
The pitfalls of personalization rhetoric in time of health crisis: COVID-19 pandemic and cracks on neoliberal ideologies

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Summary

The rise of the COVID-19 pandemic has exposed the incongruity of individualization ideologies that position individuals at the centre of health care, by contributing, making informed decisions and exercising choice regarding their health options and lifestyle considerations. When confronted with a global health threat, government across the world, have understood that the rhetoric of individualization, personal responsibility and personal choice would only led to disastrous national health consequences. In other words, individual choice offers a poor criterion to guide the health and wellbeing of a population. This reality has forced many advanced economies around the world to suspend their pledges to ‘small government’, individual responsibility and individual freedom, opting instead for a more rebalanced approach to economic and health outcomes with an increasing role for institutions and mutualization. For many marginalized communities, individualization ideologies and personalization approaches have never worked. On the contrary, they have exacerbated social and health inequalities by benefiting affluent individuals who possess the educational, cultural and economic resources required to exercise ‘responsibility’, avert risks and adopt health protecting behaviours. The individualization of the management of risk has also further stigmatized the poor by shifting the blame for poor health outcomes from government to individuals. This paper will explore how the COVID-19 pandemic exposes the cracks of neoliberal rhetoric on personalization and opens new opportunities to approach the health of a nation as socially, economically and politically determined requiring ‘upstream’ interventions on key areas of health including housing, employment, education and access to health care.

Key words: health equity, social determinants of health, Australian social policy

INTRODUCTION

The unfolding social, health and economic crisis brought about by the COVID-19 pandemic around the world have triggered strong debates and reformulations of the moral and economic fitness of national and transnational policies and institutions to manage the fallouts from the pandemic and steer the post-pandemic world.

Some of the most fervent debates have centred around the type of society and social order that should emerge once the restrictions are eased. Questions about the morality and suitability of libertarian principles of self-reliance, market driven policy and minimal government in time of crisis are emerging (Doherty, 2020; Lent, 2020; Whitzman, 2020; Wong, 2020). Some of the

arguments cited include the impact of policies in countries around the world aimed at fragmenting and privatizing health systems, which have hindered access to primary health care when it is most needed; and the manner in which market driven reforms have exacerbated poverty and social inequality with socially disadvantaged communities and groups becoming highly vulnerable in time of crisis (Soltly, 2020). Equally important, it is argued that COVID-19 challenges the dominant cultural values of individualism and self-determination, mainly because the pandemic reveals that health is not just a private asset but part a social good and a fundamental right for everyone (Watson et al., 2020). An example cited to illustrate this point is the current health crisis in the USA as a result of the policy of drawing individuals' premium payments in part from their employers. The economic crisis brought by the COVID-19 pandemic has resulted in millions of workers suddenly losing not only their jobs but also their health insurance and therefore finding themselves unable to access essential health care (Dunford and Qi, 2020).

When faced with a global pandemic such as COVID-19, the flaws of individualization approaches to health and adherences to rhetoric of individuals as rational consumers of public goods and information including health, becomes evident. Research on responses to the pandemic in the USA by disadvantaged adults with comorbid conditions has also showed that they lacked critical resources such as health literacy and engagement with the health system and health information to make informed decisions, and, despite concerns, were not changing routines or plans (Wolf et al., 2020). In the USA, anti-lockdown protests and attitudes towards the virus and protective guidelines have mostly been influenced by partisan voting patterns rather than rational assessment of risk (Vince, 2020). Interestingly enough decades of neoliberalism and social conservatism with its zealous emphasis on personal liberties and small government display their worst civil society traits in time of crisis through cultural expressions such as these refusals to wear masks as well as incidents of physical attacks on health staff and businesses in UK, Australia and USA trying to enforce mask wearing (Vince, 2020). What refusals to adopt protective measures such as these indicate is the manner in which, decades of individualization and autonomy-based approaches to the relationship between individuals, the state and society, distort the relationship between individuals and the social interdependency nature of health and wellbeing.

The advent of a global infectious disease such as COVID-19 questions our understanding of autonomous

agency in two important ways, as stated by Azétsop and Rennie (Azétsop and Rennie, 2010) a decade earlier:

First, as both a victim and a vector, a patient cannot be simply seen as a rational agent who has the final ethical word on his own decisions. Both vulnerability to infection and threat of transmission to others should shape our understanding of patient agency. Second, the concept of choice that shapes our conception of agency in bioethics can no longer be understood in isolation from society. (2010, p. 2)

Confronted with an evolving threat such as a global pandemic, governments and public health officials have not hesitated to curtail autonomous agency and personal choice when the wellbeing of third parties are involved (Bayer, 2007). Individualism and autonomy are, however, constantly evoked to account for disparities in health and economic outcomes, with the most disadvantaged groups and individuals often becoming the target of programmes and policies to address their self-care and autonomy deficiencies. At the centre of this paradox lies a fundamental flaw in the application of the 'rights' language (Kirtley, 2017) and the relationship between individuals and the state. The preference neoliberalist policy gives to notions of individual freedom as equated with an absence of constraints imposed on an individual by outside authorities fails to recognize the role of government intervention, collective action and the common good to create the conditions in which individuals can exercise their free will (Ives, 2020).

The conceptualization of health disparities and health interventions using this narrow application of individual freedom and responsibility principles, ignores the links between free will and the structural and social conditions that shape individual action and choices (Thomas and Buckmaster, 2010; Schram and Goldman, 2018). The social, economic and structural factors shaping individual choices, health behaviours and health outcomes are as evident in time of global pandemic events as they are in normal times. The brief respite to this rhetoric in favour of greater attention to the addressing the health impacts of poor housing, poverty, unemployment and underemployment are no more than a recognition that a concern for the common good requires a broader understanding of individual rights and freedom of choice.

NEOLIBERAL REFORMS AND SOCIAL DETERMINANTS OF HEALTH IN AUSTRALIA

The Australian Institute of Health and Welfare (AIHW) is a leading health and welfare statistics agency that

collects data on many health and welfare issues and topics in Australia. Decades of collecting evidence on the social determinants of health provides a sobering picture of worsening conditions in key indicators including socio-economic exclusion, unemployment and housing. Some of the figures in the 2019 report include the fact that more than 116 000 women and children in Australia were estimated to be homeless, an increase of 4.6% from 2011 (AIHW, 2019). Although the percentage of the Australian population living in poverty has not changed in the last 10 years sitting around 13%, fluctuations in the poverty gap in the last 10 years have been identified and linked to specific government policies (AIHW, 2019). A notorious example is the impact of the transfer of many sole parents to Newstart Allowance in 2015 resulted in a rise in the rate of poverty among unemployed sole parents from 35% in 2013 to 59% 2 years later (ACOSS, 2018). The government's decision to temporarily double the Newstart payment (renamed Job Seeker) in response to the pandemic is expected to have an impact on these figures with an anticipated significant decrease in the percentage of Australian living under the poverty line. This will be discussed in more detail later in this paper.

The housing situation in Australia has also worsened for low-income families. Housing, as stated by the Australian Council for Social Services (ACOSS) is the largest fixed cost in most family budgets. Housing affordability continues to be one of the most significant barriers and sources of stress for low-income families in Australia. Individuals and families with lower housing costs (especially those who own their homes outright) are in a much better position and enjoy higher standards of living than those on the same income but with higher housing costs (especially tenants) [(ACOSS, 2018), p. 5]. The 2013 – 14 report on housing affordability identified housing stress being experienced by an increasing number of renter households. According to the Australian Bureau of Statistics 50.1% of low-income renter households had housing costs >30% of gross household income (which includes Commonwealth Rent Assistance) (Parliament of Australia, 2015a,b). A report by the AIHW in 2019 found that in June 2016, around 195 000 households were on social housing waiting lists, with 47% having waited for more than 2 years. However, as the 2013 Senate Inquiry into affordable housing revealed, social housing supply has declined over the last 10 years and been redefined by successive governments as a welfare safety net measure for the most disadvantaged. This means that social housing is no longer available to most people, even people who

have chronic health problems and are experiencing extreme poverty (Parliament of Australia, 2015a,b).

A 2014 Senate Community Affairs References Committee Report called 'Bridging our growing divide: inequality in Australia'. The extent of income inequality in Australia' (Parliament of Australia, 2014) found that income inequality has increased in Australia against the backdrop of rising incomes across all income deciles. As one submission by Prof. Morawetz pointed out, in the last 20 years income inequality in Australia has increased and today the richest 20% of households in Australia account for 61% of total household net worth, whereas the poorest 20% of households account for just 1% of the total [(Morawetz, 2016), p. 6]. These findings indicate that despite economic growth in the last 20 years, Australia has an increasing number of individuals and families facing economic hardship, social exclusion and dependency on government benefits, including those on Newstart unemployment benefits, which until the advent of COVID-19 forced their recipients to live well below the poverty line (Parliament of Australia, 2014). The 2014 Senate Report concluded that, based on the evidence received by hundreds of submissions and analysis of government policy, the 2014–15 budget had disproportionately and negatively impacted people living on low incomes.

Economic policies that disadvantage and exacerbate poverty have profound impacts on health outcomes (Spencer, 2003). Income inequality affects to all areas of social and economic life, health and wellbeing. That is why it is often referred as the 'fundamental cause' (Phelan et al., 2010) due to its impact on access to resources such as knowledge, education, power, prestige and beneficial social connections. In relation to health, income inequality, as the 2014 Senate Report pointed out, was a key barrier preventing people from accessing health care or investing in preventive health and healthy lifestyles. People were also delaying seeking medical assistance for some acute injuries due to the additional costs associated with accessing care. Oral health has also been identified as a health issue for low-income families due to the high costs of accessing dental care in Australia (Sanders, 2007). Household income and health-related outcomes are strongly correlated, and as pointed by Phelan et al. (Phelan et al., 2010), with a social gradient for health being observed for life expectancy and a range of chronic diseases in Australia.

Efforts by successive Australian governments to address the social determinants of health have drawn criticism for failing to take adequate account of structural barriers preventing people from achieving positive health outcomes. The 2013 parliamentary enquiry into

Australia's response to the World Health Organization's (WHO) Commission on Social Determinants of Health report 'Closing the gap within a generation' (Commonwealth of Australia, 2013) identified a lack of commitment to structural change and action to address the social determinants of health in Australia. The recommendations made in the Report included a new approach and priority to the social determinants of health along with greater investment of policies in health, education, housing, social security and employment aimed at reducing inequality and poverty in Australia (Commonwealth of Australia, 2013). It also recommended local governments produce annual progress reports to parliament outlining the specific steps taken to meet social determinants of health in each of the areas outlined above.

Similarly, the recommendations from the 2014 Senate Report on income inequality cited above, as well as the recommendations from other key Senate inquiries on education (The Review of Funding for Schooling 2011, known as the Gonski Review), housing affordability (Out of reach? The Australian Housing Affordability Challenge, 2015), have all signalled the urgent need for greater government intervention and priority on reducing disadvantages through taxation reform, redistribution of wealth and funding models in education, housing and welfare policy. In relation to income inequality, the 2014 Report recommended the Commonwealth government undertakes an analysis of income inequality in Australia and a review of policies and programmes such as levels of income support payments for people on unemployment benefit and Family Tax Benefit (Parliament of Australia, 2014).

GOVERNMENT RESPONSE TO SOCIO-ECONOMIC INEQUALITY AND HEALTH INEQUITIES IN AUSTRALIA

The response from successive governments in Australia to the growing inequality divide and its negative impacts on education, employment, housing, health and well-being outcomes has been ad hoc and mostly focussed on mitigating its excesses. Some examples include the response from the government to the WHO Commission on Social Determinants of Health report (WHO, 2005), which emphasized their preference for a traditional focus on addressing health concerns using the health system as the primary vehicle for attaining improved health outcomes rather than addressing the social causes of ill health (Community Affairs References Committee, 2013). Another example is the response to the Senate

Report on income inequality which included refutations of the Report findings by members of the government (Parliament of Australia Coalition Senators' Dissenting Report, 2014) and arguments supporting approaches to addressing inequality through economic growth, which the government argued is the most effective way to address inequality (Community Affairs References Committee, 2013). The response reaffirmed the right of the government to continue harsh welfare policies such as a below poverty unemployment benefit and reduction in family tax benefits to restore 'fiscal sustainability'. These policies alongside reductions in company tax rates have been cited as effective responses to increase investment, employment and help improve economic conditions for business, families and individuals (Parliament of Australia, 2016).

The absence of national body responsible for coordinating responses to social determinants at the Commonwealth level has meant that there is no current consensus on an agreed framework or a national body of indicators to measure, monitor and evaluate key action on the social determinants of health across states and territories. The only exception relates to Indigenous communities with the creation in 2008, of a cooperative national effort to address alarmingly high and persistent levels of Indigenous disadvantage through the Council of Australian Governments (Cooper, 2011). There is evidence of some progress in key areas such as enrolments in early childhood education and Year 12 school attainment (Queensland Closing the Gap Snapshot Report Card, 2019). One major problem with these reports, however, is the absence of national and local progress reports identifying specific actions taken to address health inequities in key social determinants of health indicator areas such as housing, employment, education, transportation, social environment and physical environments. Such reporting would make it possible to track and monitor the impact of specific programmes and strategies to improve health outcomes through health and non-health-related programmes.

A review of policies and interventions across all jurisdictions showed that most strategies were predominantly operationalized in health care and relatively few of them addressed health equity outside of access to health care (Fisher et al., 2016). The review concluded that some strategies across Australia included strengthening Primary Health Care and targeted strategies to improve access for equity groups, specially Aboriginal and Torres Strait Islander populations. However, the research concluded: "there is also reason for concern, given that policies frequently represented and addressed health inequities as a problem of poor health among

specific disadvantaged groups and did relatively little to address (or call for cross-sectoral action to address) social gradients in health” [(Fisher *et al.*, 2016), p. 560].

The emphasis on specific health issues and health access for some priority groups, although an important strategy to mitigate health inequities, ignores the non-health factors responsible for the health outcomes of these priority groups, focussing instead on individualized promotion/prevention strategies. The persistent focus health rather than social equity tends to over-medicalize issues, veiling the fundamental problem of social inequality (Lynch, 2017). A telling example is the current interventions to address the high incidence of otitis media (OM) among Aboriginal children in Australia. These high rates, as indicated by research (DeLacy *et al.*, 2020) are linked to poor housing conditions, overcrowded housing, exposure to tobacco smoke, education and overall social and economic disadvantage. As pointed out by DeLacy *et al.* (DeLacy *et al.*, 2020): “Current interventions are primarily focussed on biomedical approaches such as investigating vaccines and antibiotics. Although vaccines and antibiotics are essential to the provision of high-quality clinical care for OM, a broader public health lens is required to address the underlying social factors reported to be driving the gap in OM rates between Aboriginal and non-Aboriginal children” [(2020), p. 495].

DISCUSSION

The emphasis on policies aimed at economic growth and competitiveness through financial deregulation and privatization, while limiting the size of the government and its social policy agenda, despite robust and repeated evidence of their negative effects on income inequality, and the social determinants of health, illustrate a pervasive commitment to neoliberal ideology (Fourcade-Gourinchas and Babb, 2002). Despite the enormous body of evidence from research and government inquiries, as those discussed above, demonstrating the link between government policy and social inequality, neoliberalist principles and agendas have continued to inform government strategies and reforms in education, health, housing, employment and welfare programmes. Under the guise of ‘common sense’ free-market principles are being applied to a large variety of microeconomic problems, and this has helped to spread neoliberal solutions to broad areas of public, business, administration, personal and social life. One of the most profound impacts of this approach relate to the manner in which neoliberalism has shifted the relationship between individuals and the state by constructing

individual responsibility rather than government policies as the decisive factor in determining how individuals’ fare in life. The birth of the responsible individual has been accompanied by moralizing discourses centred on the classification of welfare recipients, the sick, and the disabled as undeserving people whose poor choices have led them to their current predicament (Woolford and Nelund, 2013).

From a social determinants of health perspective, market driven reforms and the redefinition of the individual as the subjects of their own lives—the entrepreneurial self, has had profound impacts on government approaches to health inequalities and health care system reforms. There is an extensive body of literature outlining the impact of neo-liberalism on the public sector in general and health sectors in particular (Horton, 2007; Baum *et al.*, 2016; Sakellariou and Rotarou, 2017). These include a new managerial system skin to those of the private sector, a shift away from community-based health promotion and illness prevention to more sub-acute clinical services, budget reductions, competitive tendering and a focus on short-term measurable throughputs such as increase in hospital use or episodes of care (Baum *et al.*, 2016). Individualization models in health, with its focus on health as an individual issue determined by individuals’ genetic make-up and individual choices have led to policies to address social determinants of health through lifestyle interventions to change behaviour. The underlying belief that individuals are responsible for their health problems has led to incidents such as surgeons at Adelaide’s Queen Elizabeth Hospital in 2007 declining to perform certain elective surgery on patients who are obese or who smoke (Van Der Weyden, 2007).

CONCLUSION: A REBUKE OF INDIVIDUALISM AND THE RHETORIC OF RESPONSIBILITY

The advent of the COVID-19 pandemic and the manner in which societies and individuals respond to it, has provided many opportunities to observe how choices (particularly habitual behaviours), are influenced by cultural values, social attitudes and government policy. Decisions to follow health advice such as maintaining physical distance or wearing masks are shaped as much by environmental, social and political factors as they are by personal safety concerns. Van Der Weyden (Van Der Weyden, 2007) research on individual choice concluded that despite having access to information and resources to advert risk, people often lack the individual resources

necessary to be considered morally responsible for failing to change their behaviour. As pointed by Van Der Weyden (Van Der Weyden, 2007), when it comes to health and individual responsibility for health outcomes, it is philosophically inconsistent and potentially harmful to hold individuals as morally responsible for their health outcomes and health behaviours. The moral value associated with some behaviour fosters stigmatization of particular individuals or groups with consistently low health and social outcomes. Furthermore, it has been increasingly acknowledged that the social and economic conditions in which people live, i.e. their physical, material, cultural and social environments provide the strongest cues for the choices and behaviours that we adopt, often without awareness (Andermann and Clear, 2016). This acknowledgment should shift the focus away from largely ineffective programmes and interventions by well-meant public policy bureaucrats that focus on encouraging individuals to resist these environments and adopt healthier lifestyles. Instead there is an urgent need to focus on interventions that seek to change the environments and socio-economic circumstances in which people find themselves (Kaplan et al., 2015).

One of the most significant consequences of the COVID-19 global pandemic has been the manner in which it has dislocated this rhetoric of personal responsibility and individual choice, enabling instead a less punitive language towards the sick and unemployed. Through various policies including free access to child-care and doubling of the unemployment benefit, the Australian government has, in effect, acknowledged the importance of addressing the social determinants of health in order to protect the nation from the social, economic and health consequences of national and global responses to the health crisis. Increases in the JobSeeker payments have allowed people to pay rent, access three meals a day and buy fresh fruits and vegetables, as reported in a national survey conducted by ACOSS (ACOSS, 2020). From a health perspective, this highlights that the health choices people make are strongly determined by budgetary concerns rather than poor health literacy or poor health habits. Prior to the pandemic, social problems such as homelessness were often regarded as ‘wicked problems’ due to the complexity and interactions between causal factors, conflicting policy objectives and disagreement over the appropriate solution. The advent of COVID-19 saw Federal and State governments working together to provide short-term accommodation to more than 7000 homeless people in Australia (Knight, 2020).

The government has also put a moratorium on rental evictions for 6 months to prevent a short-term spike in

homelessness. This assistance to renters, the homeless and the unemployed has shown that often, these ‘wicked problems’ are portrayed as unsolvable because of the politics and political implications of addressing the root causes of many of these social policy challenges (McConnell, 2018). In time of crisis, protecting political reputation, controlling agendas and carving out particular ideological trajectories may not be as important as the leverage gained from demonstrating an ability to control and manage risks. However, finding long-term solutions to key social determinants of health in Australia will ultimately be the measure by which the success of the government’s response to COVID-19 pandemic will be judged. In the meantime, the brief respite from market driven, neoliberal agendas and narratives in response to the pandemic challenge decades of government dogma on the primacy of the individual and the supremacy of market solutions to complex social, economic and health challenges. It has also exposed the impact of these decades of neglect and omission of the fundamental causes of health inequalities in Australia.

REFERENCES

- ACOSS and UNSW Sydney. (2018) *Poverty in Australia*. https://www.acoss.org.au/wpcontent/uploads/2018/10/ACOSS_Poverty-in-Australia-Report_Web-Final.pdf.
- ACOSS National Survey. (2020) https://www.acoss.org.au/mediareleases/?media_release=survey-shows-increased-job-seeker-payment-allowing-people-to-eat-regularly-cover-rent-and-pay-bills-2.
- AiHW. (2019) *Homelessness and Homelessness Services*. <https://www.aihw.gov.au/reports/australias-welfare/homelessness-and-homelessnessservices>.
- Andermann, A. and Clear, C. (2016) Taking action on the social determinants of health in clinical practice: a framework for health professionals. *Canadian Medical Association Journal*, 188, E474–E483.
- Azétso, J. and Rennie, S. (2010) Principlism, medical individualism, and health promotion in resource-poor countries: can autonomy-based bioethics promote social justice and population health? *Philosophy, Ethics, and Humanities in Medicine*, 5, 1.
- Baum, F., Freeman, T., Sanders, D., Labonté, R., Lawless, A. and Javanparast, S. (2016) Comprehensive primary health care under neo-liberalism in Australia. *Social Science & Medicine*, 168, 43–52.
- Bayer, R. (2007) The continuing tensions between individual rights and public health. *Talking Point on public health versus civil liberties*. *EMBO Reports*, 8, 1099–1103.
- Commonwealth of Australia. (2013) *Coalition Senators’ Dissenting Report*. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Income_Inequality/Report/d02.

- Community Affairs References Committee. (2013) *Australia's Domestic Response to the World Health Organization's (WHO) Commission on Social Determinants of Health Report "Closing the Gap Within a Generation"*. Commonwealth of Australia, Canberra. <http://mc.manuscriptcentral.com/hpi>.
- Cooper, D. (2011) *Closing the Gap in Cultural Understanding: Social Determinants of Health in Indigenous Policy in Australia, Aboriginal Medical Services Alliance NT (AMSANT) Darwin, NT*. Australia.
- DeLacy, J., Dune, T. and Macdonald, J. J. (2020) The social determinants of otitis media in Aboriginal children in Australia: are we addressing the primary causes? A systematic content review. *BMC Public Health*, 20, 492.
- Doherty, A. (2020) *Has the Coronavirus Crisis Killed Neoliberalism? Don't Bet On It, the Guardian*. <https://www.theguardian.com/commentisfree/2020/may/16/state-interventionagenda-dont-assume-neoliberalism-deadhe>.
- Dunford, M. and Qi, B. (2020) Global reset: COVID-19, systemic rivalry and the global order. *Research in Globalization*, 2, 100021.
- Fisher, M., Baum, F., MacDougall, C., Newman, L. and McDermott, D. (2016) To what extent do Australian Health Policy Documents address Social Determinants of Health and Health Equity? *Journal of Social Policy*, 45, 545–564.
- Fourcade-Gourinchas, M. and Babb, S. (2002) The rebirth of the liberal creed: paths to neoliberalism in four countries. *American Journal of Sociology*, 108, 533–579.
- Horton, E. S. (2007) Neoliberalism and the Australian Healthcare System (Factory). In *Proceedings 2007 Conference of the Philosophy of Education Society of Australasia*, 6–9 December. Wellington, New Zealand.
- Institute of Medicine (US) Committee on Assuring the Health of the Public in the 21st Century. (2002) *The Future of the Public's Health in the 21st Century. 2 Understanding Population Health and Its Determinants*. National Academies Press (US), Washington, DC. <https://www.ncbi.nlm.nih.gov/books/NBK221225/>.
- Ives, A. (2020) Neoliberalism and the Concept of Governance: Renewing with an Older Liberal Tradition to Legitimate the Power of Capital. *Mémoire(s), Identité(s), Marginalité(s) Dans le Monde Occidental Contemporain [En Ligne]*, 14|2015, Mis en Ligne le 26 Août 2015, Consulté le 14 Août. <http://journals.openedition.org/mimmoc/2263;10.4000/mimmoc.2263>.
- Kaplan, R., Spittel, M. and David, D. (eds) (2015) *Population Health: Behavioral and Social Science Insights*. AHRQ Publication No. 15-0002. Agency for Healthcare Research and Quality and Office of Behavioral and Social Sciences Research, National Institutes of Health, Rockville, MD, pp. 143–168.
- Knight, B. (2020) Has the coronavirus pandemic proved that homelessness is solvable? *ABC News*. <https://www.abc.net.au/news/2020-06-08/housing-homeless-in-pandemic-has-worked-lets-make-it-permanent/12330442>.
- Lent, J. (2020) Coronavirus Spells the End of the Neoliberal Era. What's Next? Originally published by Patterns of Meaning Blog April 3. <https://www.resilience.org/stories/2020-04-03/coronavirus-spells-the-end-of-the-neoliberal-era-whats-next/>.
- McConnell, A. (2018) Rethinking wicked problems as political problems and policy problems. *Policy & Politics*, 46, 165–180.
- Morawetz, D. (2016) Australian Communities Foundation, Submission to the Senate Standing Committee on The extent of income inequality in Australia. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Income_Inequality/Report.
- Parliament of Australia. (2014) *Bridging Our Growing Divide: Inequality in Australia The Extent of Income Inequality in Australia, Report*. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Income_Inequality/Report.
- Parliament of Australia. (2015a) *Housing Affordability in Australia*. https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BriefingBook45p/HousingAffordability.
- Parliament of Australia. (2015b) *Out of Reach? The Australian Housing Affordability Challenge, Report*. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Economics/Affordable_housing_2013/Report.
- Parliament of Australia. (2016) *Corporate Tax Rate Reduction—Large Businesses Budget Review 2016–17 Index*. https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201617/Corporate.
- Phelan, J. C., Link, B. G. and Tehranifar, P. (2010) Social conditions as fundamental causes of health inequalities: theory, evidence, and policy implications. *Journal of Health and Social Behavior*, 51, S28–S40.
- Sakellariou, D. and Rotarou, E. S. (2017) The effects of neoliberal policies on access to healthcare for people with disabilities. *International Journal for Equity in Health*, 16, 199.
- Sanders, A. E. (2007) *Social Determinants of Oral Health: Conditions Linked to Socioeconomic Inequalities in Oral Health and in the Australian Population*. AIHW Cat. No. POH 7. Australian Institute of Health and Welfare (Population Oral Health Series No. 7), Canberra.
- Schram, A. and Goldman, S. (2018) *Paradigm Shift: New Ideas for a Structural Approach to NCD Prevention*. Comment on “How Neoliberalism Is Shaping the Supply of Unhealthy Commodities and What This Means for NCD Prevention”.
- Solty, E. (2020) *COVID-19 and the Western Working Classes: The COVID-19 Shock Meets an Impending Economic Recession*. RLS Publications. <https://www.rosalux.de/en/publication/id/41800/covid-19-and-the-western-working-classes>.
- Spencer, N. (2003) Social, economic, and political determinants of child health. *Pediatrics*, 112, 704–706.

- Thomas, M. and Buckmaster, L. (2010) Paternalism in social policy—when is it justifiable? Research Paper No. 8, 15 December 2010–11, p. 2.
- Van Der Weyden, M. (2007) Personal responsibility for health. *Medical Journal of Australia*, **187**, 377–377.
- Vince, G. (2020) Why It's So Hard to be Rational About Covid-19. *BBC*. <https://www.bbc.com/future/article/20200505-why-its-so-hard-to-be-rational-about-covid-19>.
- Watson, M. F., Bacigalupe, G., Daneshpour, M., Han, W. J. and Parra-Cardona, R. (2020) COVID-19 interconnectedness: health inequity, the climate crisis, and collective trauma. *Family Process*, **59**, 832–846.
- Whitzman, C. (2020) Silver lining: could COVID-19 lead to a better future? *The Conversation*. https://theconversation.com/silver-lining-could-covid-19-lead-to-a-betterfuture-134204?fbclid=IwAR3nPuX_NAiRrNJ3BCSzZ09_p8nKleygWwjweESQuFhhMEdm6HoKmG5Nlw.
- WHO. (2005) *Commission on Social Determinants of Health, 2005 – 2008*. https://www.who.int/social_determinants/the_commission/en/.
- Wolf, M. S., Serper, M., Opsasnick, L., O'Connor, R. M., Curtis, L., Benavente, J. Y. *et al.* (2020) Awareness, attitudes, and actions related to COVID-19 among adults with chronic conditions at the onset of the U.S. outbreak: a cross-sectional Survey. *Annals of Internal Medicine*, **173**, 100–109.
- Wong, T. (2020) Coronavirus: Why Some Countries Wear Face Masks and Others Don't. *BBC News*, Singapore.
- Woolford, A. and Nelund, A. (2013) The responsibilities of the poor: performing neoliberal citizenship within the bureaucratic field. *Social Service Review*, **87**, 292–318.

