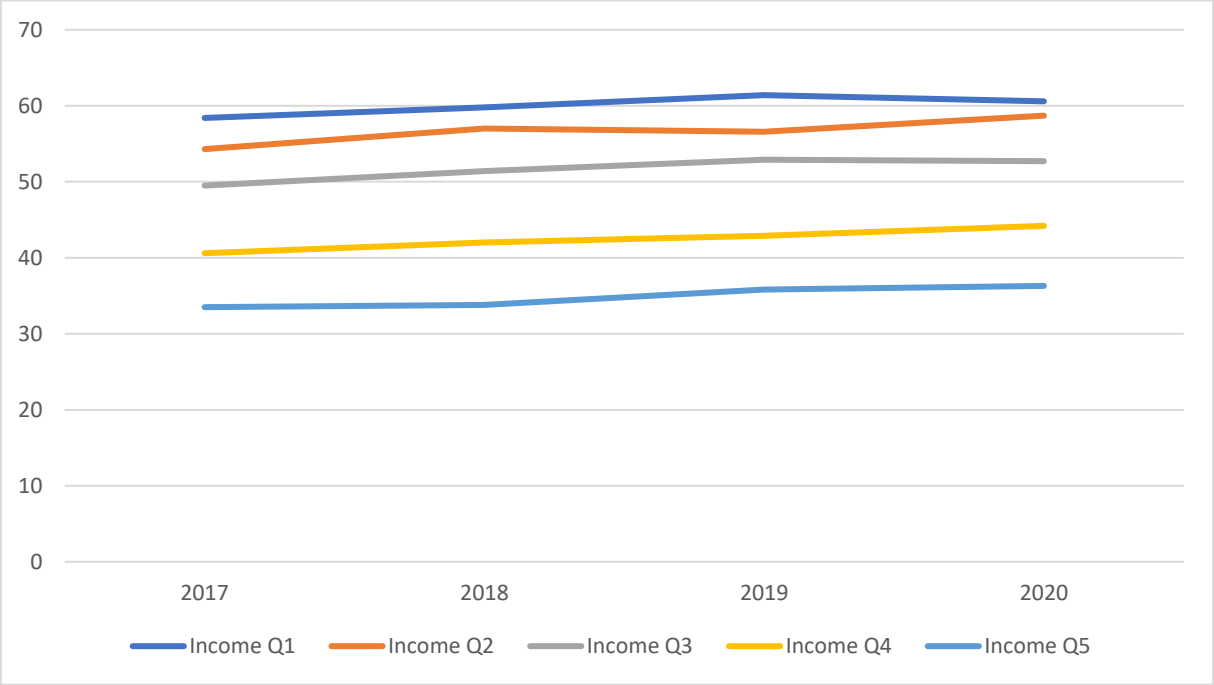


Figure A107 presents the scores for digital ability from 2017 to 2020. Digital ability increased for all quintiles over this period but from a lower base than the other dimensions of digital inclusion, reflecting low scores for more advanced activities and attitudes components of digital ability.[114]The increase in digital ability between 2017 and 2020 was smaller compared with other dimensions of digital inclusion. The increase was very small for the lowest income quintile from 2017 to 2020 compared with quintiles 2, 3, and 4, but was even smaller for the highest income quintile. There was a 24.3 point gap between the digital ability score for the highest income quintile and the lowest income quintile in 2020. This is slightly smaller than the 24.9 point gap in 2017 and equates to a rate ratio of 0.60 which still reflects substantial inequality. As with other dimensions of digital inclusion, scores for digital ability decrease with lower income.

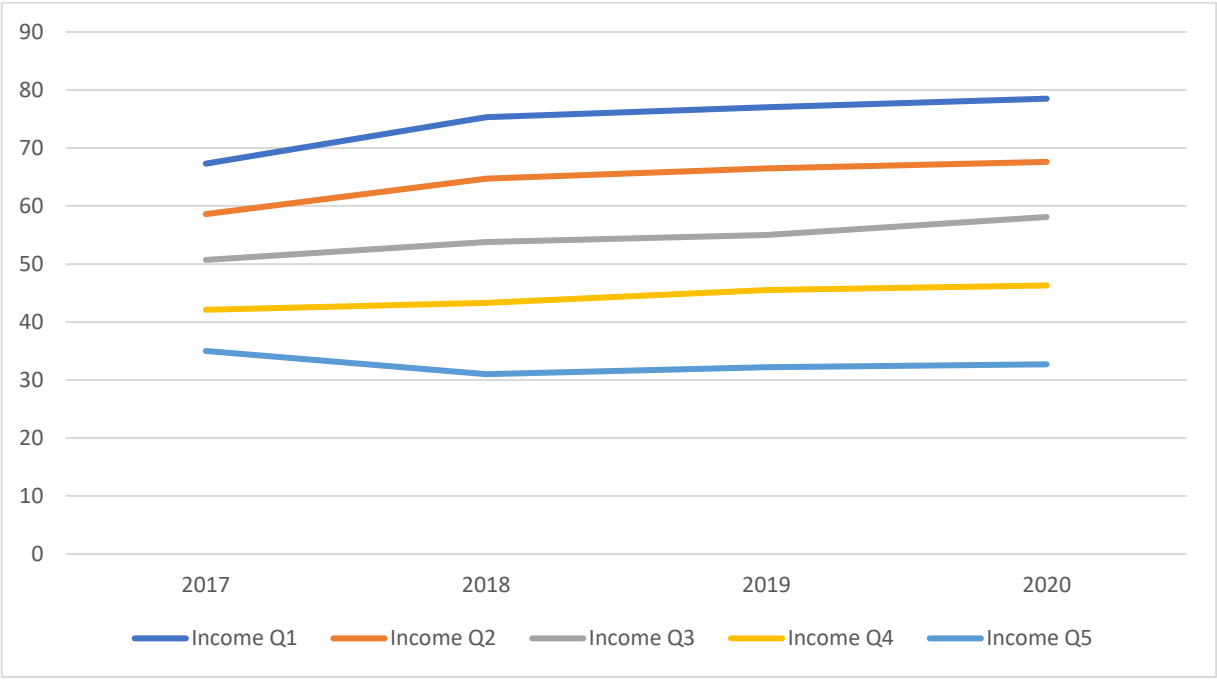


Figure A106: Australian Digital Inclusion Index, Affordability, by Income Quintile, 2017 to 2020 (Measuring Australia's Digital Divide, Australian Digital Inclusion Index, various years)

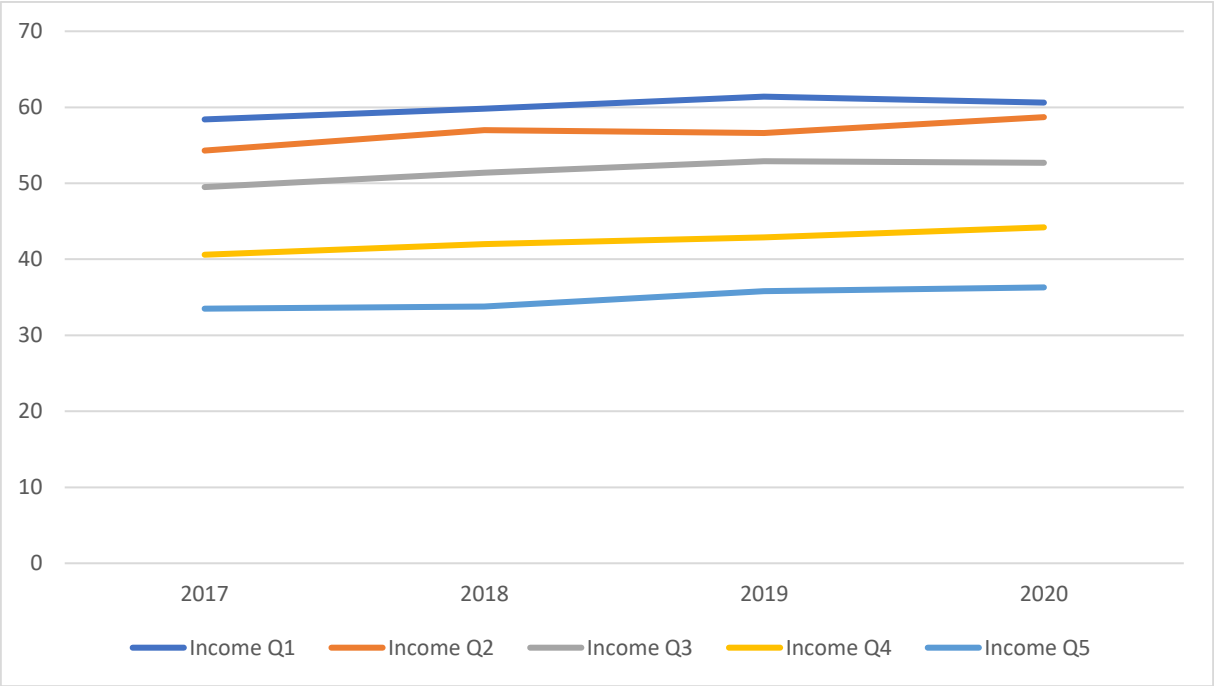


Figure A107: Australian Digital Inclusion Index, Digital Ability, by Income Quintile, 2017 to 2020 (Measuring Australia's Digital Divide, Australian Digital Inclusion Index, various years)

There is a clear digital divide between high income and low-income Australians. Differences in affordability impact on overall inequality, and relative expenditure is the key difference. Expenditure on internet access comprised approximately 4% of household income for people in the lowest income quintile, compared with less than 1% of household income for people in the highest income quintile. There was also a large employment gap in digital inclusion between people not in the labour force and people who are employed in 2020, and the gap has widened since 2014. People who only have internet on their mobile, people aged 65 and over, people with education less than secondary education, and people with disability had the lowest digital inclusion. Digital inclusion is higher in capital cities compared with rural areas, but the gap has narrowed since 2015. Aboriginal and Torres Strait Islander people also have relatively lower digital inclusion, and affordability was the key issue due to high use of prepaid connectivity and mobile only which has higher costs per gigabyte.[114]

Other measures of social inclusion

The Social Exclusion Monitor identified groups who continue to experience the highest rates of social exclusion. Women were more likely to be socially excluded than men, and people aged over 65 have the highest rate of social exclusion of all age groups, with more than 44% experiencing social exclusion.[103] Almost half (47%) of Aboriginal and Torres Strait Islander people experience social exclusion, and more than half of people with a disability or long-term health condition.[103] Social exclusion is associated with key social determinants of health: early school leavers were three times as likely to experience social exclusion compared with people with a diploma or degree, and almost 80% of public housing tenants (who generally have low incomes) experienced social exclusion, more than twice the rate of people living elsewhere.[103]

Social exclusion worsened for men between 2009 and 2018, from 20.8% of men to 23.3%. The percentage of women experiencing social exclusion was little changed over this period: it was 26.2% in 2009 and 26.6% in 2018. Migrants from non-English speaking countries were more likely to experience social exclusion, with 27.2%

experiencing social exclusion in 2018 compared with 24.7% of Australian born people and 23.8% of English speaking migrants. Social exclusion increased for people born in Australia between 2009 and 2018 and decreased for non-English speaking migrants and English speaking migrants. The prevalence of social exclusion for Aboriginal and Torres Strait Islander people was almost double that for all Australians, and 15% of Aboriginal and Torres Strait Islander people experience deep social exclusion, four or more types of social exclusion.[103]

From 2010 to 2018 there were fluctuations in the rate of social exclusion for people with a long-term health condition or disability, but the percentage remained about 50% for this period.[103] The rate of social exclusion for people with a long-term health condition or disability was more than double that of all Australians in 2018.[103] People with a long term health condition or disability had a high rate of deep social exclusion in 2018, 16.2%, which was higher than the 2009 estimate of 14.7%.[103]

The Inclusive Australia Social Inclusion Index score at the end of 2019 was 63 out of 100.[115] The 2019 results showed a minor decrease for 'belonging and wellbeing' and minor increases for 'contact', 'volunteering', and 'advocacy'.[115] Social inclusion as measured by the Inclusive Australia Social Inclusion Index remained stable between the first wave of data collection in May 2017 and the fourth wave of data collection in December 2019.[115] The December 2019 results found that 23% of Australians reported experiencing a major form of discrimination, and discrimination is even more common with people with intersecting forms of disadvantage, such as Aboriginal and Torres Strait Islander people with a disability, or Aboriginal and Torres Strait Islander people who identify as LGBTQI+.[115]

The Inclusive Australia Social Inclusion Index identified five profiles based on behaviour and attitudes. There were: Allies who were prepared to act to support social inclusion (22.4% of respondents); affected activists who were affected by exclusion and wanted to do something about it (18.4%); the disillusioned who were affected by exclusion and in need of support (around 20%); the indifferent who were disinterested and inactive (26.6%); and the contented who were happy with the status quo (13%).[104] Allies and affected activists were more likely to be university-educated, with the affected activists mostly female.[104] The disillusioned tended to have relatively lower household income, while the indifferent tended to have average income and education.[104] The contented had very little personal experience of discrimination, high levels of prejudice, low willingness to volunteer or advocate for inclusion and tended to be older (approximately 75% aged 50 and over) and identify as White/Caucasian (approximately 80%).[104]

Jurisdiction analysis: Homelessness

The Northern Territory has continually had the highest rates of people experiencing homelessness, but the rate has declined in each Census since 2006 (see **Table A35**). Rates of homelessness fluctuated by jurisdiction, increasing in four jurisdictions between 2006 and 2011, increasing in four jurisdictions again between 2011 and 2016, and increasing in four jurisdictions between 2016 and 2021 but decreasing in other jurisdictions in each of these periods. Rates of homelessness were higher in 2021 than in 2006 in NSW, Victoria, SA, Tasmania, and the ACT. Rates decreased between 2006 and 2021 in Queensland, WA, and the NT. In 2021, the jurisdictions with the lowest rate of homelessness were WA, followed by the ACT.

Table A35: Rates per 10,000 of people experiencing homelessness by state/territory, 2006 to 2021 (Data source: ABS Census, Estimating Homelessness, 2023[110])

	2006	2011	2016	2021
NSW	34	40	50	43
Victoria	35	42	42	47
Qld	48	44	46	44
SA	37	36	37	42
WA	42	41	36	37
Tas.	24	31	32	42

NT	792	724	600	564
ACT	30	49	40	39
Australia	45	48	50	48

The composition of people experiencing homelessness by jurisdiction differed, with higher shares of certain homeless operational groups in certain jurisdictions (see **Figure A108**). The NT had by far the largest share of people in 'severely' crowded dwellings, which made up 76% of people experiencing homelessness in the NT. The ACT had a much larger share of people in supported accommodation for the homeless, 49%. Victoria and NSW had higher shares of people living in boarding houses, 28% and 25% respectively. Tasmania had the highest share of people staying temporarily with other households (25%), followed by WA and QLD (both 22%). WA had the highest share of people living in improvised dwellings, tents or sleeping out (24%).

Rates of homelessness for Aboriginal and Torres Strait Islander people by jurisdiction mostly followed the national trend of a decline in the rate of homelessness between 2006 and 2021 (see **Table A36**6). Rates per 10,000 decreased in all jurisdictions except for Tasmania in 2021 compared with 2006. The rate of homelessness for Aboriginal and Torres Strait Islander people in Tasmania fluctuated between 2006 and 2021 but was higher in 2021 than in 2006. Rates of homelessness in **Table A36** increased in 2021 compared with 2016 in SA, WA, Tasmania, and Victoria. The highest rates of homelessness for Aboriginal and Torres Strait Islander people were in the NT, followed by WA and SA. The lowest rates of homelessness for Aboriginal and Torres Strait Islander people were in Tasmania and NSW.

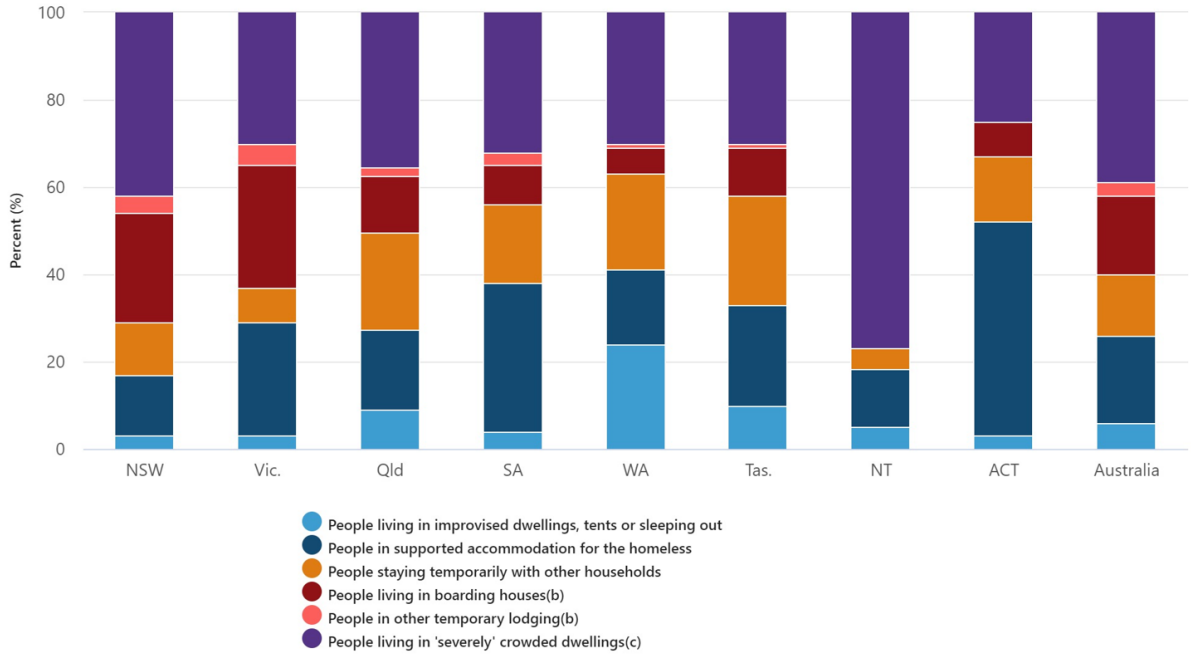


Figure A108: People experiencing homelessness by homeless operational groups, state and territory 2021 (Data source: ABS Census, Estimating Homelessness, 2023[110])

Table A36: Rates of Aboriginal and Torres Strait Islander people experiencing homelessness by state/territory, 2006 to 2021 (Data source: ABS Census, Estimating Homelessness, 2023[110])

	2006	**2011**	**2016**	**2021**
NSW	136	128	105	90
Vic.	212	218	164	169
Qld	375	309	239	201

SA	493	359	274	327
WA	564	485	345	381
Tas.	56	85	55	82
NT	2,594	2,462	2,083	1,865
ACT	186	504	146	141
Australia	571	487	361	307

The Australian Homelessness Monitor reports included some statistics on homelessness by jurisdiction. The 2018 report highlighted that there was a 48% increase in homelessness in Sydney between 2011 and 2016, a 36% increase in Darwin, a 32% increase in Brisbane, and a 21% increase in Hobart. Increases were smaller for other jurisdictions and in the ACT homelessness decreased by 8% between 2011 and 2016. Levels of rough sleeping increased between 2011 and 2016, by 50% in SA, 35% in NSW, and 29% in the NT. According to Census data, there was an 11% reduction in rough sleeping in Tasmania between 2011 and 2016.[111] Between 2018 and 2022, numbers of people experiencing homelessness in SA remained about the same, but there was a 24% increase in the number of people experiencing homelessness in Tasmania, and a 22% increase in Queensland. The growth in the number of people experiencing homelessness was higher in regional Australia, with a 29% increase in regional Queensland and a 35% increase in regional Western Australia.[112]

Jurisdiction analysis: Digital inclusion

There were large increases in the percentage of dwellings where internet was accessed in each jurisdiction between 2006 and 2016 (**Figure A359**). In 2006, there was high socio-economic inequality in all jurisdictions but particularly in the NT (RR=0.26), SA (RR=0.65) and Queensland (RR=0.66). The ACT had the highest percentage of dwellings in each quintile with internet access in 2006 and the lowest inequality (RR=0.82). The NT had a very low percentage of dwellings in the most disadvantaged quintile with internet access in 2006, but the NT had the highest proportional increase in the percentage of dwellings with internet access for the most disadvantaged quintile between 2006 and 2016. The NT still had the lowest internet access and the highest inequality in internet access in 2016 (RR=0.57) but internet access almost tripled for the most disadvantaged quintile between 2006 and 2016. Tasmania and SA were the other jurisdictions with internet access that was lower than the national average for each quintile. The ACT had the lowest proportional increase in dwellings accessing the internet, but still had the highest internet access in 2016 and the lowest inequality (RR=0.93).

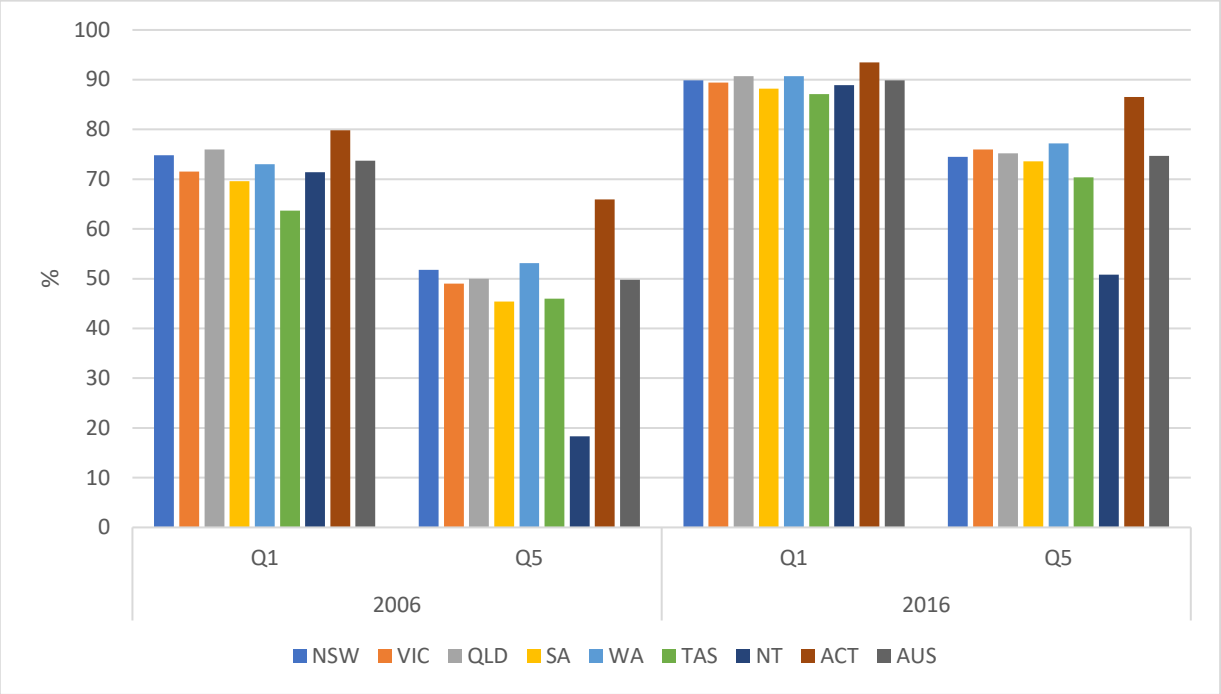


Figure A359: Percent of Dwellings where Internet Accessed from Dwelling years in each Jurisdiction in Australia, by quintile 1 (Q1, least disadvantaged) and quintile 5 (Q5, most disadvantaged) 2006 and 2016 (Data source: Social Health Atlas, PHIDU, 2022)

Table A37 presents Australian Digital Inclusion index report data by jurisdiction. The ACT has had the highest ADII score from 2016 to 2020, and the 2020 Australian Digital Inclusion Index report notes that the ACT has recorded the highest score of all states and territories since 2014, the first year for which the ADII score was calculated.[114] Tasmania and SA have had the lowest ADII scores over this period. The largest improvements in ADII score were in Tasmania and SA.

Table A38 presents Australian Digital Inclusion Index scores by jurisdiction for the three dimensions of access, affordability, and ability for 2016 and 2020. The ACT had the highest scores for all three aspects of digital inclusion in 2016 and in 2020. Tasmania had the lowest scores in 2016 for all three aspects and with the exception of the NT (where sample size was small and estimates should be interpreted with caution) Tasmania had the lowest scores in 2020 as well for all three aspects of digital inclusion. SA had the next lowest scores after Tasmania for all three measures in 2016, and the next lowest score after Tasmania for access in 2020. SA and Queensland both had similarly low scores for affordability in 2020 relative to most other jurisdictions, and Queensland had a slightly lower score for digital ability then SA with both having lower scores than the national average.

Table A37: Australian Digital Inclusion Index Scores by Jurisdiction in 2016 and 2020 (Data source: The Australian Digital Inclusion Index, 2016 and 2020)[114, 116]

	2016 ADII Score	2020 ADII Score	Change in ADII Score
NSW	54.9	63.5	+8.6
VIC	55.9	63.1	+7.2
QLD	53.5	62.2	+8.7
SA	51.6	61.9	+10.3
WA	54.2	64.1	+9.9
TAS	48.2	59.6	+11.4
NT*	54.8	-	

ACT	59.7	67.5	+7.8
AUS	54.5	63.0	+8.5

*NT ADII score was calculated using a very low sample size and should be interpreted with caution

Table A38: Australian Digital Inclusion Index Scores by Jurisdiction for Access, Affordability and Digital Ability in 2016 and 2020 (Data source: The Australian Digital Inclusion Index, 2016 and 2020[114, 116])

	2016			2020		
	Access	Affordability	Ability	Access	Affordability	Ability
NSW	65.9	52.5	46.3	76.4	61.7	52.5
VIC	68.2	52.0	47.6	76.3	60.7	52.2
QLD	66.1	49.6	45.0	76.1	59.7	50.7
SA	64.0	47.5	43.2	75.3	59.5	51.0
WA	65.4	51.8	45.3	77.5	61.5	53.4
TAS	61.4	44.1	39.0	74.0	57.9	47.1
NT*	67.8	52.6	43.9	71.0	54.9	46.5
ACT	69.2	55.7	54.4	77.0	69.9	55.7

Table presents Australian Digital Inclusion Index scores for all three aspects of digital inclusion for capital cities and for rural areas in each state in 2016 and 2020. When scores are disaggregated into capital city scores vs rest of state Melbourne's score for access is comparable with the access score for the ACT, and all capital cities have higher scores for access, affordability, and digital ability compared with rural areas in each respective state. Hobart had the lowest scores for all three aspects of digital inclusion compared with all other capital cities in 2016 and the lowest digital ability score of all capital cities in 2020 but Hobart had a higher access score than the ACT and all other capital cities in 2020, and Adelaide had the lowest affordability score among capital cities with Hobart having the second lowest affordability score among capital cities. Sydney had the highest score for affordability and digital ability among capital cities in 2020.

Rural WA had the highest rural access score in 2016, which was comparable with the lowest capital city score for Hobart. Rural SA had the lowest access score in 2016, followed by rural Victoria then rural Tasmania and while scores were improved between 2016 and 2020, rural SA still had the lowest access score in 2020 followed by rural Tasmania then rural Queensland. By 2020, rural WA still had the highest rural access score, but this score was still lower than all but the lowest capital city score. Affordability scores were much lower in rural areas in 2016 and in 2020 compared with all capital cities. Rural Tasmania and Rural SA had comparably low affordability scores in 2016, followed by rural Victoria, but in 2020 rural Queensland had the lowest affordability score, followed by rural NSW and rural Victoria. Rural Tasmania had the lowest digital ability score in 2016, followed by rural Victoria then rural SA. In 2020, rural SA had the lowest digital ability score, followed by rural Tasmania. The gap in digital ability between capital cities and rural areas grew in all states except Victoria and WA.

Table A39: Australian Digital Inclusion Index Scores for Access, Affordability and Digital Ability for Capital Cities and Rural Areas in each Jurisdiction, 2016 and 2020 (Data source: The Australian Digital Inclusion Index, 2016 and 2020[114, 116])

	2016			2020		
	Access	Affordability	Ability	Access	Affordability	Ability
Sydney	68.1	55.5	48.8	77.7	65.5	55.5
Rural NSW	62.0	46.8	41.6	73.0	53.5	46.3
Melbourne	70.7	54.3	50.4	77.1	62.5	53.7
Rural VIC	60.3	44.3	38.8	73.0	53.7	46.8
Brisbane	68.6	52.5	48.0	77.9	63.8	54.1

Rural QLD	63.7	46.6	42.2	72.8	52.3	45.2
Adelaide	65.4	48.8	44.2	77.1	60.9	53.3
Rural SA	59.1	43.2	39.7	69.0	54.2	42.9
Perth	66.2	53.4	46.6	78.2	63.0	54.5
Rural WA	62.3	45.6	40.5	74.8	55.4	49.1
Hobart	62.4	45.6	41.5	79.0	61.4	52.1
Rural TAS	60.6	43.0	37.1	70.0	55.1	43.2

Figure A360 presents ADII scores by jurisdiction for the lowest income quintile and highest income quintile in 2017 and 2020. There were increases in ADII scores for all jurisdictions and for all quintiles in 2020 compared to 2017, but the scale of increase differed by jurisdiction and by quintile. The large increases in overall ADII score for Tasmania and SA observed in **Table A37** are not shared equally by income level, with large increases in ADII scores for the highest income quintile for Tasmania and SA but only low increases for the lowest income quintile. The increase in ADII score was higher for the highest income quintile than the lowest income quintile in all states except Victoria, where there was a higher increase for the lowest income quintile compared with the highest income quintile. Inequality in digital inclusion was still high in Victoria in 2020 (RR=0.62), but inequality did decrease in Victoria compared with 2016 (RR=0.59) (higher RR equals lower inequality). There was an increase in inequality in all other states. NSW had the highest inequality in digital inclusion in 2020 (RR=0.56) followed by Tasmania (RR=0.59). All states had very high socioeconomic inequality in digital inclusion, but Victoria had the lowest inequality when compared with other states, followed by WA.

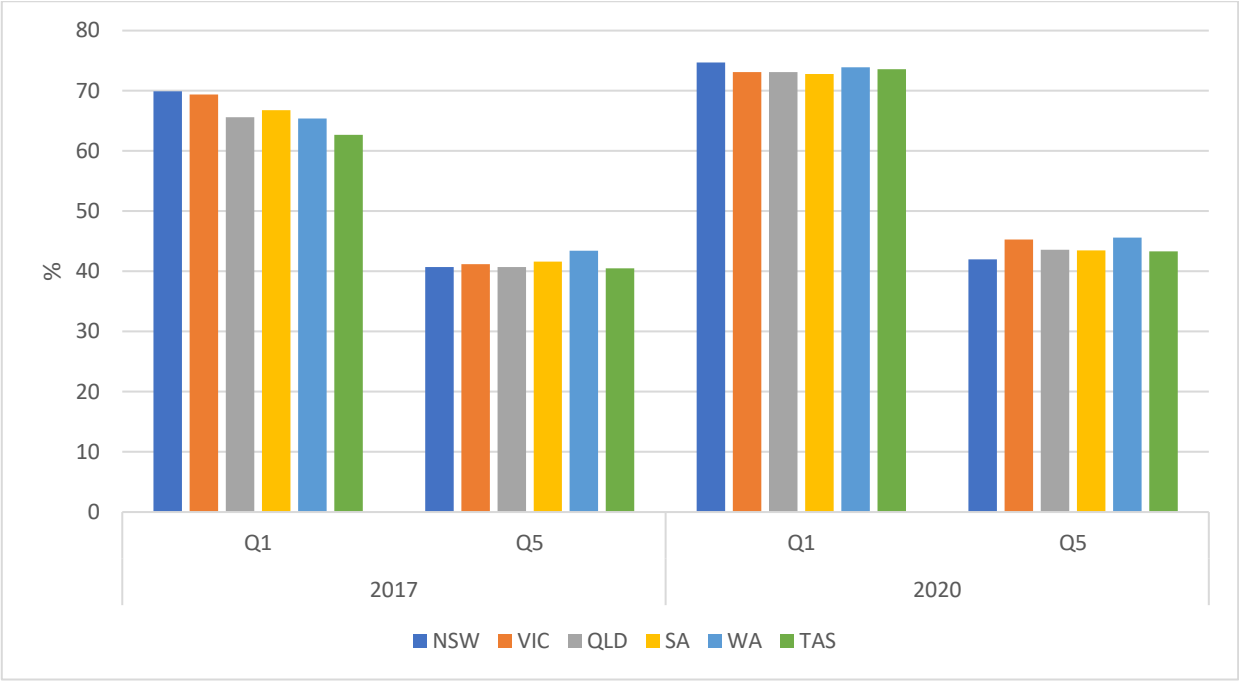


Figure A360: Australian Digital Inclusion Index Score in each State in Australia, by quintile 1 (Q1, highest income) and quintile 5 (Q5, lowest income) 2017 and 2020 (Data source: Australian Digital Inclusion Index, 2017, 2020)

Other determinants of health inequities

Smoking

Age standardised rates per 100 of people aged 18 years and over who were current smokers decreased for every quintile of socio-economic disadvantage between 2007-08 and 2017-18 (**Figure A37**). The reduction in age-standardised rates of smoking was higher for less disadvantaged quintiles, a reduction of more than 30% for

quintiles 1 and 2 compared with 28% for quintile 3, 16% for quintile 4 and 18% for quintile 5. Socio-economic inequality in age standardised smoking rates increased between 2007-08 and 2017-18 due to the higher reductions in smoking rates for the less disadvantaged. The rate ratio increased from 2.41 in 2007-08 to 2.87 in 2017-18.

The highest rates of smoking were in the NT, followed by Tasmania. The highest inequality of smoking was in WA (RR-3.61), primarily due to WA having the lowest rate of smoking for the least disadvantaged quintile and a much lower reduction in smoking rates for the most disadvantaged compared with the least disadvantaged. The ACT had the lowest smoking rates particularly for more disadvantaged quintiles, and the second lowest inequality in smoking rates (RR=2.44). Victoria had the lowest inequality in smoking rates (RR=2.00).

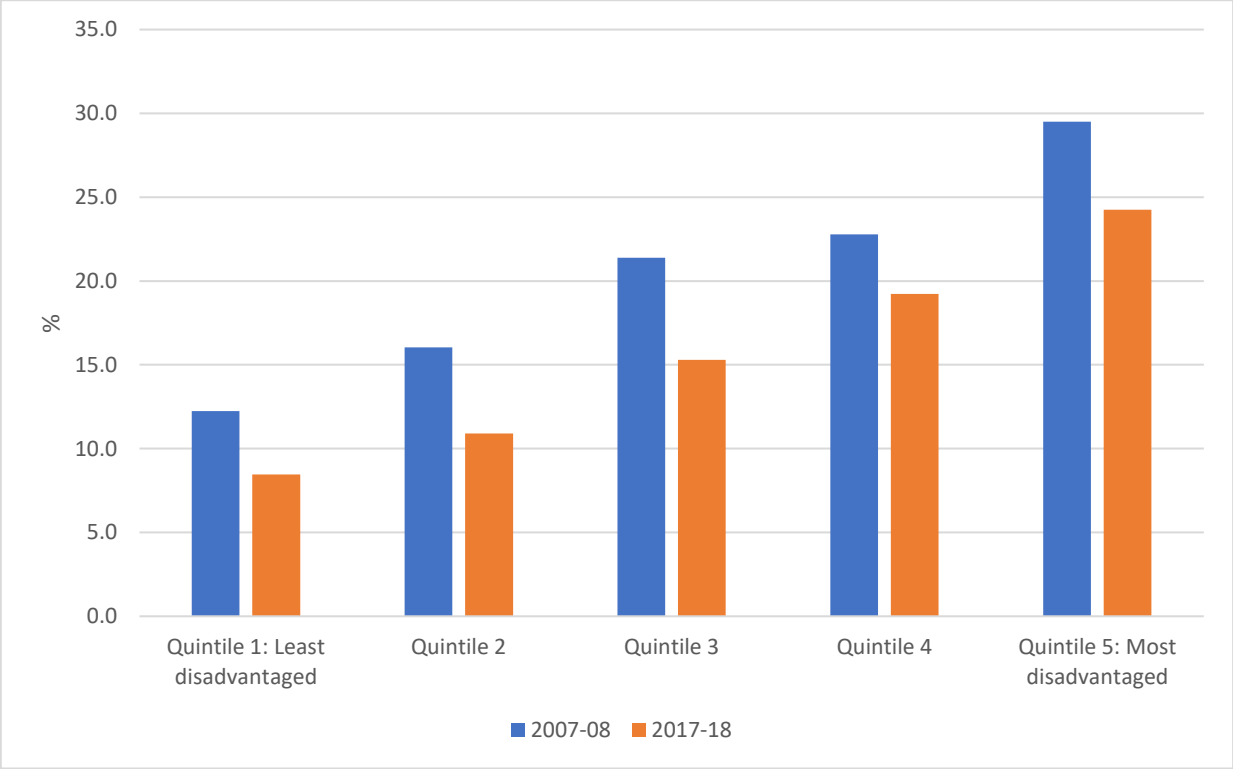


Figure A37: Estimated Age-Standardised Rate of People aged 18 years and over who were current smokers, by Quintile of Socio-economic Disadvantage, 2007-08 and 2017-18 (Data source: Social Health Atlas, PHIDU, 2022[14])

Food insecurity

A 2020 report published by the Australian Institute of Family Studies estimated that between 4 and 13% of the general population in Australia and between 22 and 32% of Aboriginal and Torres Strait Islander people were food insecure. Some groups were identified as being more vulnerable to food insecurity: low-income earners, Aboriginal and Torres Strait Islander people, people who are isolated either socially or geographically, single parent families, culturally and linguistically diverse groups, older people, and people experiencing homelessness. The primary reason for food insecurity was inadequate financial resources, but other contributing factors included financial or geographic difficulty in accessing healthy food.[117]

An August 2022 Taking the Pulse of the Nation survey asked respondents three questions to identify prevalence of food insecurity: whether they had skipped meals, eaten less than they should due to lack of money, or whether a member of their family had received groceries or meals from a food bank or charity. The rates of food insecurity in results from this survey far exceeded the 2020 estimates from the Australian Institute of Family Studies report.

Almost 45% of people aged 18 to 24 reported food insecurity. Around 30% of people aged 25 to 34 and almost 27% of people aged 35 to 44 reported some level of food insecurity. The level of food insecurity was much lower among people aged 45 and over, less than 15%.[118]

Tasmania had the highest prevalence of food insecurity, followed by NSW, Queensland and Victoria. Levels of food insecurity are high in all states for people aged 18 to 44. Even SA with the lowest rate of food insecurity compared to other jurisdictions had a prevalence exceeding 20% for people aged 18 to 44, but the prevalence exceeded 55% in Tasmania, was 35% in NSW, around 30% in QLD, 27% in Victoria, and 27% in WA.[118]

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