Public Consultation: Australia's First National Health and Climate Strategy

Response by

Australian Podiatry Association (APodA)

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Australian Podiatry Association

The Australian Podiatry Association (APodA) is Australia's national peak body representing podiatrists.

The Association is steeped in a long history of integrity, community care, advocating for the profession and committed to advancing podiatry to improve foot health in the community and to improve national standards.

The positive impact of podiatric care changes the lives of one in five Australians who suffer from foot pain, showcasing its crucial role in maintaining mobility and overall health. Podiatry plays a significant part in addressing climate change and promoting sustainable change for the benefit of all individuals, regardless of age or condition. By working together, we can ensure that proper foot health becomes an essential element in fostering a more sustainable and healthier future for our communities.

Through advocacy, education, and support services, the APodA helps to promote the podiatry profession, advance the quality of podiatric care, and support the professional and personal development of podiatrists in Australia.

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Introduction

The APodA welcomes the opportunity to respond to Australia's first National Health and Climate Strategy.

The APodA congratulates the Department of Health and Aged Care on driving forward in progressing this critical area and its impact on planetary health. We look forward to participating in future consultations towards implementing specific initiatives that will strengthen Australia's approach to creating a resilient and sustainable health system that supports all.

As a member of the Climate and Health Alliance (CAHA), APodA believes that working together in striving towards a standard national approach to sustainability in healthcare is essential in improving; Australia's health system, addressing the current and future impacts of burden of disease and enhancing person-focused care.

The world's biophysical and ecological systems are changing at a rate not seen before as a result of human pressures. These biophysical and ecological systems are vital to human health and existence. Rampant disruptions caused by climate change are shifting the goalposts in tackling health inequalities.

We look forward to participating in future consultations towards supporting initiatives and strategies that seek to reduce our ecological footprint while fostering healthier practices for our patients and the planet.

Podiatry and Protecting Australians

The effects of climate change pose a real risk to the future health and well-being of people worldwide (1). Human-induced climate change, including more frequent and intense extreme events, has caused widespread adverse impacts and related losses and damages to nature and people beyond natural climate variability (2).

In the face of increasingly frequent climate-related emergencies, such as flooding or wildfires, ensuring equitable access to essential healthcare services becomes paramount.

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Podiatry, being a critical component of primary healthcare, is vital, providing ongoing support to the community. Through several services ranging from surgery, prescription of certain medicines, reablement, vascular and neurological assessments and wound care.

With the understanding that there are direct links to climate change impacts on health, either directly via extreme weather events or via the impact on air quality, clean water, or an increase in certain prevalence of communicable diseases, continued access to health services is vital and most often a problem.

The continuance of podiatric health care during times of emergency is vital; these services span not only acute injuries but ongoing care, which can reduce the likelihood of preventable amputations or the development of other serious complications. Putting it into perspective, in 2021, an estimated 1 in 20 Australians were living with diabetes (3). It was recorded that between 2012–13, there were 3,570 lower limb amputations in hospitals for admitted patients diagnosed with diabetes (4).

Climate change has been shown to affect low-income households and disadvantaged communities disproportionately. Low-income earners tend to live in areas more likely to be adversely affected by climate change and have far less ability to move or make other necessary adjustments to their living circumstances (5). Combining this train of thought with the knowledge, preventable amputations are highest among people living in very remote areas, who experienced rates over four times as high as those living in major cities and Inner regional areas, equitable, sustainable and resilient access to health care services and education is essential (4).

Impacts from climate change are not isolated to simply Australian state or territories, as such there is a need for a focus on planetary health and the integration of its emphasis on the interconnectedness of human health with the health of ecosystems and the planet as a whole (6). Planetary health recognises that the well-being of human populations is deeply influenced by the health of the environment in which they live. As such, climate change, as a major driver of planetary health (7), has significant implications for podiatry and ongoing foot care in communities impacted by its effects, particularly during emergencies when mobility and safety are at risk.

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To address this challenge, it is imperative to prioritise and implement digital solutions that enable distant care and develop robust health business continuity plans that support access for seamless communication with patients and their carers (8).

Summary of Overarching Areas of Focus



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Detailed Overarching Areas of Focus

1. Improve access to healthcare for all

When extreme weather events impact communities, the operation of health services is all too often unavoidably affected, which has repercussions on both health and healthcare (9). Additionally, changes in service demand arise as extreme weather directly impacts human health. It is anticipated that heatwaves and floods, in particular, will occur more frequently, albeit with regional variability. Therefore, strategic planning must account for the within-country variations in extreme weather and its potential impacts on the healthcare system(10).

In responding to these challenges, it is imperative to prioritise equitable access to resilient digital health technologies that provide alternative avenues for continued care. This includes improving digital literacy among both healthcare providers and patients to maximise the utilisation of digital services. Moreover, there is a pressing need for the development of infrastructure that better enables individuals separated from critical health services to access timely care during extreme weather events(11).

By fostering adaptation to these climate-induced changes, we can better comprehend their impact on population health and healthcare systems, thus paving the way for more effective and inclusive healthcare planning and delivery(12).

2. Strengthen and establish a resilient Health Workforce

A key priority should be the enhancement of tertiary healthcare course delivery through co-design and peer to peer learning, focusing on empowering and enabling health care workers to improve their knowledge, skill set, and qualifications to handle better the challenges posed by the developing climate crisis. This includes offering comprehensive climate health education and training to healthcare professionals and the wider health system, equipping them to address climate change-related health issues effectively.

Integrating climate change and its impact on health into all health professional training degrees will develop a future workforce empowered to adapt to the evolving needs of our communities during climate-related health risks.

By investing in and strengthening our healthcare workforce's climate health capacity, we can ensure equitable access to essential healthcare services and a sustainable, climate-resilient healthcare system for a healthier future.

3. Address Health threats from Climate Change

Addressing health threats from climate change is of utmost importance to ensure the well-being of our communities and the planet. To effectively combat these challenges, it is crucial to implement a comprehensive approach that involves transparent monitoring, preventing and managing systems.

- Monitoring and the establishment of a national database supports tracking the impact of climate change on public health, allowing for timely interventions and more rigorous future planning.
- Protection involves safeguarding vulnerable populations from the adverse effects of extreme weather events and environmental changes through equitable access to health care and services.
- Effective management of health threats requires a coordinated response from healthcare systems, policymakers, and communities.
- Furthermore, promoting climate-resilient practices, sustainable living, and environmental stewardship is key to building a healthier and more sustainable future for generations to come.

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Focus: High Level Structure of the Strategy

Population Health and Wellbeing

The need for a comprehensive strategy to address the impact of climate change on population health is paramount. The current consultation paper lacks an understanding of the broader definition of health and the necessary strategies to protect and promote population health in a climate-changed world.

The primary focus of the Strategy should be to capture diseases that are worsened by climate change, including non-communicable diseases (e.g., renal, cardiovascular, neurological conditions) and communicable diseases (e.g., vector-borne diseases following extreme weather events).

The main objective of the Strategy should be to reduce the current risks to population health caused by climate change and to maximise the health co-benefits of well-designed climate mitigation and adaptation measures (13). To achieve this, the implementation of a Health in All Policies (HiAP) initiative is essential, along with strategy's main objective should be to reduce the current risks to population health caused by climate change and a broader focus on the wider determinants of health, as outlined in the Healthy, Regenerative and Just document, which received broad endorsement from health and environment stakeholders (14).

The ultimate outcome of the Strategy should be to prevent illness, injury, and death associated with climate change while also minimising the healthcare system's contribution to Australian emissions and ensuring health systems' resilience. To accomplish this, dedicated systems and processes should be in place to evaluate the potential health benefits and harms of policies in other sectors such as energy, resources, transport, agriculture, infrastructure, planning, and the environment.

The Strategy must clearly outline how the Department of Health and Climate Change (DHAC) will lead and contribute to this collaborative effort and how this change will be measured. Addressing the health threats to climate change, the strategy must give consideration to the broader determinants of health: social, cultural, economic and environmental (15). Policies that achieve better health and well-being outcomes while reducing greenhouse gas emissions and creating jobs are win-win options and should be at the heart of the Strategy.

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Conclusion

The APodA acknowledges the significance of Australia's first National Health and Climate Strategy as it offers opportunity to collaborate and to redefine our national approach to addressing climate change and its evolving impact on health.

As a proud member of Climate and Health Alliance (CAHA), quoting the CAHA-led 'Healthy, Regenerative and Just' framework for a national strategy on climate, health and wellbeing(16): "Achieving a better future involves a clear-eyed look at current structural political, social, economic, environmental and public health challenges, identifying and implementing integrated strategies. The approach must be holistic. We must move beyond silos in terms of public dialogue, policy portfolios, investment strategies, political and business priorities, and leadership".

Podiatrists in Australia share a collective responsibility within the community as healthcare practitioners. Beyond providing care and support to those in need, we recognise our unique position to promote healthy behavioural changes that can lead to a positive impact on both foot health and the environment. We are committed to further developing the concept of green podiatry, aiming to reduce our ecological footprint while fostering healthier practices for our patients and the planet (17). Through collaborative efforts and holistic thinking, we can pave the way for sustainable change and a healthier future for all.

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National Climate Health Strategy

Feedback from the Victorian Department of Health officials

Overarching feedback regarding the National Strategy, including the strategy's high-level purpose, objectives and guiding principles.

The National Strategy should draw upon international examples from leading health systems, including England's National Health Service (NHS) and Health Canada's *HealthAdapt* program.

With respect to the overarching purpose of the strategy, the department notes the work of the *Alliance for Transformative Action on Climate and Health (ATACH)* and its work to build the collective power of WHO member states to build climate resilient sustainable health systems. There are fifty-nine countries which have committed at Ministerial level to strengthen the climate resilience and lower the carbon emissions of their health systems. Twenty of these countries have set a target date for their health systems to reach net zero emissions before 2050. Australia is yet to make a commitment under ATACH. Making such a commitment will send a clear message to all stakeholders about the ambitions of the Australian Government in supporting efforts towards building a climate resilient health system.

Strategy objectives

In relation to the strategy's 'mitigation' objective, it is recommended that this includes a focus both on accelerating greenhouse gas emissions reductions associated with the health system and advocating and supporting accelerated emissions reduction efforts more broadly across Australia at the scale and pace required to prevent the worst of the impacts on health that could arise as a result of climate change.

In relation to the 'adaptation' objective, we recommend that this is includes a more prevention focus. For example, 'Strengthen the resilience of the health system and communities to anticipate and minimise (or prevent) health impacts.'

Alternatively, if the intent of the '*health in all policies*' objective is to reflect planned efforts to advocate for/support accelerated action across multiple sectors and systems, we would recommend it is expanded to have a broader focus beyond lessoning '*the impact of climate change on the social and cultural determinants of health and wellbeing'*. For example, it could be amended to '*Maximise the synergies between good climate policy and public health policy by working across policy areas and sectors to support accelerated emissions reduction and adaptation efforts to protect and improve public health and wellbeing*.'

Strategy principles

In relation to the principle 'tackling health inequities' we suggest replacing words like 'vulnerable' with 'disproportionately impacted' to avoid implying that certain groups are inherently vulnerable where systemic factors could be the cause.

In relation to the principle '*population health and prevention*' in addition to the existing statement '*prevention of disease and maintenance of good health…assists both mitigation and adaptation*,' this

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principle could be strengthened to emphasise how actions to tackle climate change can have health co-benefits i.e., active transport, increasing green open spaces, locally grown food.

The 'One Health' principle could be expanded upon to explicitly highlight the importance of conservation, restoration and expansion of our natural infrastructure and environment. These are protective factors for the health of the environment (i.e., clean air, biodiversity, healthy waterways) as well as our social, emotional, and physical health, i.e., urban growth boundaries, land use and management, public spaces, tree cover).

Question 4. what existing First Nations policies, initiatives, expertise, knowledge and practices should the Strategy align with or draw upon to address climate change and protect First Nations country, culture and wellbeing?

The department would like to highlight the following First Nations policies and initiatives:

- **Community policies:** VACCHO On Solid Ground: Strategic Plan 2021-2026
- **Victorian Government policies:** Victorian Aboriginal Health and Wellbeing Partnership Forum priorities/agreement/action plan, Aboriginal Social and Emotional Wellbeing Outcomes Framework, Victorian Cultural Safety Framework, Victorian Government Aboriginal Affairs Report, Closing the Gap Implementation Plan, Victorian state-wide Caring for Country Partnership forum (DEECA), Upcoming Victorian treaty negotiations
- **National Government policies:** National Agreement on Closing the Gap, National Aboriginal and Torres Strait Islander Health Plan 2013-2023
- **International policies:** United Nations Declaration on the Rights of Indigenous Peoples
- **Victorian Government initiatives**: Outcomes-based funding reform (relevant for funding any future Victorian initiatives to align with the national climate and health strategy), Victorian Aboriginal Research Accord (relevant for any future research plans to inform national climate and health strategies/initiatives)
- **Victorian community initiatives or knowledge**: Seed mob (Australia's first Indigenous youth climate network), Lowitja Institute Climate Change and Aboriginal and Torres Strait Islander Health – Climate in health
- **Policies and initiatives from across other jurisdictions**: Arabana Adaptation Strategy (SA), 'Healthy Country, Healthy People' program (NT)

Question 5. What types of governance forums should be utilised to facilitate co-design of the Strategy with First Nations people to ensure First Nations voices, decision-making and leadership are embedded in the Strategy?

The department would like to highlight the following Victorian governance mechanisms:

- Victorian Aboriginal Health and Wellbeing Partnership Forums (and associated Koori caucus)
- VACCHO Members' Forums
- First Peoples' Assembly of Victoria
- Upcoming Victorian treaty negotiations
- National Health Leadership Forum (NHLF)
- Caring for Country Partnership forum (Department of Energy Environment and Climate Action).

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Proposed Objective 1: Measurement of greenhouse gas emissions

Australian research has demonstrated the health sector is responsible for up to **7%** of Australia's carbon footprint (noting that this figure is now likely to be higher, given this research was based on 2014-15 data)[1]. Scope 3 emissions account for 60% of the system's carbon footprint. Given healthcare's significant contribution to Australia's greenhouse gas emissions the National Strategy needs to outline how it will ensure:

- **national consistency** with respect to the measurement, reporting and monitoring of health system emissions
- **a coordinated national approach**, for those sources of emissions which require a national approach (i.e., supply chain emissions).

With respect to the additional sources of data and information are needed to measure and support emissions reductions, the following are suggested as priorities:

- an Australian database of standard CO_2e conversion factors for healthcare utilisation (e.g., ED, clinic attendance, GP appointments), medical equipment and devices and pharmaceuticals.
- a consistent (and more fulsome) approach to data collection at the health service facility level
- improved measurement of healthcare related emissions at the health system level to inform the development of roadmap and coordinated system response.

While the strategy notes that the healthcare sector's contribution to Scope 2 emissions within Australia's National Greenhouse Accounts, are captured within the Commercial Services Divisions of the Australian and New Zealand Standard Industrial Classification (ANZIC) system. The strategy should better articulate, how the healthcare's contribution to the national greenhouse accounts will be articulated going forwards.

Best practice international example

The NHS' net zero strategy provides the best international example of a health system's efforts to measure and reduce its emissions. The NHS has demonstrated that setting evidence-based road maps to guide the coordination and measurement of decarbonisation across the health system is effective. Actions taken by the NHS resulted in a 26 per cent reduction in greenhouse gas emissions by 2020 from a 1990 baseline, and an estimated £90 million in savings between 2009 and 2017.

The National strategy should aim to reflect best practice international examples such as this, acknowledging that it may take time to improve data collection enabled to do so.

- Rather than framing a commitment in terms of Scope 1, 2 and 3 emissions, consideration could be given to an approach akin to that adopted by the NHS. This

[1] Malik, A., Lenzen, M., McAlister, S., & McGain, F. (2018). The carbon footprint of Australian health care. *The Lancet Planetary Health*, *2*(1), e27-e35.

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differentiates between emissions under the NHS' direct control (NHS Carbon Footprint) and emissions that the NHS can influence (NHS Carbon Footprint Plus).

- In addition, adopting the NHS framework where sources of emissions are grouped within high-level categories, '*delivery of care*', '*personal travel*', '*supply chain emissions*' and '*commissioned care*', may assist with engaging with clinicians, as it is more relatable to their day-to-day work.

Consideration could also be given to distinguishing between Scope 3 emissions from within Australia and Scope 3 emission outside of Australia.

Current Victorian government requirements

The Victorian government requires all public sector agencies, including public hospitals and health services to report on environmental data under the *Financial Reporting Direction 24: Reporting of environmental data by government entities* (FRD 24).

From 1 July 2022, an expansion to environmental reporting requirements came into effect. The expansion applies new whole-of-government environmental reporting requirements. All entities defined as either a public body or a department under section 3 of the *Financial Management Act 1994* must meet FRD 24 environmental data reporting requirements. This includes the Department of Health itself, health services, Class A cemetery trusts, and other health portfolio offices and agencies. FRD 24 specifies the environmental performance indicators that entities must measure and report in their annual report of operations (12 months of data), including aspects of energy and resource consumption and environmental performance (emissions).

An environmental data management system (EDMS) has been developed by the department to assist the sector to meet their reporting requirements. The EDMS provides a standardised, web-based platform to manage the public health system's environmental and utility data.

Proposed Objective 2: Mitigation

The National Strategy should prioritise mitigation to effectively address the root causes of climate change. Adaptation strategies are likely to become less effective as global warming increases and the ecosystem reaches its adaptation limits (IPCC, 2023).

Further, the lack of strong and effective actions may exacerbate climate-related anxiety, which for Australians in 2020, exceeded concerns around the global pandemic[2] [3]. There is an opportunity to engage communities, particularly people disproportionately affected by climate change, to co-design mitigation strategies. As critical drivers of mental wellbeing, a participatory approach will strengthen communities' sense of agency and purpose[4], as well as their connection to nature, and reduce climate-related mental distress amongst communities, especially young people, First Nations communities and rural/regional communities.

[2] Climate Council (2023) Survey Results: National study of the impact of climate fuelled disasters on the mental health of Australians

[3] Patrick, R., Garad, R., Snell, T., Enticott, J., & Meadows, G. (2021). Australians report climate change as a bigger concern than COVID-19. *The Journal of Climate Change and Health*, *3*, 100032.

[4] Dudgeon, C Scrine, A Cox and R Walker, 'Facilitating empowerment and self-determination through participatory action research: Findings from the National Empowerment Project', International Journal of Qualitative Methods, 2017,16(1)

The mitigation objective should also include a greater focus on maximising synergies with other public health and health system priorities, including prevention and high value healthcare.

For example, there are untapped opportunities to reduce low value healthcare which has been estimated to represent 30% of all healthcare[5], with little patient benefit and nationally contributes to over 8,000 kilotonnes of carbon dioxide equivalent[6]. Consideration could be given to incorporating the quantification of avoided greenhouse gas emissions associated with avoided low value tests and procedures within the *Choosing wisely Australia* Program.

Other specific areas for action include:

- Publication of NABERS for Public Hospital ratings to increase transparency of public hospital environmental performance across Australia.
- Adopting circular economy principles; waste prevention, for example, expanding the healthcare related products on the Ministers Priority List (for product stewardship), noting that *plastics in healthcare* has recently been added.
- Funding research to evaluate telehealth initiatives, to determine the extent to which telehealth models of care deliver emissions reductions.
- Invest in research across a range of fields to inform and support a transition to a lower carbon health system, this includes health related Life Cycle (LCA) research, sustainable models of care, implementation studies to improve the uptake of evidence-based care.
- Mandating the upcoming Sustainable healthcare module developed by the Australian Commission on Quality and Safety in Healthcare (ACQSHC), after this has been piloted as a voluntary accreditation standard.
- Facilitate and support the installation of public electric vehicle charging stations.
- Investigate the use of telematics to make fleet management more efficient.
- Explore options to incentivise active transport via salary packaging, i.e., allow e-bike and bike purchases to be salary packaged.

For a health sector perspective, we note that a recent Victorian study which interviewed executive environmental steering committee members from a large tertiary hospital in Melbourne, Australia[7]. The study identified sixteen actions which spanned staff education, procurement, pharmaceuticals, waste, transport and advocacy on all-electric capital works upgrades.

Best practice international example

As outlined above, the NHS provides the best international example of a health system's efforts to reduce its emissions. In order to support low carbon models of healthcare, the *Centre for Sustainable Healthcare* [8]developed a framework which is applied across the NHS to assess quality and value of care against its environmental, social and economic costs to determine its 'sustainable value.'

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[7] Davies, J. F., McGain, F., & Francis, J. J. (2023). Consensus on Prioritisation of Actions for Reducing the Environmental Impact of a Large Tertiary Hospital: Application of the Nominal Group Technique. *International Journal of Environmental Research and Public Health, 20(5), 3978m*
[8] Centre for Sustainable Healthcare (2023) available at www.sustainablehealthcare.org.uk

The Centre for Sustainable Healthcare delivers short courses which equip healthcare professionals with the methods and metrics to identify, pilot and establish sustainable models of care. There is a need to for similar training in the Australian context to support clinicians and healthcare organisations to quantify the emissions savings associated with shifting care from resource intensive tertiary hospitals to community settings including hospital in the home, where clinically appropriate.

Additional international examples which have demonstrated opportunities for emissions reductions within health systems, when implemented at scale are provided below.

- converting from single use to reusable sharps containers across 40 NHS sites resulted in a reduction of 3267.4 tonnes CO2 e (−83.9%), eliminated the incineration of 900.8 tonnes of plastic, disposal/recycling of 132.5 tonnes of cardboard and reduced container exchanges by 61.1%[14].
- modelling in England has estimated the Environmental impact of personal protective equipment distributed for use by health and social care services in England in the first six months of the COVID-19 pandemic. Scenario modelling estimated that a range of strategies including domestic manufacture, rationalising glove use, using reusables where possible and optimising waste management could have reduced the carbon footprint by 75% compared with the base scenario, save an estimated 183 Disability Adjusted Life Years, and US $7.4m (GBP £5.4m) due to resource depletion[9].
- A study conducted by US radiologists has estimated the potential savings from choosing clinically appropriate alternative, lower energy imaging alternatives. The authors estimated that if lower energy imaging alternatives (as defined by the American College of Radiology Appropriateness Criteria) were selected in 1-10 per cent of patient cases, this would lead to an annual US healthcare improvement of 24-240 million kWh per year, saving between $2.5 million – $25 million US dollars per year[10].

Proposed Objective 3: Adaptation

Question 18. What health impacts, risks and vulnerabilities should be prioritised for adaptation action through the Strategy? What process or methodology should be adopted to prioritise impacts, risks and vulnerabilities for adaptation action?

The strategy should seek to drive and invest in adaptation action to address the wide-reaching risks and impacts to health and wellbeing associated with climate change, including direct and indirect impacts, and impacts on the social determinants of health. While it is recognised that many of the levers to address risks and impacts to the social determinants of health sit outside the health system, there are significant opportunities for the Commonwealth to play a leadership role in advocating for and influencing stronger action across portfolios and sectors to protect and improve the health and wellbeing of Australian communities.

Health risks and impacts which may require a more significant or dedicated focus in terms of adaptation action could be determined through a national climate and health vulnerability and

[9] Rizan, C., Reed, M., & Bhutta, M. F. (2021). Environmental impact of personal protective equipment distributed for use by health and social care services in England in the first six months of the COVID-19 pandemic. *Journal of the Royal Society of Medicine*, *114*(5), 250-263

[10] Alshqaqeeq, F., McGuire, C., Overcash, M., Ali, K., & Twomey, J. (2020). Choosing radiology imaging modalities to meet patient needs with lower environmental impact. *Resources, Conservation and Recycling*, *155*, 104657.

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adaptation assessment. This could be informed by methodologies aligned with international frameworks and guidelines for such assessments, which typically include:

- a vulnerability assessment focussed on the current burden of climate sensitive health outcomes and vulnerabilities to climate change
- a capacity assessment focussed on assessing the capacity of health and health-relevant systems
- a future risk assessment, focussed on projecting the health risks of climate change. This could be informed by Australian climate projection data, and where it is available at a finer spatial resolution (such as is the case in Victoria), state and territory climate projection data
- an adaptation assessment focussed on identifying and prioritising action to address current and projected health risks.

It is also recommended that adaption actions be informed by an assessment of strengths and opportunities within communities across various disaster recovery capitals (i.e., human, social, cultural, built, financial and political capital)[11].

Question 19. Should the Australian government develop a National Health Vulnerability and Adaptation Assessment and National Health Adaptation Plan? If yes:

- **What are the key considerations in developing a methodology?**
- **How should their development draw on work already undertaken, for example at the state and territory level, or internationally?**

What are the key areas where a national approach will support local/jurisdictional vulnerability assessment and adaptation planning?

It would be beneficial for the Australian government to develop a national health vulnerability and adaptation assessment and a national adaptation plan.

In terms of a national health vulnerability and adaptation assessment, the methodology could draw on international best practice guidelines and frameworks (adapted for the Australian context where required). For example, the World Health Organization *Climate change and health vulnerability and adaptation assessment* guidance (2021).

Additionally, a national climate change and health vulnerability and adaptation assessment should consider how climates and therefore climate projections both between states and territories, and *within* states and territories can vary. For example, we have seen from past climate-driven events in Victoria that barriers to effectively adapting to the impacts of climate change differ across metropolitan, regional, and rural areas. Therefore, a national vulnerability and adaptation assessment that is founded on comprehensive local-level climate data will be more effective in identifying areas of vulnerability and requirements to improve adaptive capacity than a high-level assessment of the country. For example, the Victorian government has invested in a comprehensive set of 5 km datasets for use in impact/risk assessment.

Similar to international best practice, national health and vulnerability and adaptation assessments should also be repeated at set intervals to ensure their currency, as population vulnerabilities and impacts change and as adaptation efforts progress (along with the state of knowledge and evidence). A recent report which could be looked at as a leading example is *Health of Canadians in a Changing Climate* (2022).

[11] P Quinn, L Gibbs, D Blake, E Campbell, D Johnston and G Ireton, Guide to Post-Disaster Recovery Capitals (ReCap), Bushfire and Natural Hazards Cooperative Research Centre, 2021. recoverycapitals.org.au

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A national climate change and health vulnerability and adaptation assessment would acknowledge the communities most affected by climate change beyond geographical region, and the unique needs within those communities to cope and adapt (i.e., young people, First Nations people, disability communities).

Question 20. Would there be value in the Australian government promoting a nationally consistent approach to vulnerability assessment and adaptation planning for the health system specifically, for instance by issuing guidance and associated implementation support tools for states, territories and local health systems? If yes, what topics should be covered to promote a nationally consistent approach? What examples of existing guidance (either from states/territories or internationally) should be drawn from?

There would be value in the Australian government promoting a nationally consistent approach to vulnerability assessment and adaptation planning for the health system. Guidance and tools could be informed by international examples, such as:

- *Climate change and health vulnerability and adaptation assessments: A knowledge to action resource guide* (Health Canada, 2021)
- *Climate change and health vulnerability and adaptation assessment: Workbook for the Canadian health sector* (Health Canada, 2022)
- *Climate change and health vulnerability and adaptation assessment guidance (World Health Organisation, 2021*

Q.21 What immediate high-priority health system adaptation actions are required in the next 12 to 24 months?

Establishment of a dedicated climate and health fund to support health systems to prepare for and respond to the impacts of climate change on health. Health Canada's HealthAdapt program and the US Centre for Disease Control and Prevention's Climate-Ready States & Cities Initiative could provide useful models. A national climate and health fund (or funds) could also seek to support local councils and other key organisations to support community adaptation at a local level, with a particular focus on communities that bear a disproportionate burden of the health impacts of climate change.

Dedicated and ongoing national investment in climate change and health research. This could inform national, state and local vulnerability and adaptation assessments and support accelerated actions to tackle climate change and its impacts on health. In part, national research investment could support:

- modelling of the future impacts of climate change on health under various greenhouse gas emissions, interventions, and adaptation scenarios. Data-driven decision making on climate action is crucial in ensuring the correct priorities and targets are chosen for preventing and reducing current and future health impacts from climate change.
- Evidence of the future economic burden to not only the health system but across other portfolios can further assist key decision makers across government, the private sector and non-government organisations build a strong case for investment towards accelerating emissions reduction and adaptation efforts.

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    - quantifying the health, economic and broader benefits of a range of adaptation and emission reduction actions to further accelerate action at national, state and local levels.
- Establishing and utilising existing sector governance mechanisms to provide leadership and direction across the health sector on climate change. Establishing shared system-wide vision and direction
    - Developing a roadmap for the sector to reach net zero emissions and establishing a baseline carbon footprint of the system (including scope 3 emissions).
    - Providing visibility (e.g., dashboard) to the health system and stakeholders to demonstrate progress.
- Bringing together existing data to better inform climate adaptation work and uplift ability to quantify emissions reduction benefits of existing and new initiatives across sector.
- Continuing to explore opportunities to collaborate with intergovernmental stakeholders on the intersection of health, climate, and sustainability of services.

Proposed Objective 4: Health in All Policies

A Health in All Policies approach should seek to address both upstream determinants of exposure and vulnerability to climate change (including addressing existing inequalities, noting that climate change will affect those most sensitive to impacts first and worst) as well as on the key social determinants of health, with a particular focus on areas where actions are expected to deliver significant health co-benefits. For example:

- Development and implementation of a holistic food policy for Australia could seek to deliver a local carbon food system, and provide equitable access to safe, healthy, affordable and culturally appropriate food to Australia's diverse communities.
- Improved planning standards, including to support the safe uptake of active modes of transport, recent analysis undertaken by the Victorian Injury Surveillance Unit quantified the scale and growth of serious injuries sustained by on-road cyclists in Victoria, and made recommendations to improve safety for people who ride bicycles [12].
- Housing policy is a key area is which a 'Health in All Policies' approach should be adopted. The links between housing and health are well-established, recent Australian research has found exposure to home damage from climate-related disasters has negative effects on health and wellbeing for up to 1-2 year following disaster, the authors point to multiple areas for policy intervention[13], including improved building standards.
- Influencing commercial actors and activities, such as through climate related financial disclosure, to ensure large businesses and financial institutions provide Australians and investors with greater transparency and accountability on climate-related plans, financial risks, and opportunities. Similarly, there is a growing call for governments to address the harmful actions of commercial actors that negatively impact on health, including planetary health (see commercial determinants of health).
- Increasing local availability and access to green and blue spaces will simultaneously strengthen biodiversity and connection with nature in communities. Engaging in nature can reduce negative

[12] Victorian Injury Surveillance Unit (VISU), 2020. Hazard Edition No.87: Adult On-Road Cyclist Injuries in Victoria, 2008/09 to 2017/18, Monash University Accident Research Centre (MUARC) available at:www.monash.edu/muarc/visu

[13] Li A, Toll M, Bentley R. Health and housing consequences of climate-related disasters: a matched case-control study using population-based longitudinal data in Australia. The Lancet Planetary Health. 2023 Jun 1;7(6):e490-500.

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emotions including sadness, anxiety and anger, while strengthening physical health[14] [15]. Further, research suggests the mental health and workplace productivity benefits of visiting national parks and protected areas is approximately $12.3 billion annually [16].

- There is an opportunity to strengthen connection to nature and increase green infrastructure through social prescribing, which will involve collaboration across sectors to connect communities with non-clinical, community-based activities.

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[14] DE Bowler, L Buyung-Ali, TM Knight and AS Pullin, 'Urban greening to cool towns and cities: A systematic review of the empirical evidence', *Landscape and urban planning,* 2010, 97(3):147-155

[15] PY Nguyen, T Astell-Burt, H Rahimi-Ardabili and X Feng, 'Effect of nature prescriptions on cardiometabolic and mental health, and physical activity: a systematic review', *The Lancet Planetary Health,* 2023, 7(4)

[16] C Lund, C Brooke-Sumner, F Baingana, EC Baron, E Breuer, P Chandra, J Haushofer, H Herrman, M Jordans, C Kieling, ME Medina-Mora, E Morgan, O Omigbodun, W Tol, V Patel and S Saxena, 'Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews', *Lancet Psychiatry,* 2018, 5(4):357-369



DANA Disability Advocacy Network Australia

National Health and Climate Strategy

Submission

Disability Advocacy Network Australia
July 2023

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About DANA

DANA is the national representative body for a network of independent disability advocacy organisations throughout Australia.

Our Vision

DANA's vision is of a nation that includes and values people with disabilities and respects human rights for all.

Our Purpose

DANA's purpose is to **strengthen, support and provide a collective voice for independent disability advocacy organisations across Australia** that advocates for and with people with disability.

We achieve this by

- promoting the role and value of independent disability advocacy
- providing a collective voice for our members
- providing communication and information sharing between disability advocacy organisations
- providing support and development for members, staff and volunteers of disability advocacy organisations
- building the evidence base to demonstrate the value of disability advocacy
- promoting the human rights, needs, value and diversity of people with disabilities

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July 2023

To the Department of Health and Ageing

Thank you for the opportunity to submit a submission to the National Health and Climate Strategy Consultation Paper.

DANA and our members are on the frontline of dealing with the impacts of climate change for people with disability, their families and supporters. In addition, our members, independent disability advocacy organisations, play a vital role in connecting people with disability with government services and systems, particularly in a crisis or disaster.

People with disability are disproportionately impacted by climate change and have a wide range of significant gaps in health-related indicators, with some people with disability dying decades younger than other Australians. People with disability are also significantly impacted by climate related issues, such as excessive heat, mental health and respiratory illnesses.

DANA is calling for people with disability to be a priority cohort for the implementation of the National Health and Climate Strategy, with independent advocacy organisations resourced to undertake preventative and proactive work in communities.

I have also included our discussion paper about Fires, Floods and COVID for the NDIS Review for your attention.

I would be pleased to speak with you further about these matters at your earliest convenience.

Kind regards



Jeff Smith

CEO, DANA

jeff.smith@dana.org.au

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Introduction

People with disability face increased risks to their health and wellbeing from the impacts of climate change. It is crucial that this increased exposure is managed and resourced properly with adequate services and supports, including for independent disability advocacy,

The National Health and Climate Strategy rightly names people with disability and pre-existing health conditions as more at risk from the impacts of climate change. However, the labelling of people with disability as vulnerable fails to acknowledge the causes of that vulnerability – namely, the barriers to accessible, equitable and timely services and supports to manage the increased climate risk.

In addition, people with disability have significant expertise and knowledge about climate change impacts and mitigation and are already working in their communities to innovatively respond to disasters, implement preventative measures and set up systems for the future. The leadership of people with disability will be vital in ensuring a successful implementation of this Strategy.

The principles outlined need to include the leadership and expertise of the communities most impacted by climate change and recognise the capacity and resources of those communities to lead responses.

For First Nations people with disability, climate change and health work needs to align with associated work being implemented by First Peoples Disability Network through the Closing the Gap Sector Strengthening process. FPDN must be included and leading in developing responses to climate and health.

Feedback to questions

Q1. The objectives of the Strategy need to include the impact of climate change, not just measuring greenhouse gas emissions, such as increased temperatures, increased continuous days of increased temperature, and health impacts from these impacts, such as increased hospitalisations and GP visits.

In addition, measurement needs to consider and benchmark existing health inequalities for many people with disability, including intersectional factors.

Q2. The principles should include acknowledgement of the strengths, knowledge and expertise of affected communities, and their leadership in developing and implementing solutions.

Q5. FPDN must be included and lead co-design for First Nations people with disability.

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Proposed Objective 1: Measuring health system greenhouse gas emissions

It is not clear from the Strategy if the disability support system, including disability advocacy organisations are to be included in any proposed greenhouse gas emissions monitoring or reporting efforts.

Some disability services are large organisations, equivalent in size to aged care facilities and health services. In addition, disability advocacy organisations, while much smaller in size, will need significant resources to manage any new reporting or monitoring programs.

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Proposed Objective 2: Mitigation

People with disability can play a key role in reducing emissions. It is also imperative that governments at all levels lead on emissions reductions, as opposed to putting the onus on people to make changes at an individual level. The focus areas to reduce emission include many that people with disability both use and operate; however, it is unclear whether the needs of people with disability have been considered.

Services and supports that people with disability use, including mainstream and disability-specific, emit greenhouse gas emissions. It is unclear what incentives will be provided to disability facilities to improve emissions and transition to renewable energy.

People with disability face barriers in accessing much of the current built environment, including housing, public facilities and transport. Health care services also are often inaccessible. This must be addressed as part of any changes to building design and construction done to mitigate against climate impacts.

If accessibility barriers are not reduced, people with disability and older people face a future stranded and isolated away from public infrastructure, making climate mitigation even harder to achieve.

Many homes that people with disability live in, including legacy group homes, boarding houses, hostels and even new Specialist Disability Accommodation, do not have any measures in place to mitigate against climate change impacts. It is vital that these homes are resourced to include climate measures.

People with disability use infrastructure in different ways to non-disabled people and need different solutions to ensure that we can get around in a low emissions environment.

Travel and transport

Active transport to healthcare, as outlined in the Strategy, excludes many people with disability and older people, who rely on private vehicles as public transport remains significantly inaccessible.

Urgent action on meeting accessible transport standards is needed as part of any active transport strategy, that includes provision for some people with disability and older people to continue to use vehicles.

Existing public transport and public space isn't accessible, affordable or available for many disabled and older people. A less emissions intensive transport system also needs to be a more accessible and affordable one.

In addition, the Disability Resource Centre surveyed people with disability[1] about the barriers they found when using public transport. They included:

- Lack of accessible, timely information, particularly about accessible services, and service changes
- Poor public attitudes, including harassment and abuse

[1] https://drc.org.au/wp-content/uploads/2018/11/drc0001-transport-report-online.pdf

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- Limited availability, accessibility and cost of ride share and commercial passenger vehicles
- Inaccessibility of infrastructure.

Many people with disability talked about how important access to transport is for seeing friends and family and accessing the community.

The ABC surveyed[2] train stations around Australia and found nearly half were inaccessible. Trains themselves are often inaccessible, including because of the behaviour of non-disabled transport users. People with disability with diverse access needs find public transport currently incredible hard to use.[3]

Many people with disability and older people use a range of innovative transport solutions that already address barriers, such as community transport, on-demand transport or ride-share vehicles. These need to be incorporated into any sustainability vision, and their design led by those who use them.

Melissa Parker writes for Greenpeace UK[4] that:

> "Disabled public transport users report inaccessible services, poor customer service, including abuse and comments about the inconvenience of making accommodations, negative attitudes from drivers, and a lack of up-to-date information. The situation has worsened recently, as people with hidden disabilities are condemned for being unable to wear a mask. Such incidents have become normalised within our society and internalised by disabled people."

There are also existing accessibility standards[5] that have been developed by and with people with disability, with specific measures for particular transport users.

People with disability and older people use public space and public transport differently to non-disabled people and often need different infrastructure to be prioritised. Footpaths that are well-maintained and include curb cuts are essential for anyone using a mobility device such as a scooter or wheelchair. Regular and accessible seating is important to include in any vision for a more walkable place, as well as thinking about different paces and ways of walking and moving. There needs to be room for slow walkers, people who roll or limp or lurch, and people who need regular and frequent rest.

Supply chains

Procurement by governments is a powerful tool to incentivise and reward social and environmental outcomes. However, many current procurement settings include incentives to use suppliers who pay people with disability sub-minimum wages as low as $2.70 per hour.

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[2] https://www.abc.net.au/news/2023-01-16/australia-misses-20-year-public-transport-accessibility-target/101858532
[3] https://cid.org.au/resource/position-statement-on-transport/
[4] https://www.greenpeace.org.uk/news/transport-disabled-people-passengers-rights/
[5] https://www.industry.gov.au/building-and-construction/premises-standards; https://www.infrastructure.gov.au/infrastructure-transport-vehicles/transport-accessibility

DANA joins with Inclusion Australia[6] and people with disability and their families calling for an end to sub-minimum wages for people with disability.

Action to reduce plastic waste can have a negative impact on people with disability who may rely on a range of products for essential functions and hygiene. People with disability have reported negative impacts[7] from regulatory changes[8] to remove easy access to single use plastics, and significant care needs to be taken to ensure that these impacts are reduced.

Medicines and gases

Many people with disability rely on a wide range of medicine, including those that are delivered by inhalation. Any changes to systems and availability must be co-designed with people with disability. There must not be a negative impact on people with disability, including people with chronic conditions.

Waste

See the discussion on supply chains.

Prevention and optimising models of care

Many people with disability experience significant barriers to accessing healthcare, including preventative healthcare and screening. People with an intellectual disability[9], First Nations people with disability and other marginalised people with disability[10] face even higher barriers.

Any changes to healthcare and screening delivery needs to address these existing service gaps and accessibility for people with disability, and also ensure that people with disability are not further disadvantaged by them.

Feedback to questions

Q8. Disability specific services and supports need to be included as eligible for emissions reductions incentives, but also resources to implement this.

Accessibility, transport standards, and resources to improve access must be included in any transition to using more active transport to access healthcare.

Q9. Homes for people with disability need to be included for mitigation efforts, and accessibility improvements incorporated in all mainstream services in any transitional building program.

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[6] https://www.inclusionaustralia.org.au/submission/equal-pay-equal-rights/
[7] https://theconversation.com/banning-straws-might-be-good-for-the-planet-but-bad-for-people-with-disability-or-swallowing-problems-what-is-eco-ableism-199183
[8] https://www.abc.net.au/news/2022-08-07/plastic-straw-ban-prepared-meals-shame-people-disability-recycle/101303934
[9] https://www.health.gov.au/our-work/national-roadmap-for-improving-the-health-of-people-with-intellectual-disability
[10] https://www.tandfonline.com/doi/abs/10.1080/09687599.2020.1815523?journalCode=cdso20

Q10. Action to address accessible transport barriers must be included in any climate related transport investment and funding. Active transport programs and policies need to be co-designed with people with disability.

Q11. Consider the needs of people with disability when making changes to supply chains, including action against sub-minimum wages.

Q12. Consult and co-design any changes with people with disability.

Q13. Consult and co-design any changes with people with disability.

Q14. Address existing service gaps for people with disability as part of improving prevention and optimisation of care services.

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Proposed Objective 3: Adaptation

People with disability are often one of the most impacted communities due to climate-related disasters. Recently, DANA has commissioned and published a paper for the NDIS Review, called Fires, Floods and COVID-19,[11] which is attached to this submission. In this paper, we say:

> "The disability community has been one of the groups most impacted by these disasters, particularly from poor disaster planning, response and reconstruction. Not only are people with disability at greater risk of death and injury during a disaster, but the Disability Royal Commission (DRC) also found that during COVID-19, people with disability were at greater risk of violence, abuse, neglect and exploitation.[12]
>
> In times of disaster, disability advocacy organisations provide crucial support to people with disabilities, helping them regain access to vital services, navigate crisis-ridden systems, and develop accessible communication materials. However, this assistance significantly increases the organisations' workloads and poses financial and long-term sustainability challenges due to inadequate funding.
>
> However, it is possible to address the current failures and put in place solutions that uphold the human rights of people with disability and focus on centring the voices of people with disability and their experiences during disaster events. Governments at all levels must include people with disabilities in their disaster planning, response, and reconstruction processes. Most importantly, it is essential to increase access to Person-Centred Emergency Planning, which can prevent many issues from arising during a disaster event."

We have recommended to the NDIS Review the following:

- Establish a Disability Disaster Management Centre
- Invest in Person-Centred Emergency Planning
- Flexible use of NDIS funds during disasters
- NDIA to develop a Workforce Disaster Surge Plan
- Specific disaster funding stream for advocacy organisations
- Strengthening safeguards

Further recommendations will be developed through workshops and surveys and delivered to the NDIS Review in August 2023.

DANA agrees that specific consideration should be given to emergency responses for people with disability, including through Australia's Disability Strategy Emergency Management Targeted Action Plan[13].

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[11] https://www.dana.org.au/wp-content/uploads/2023/07/DANA-Discussion-Paper-NDIS-Review-Fire-Floods-COVID-2023.pdf

[12] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, (2020), Commissioners' Report on Public hearing 5: Experiences of people with disability during the ongoing COVID-19 Pandemic, https://disability.royalcommission.gov.au/system/files/2020-11/Report

[13] https://www.disabilitygateway.gov.au/sites/default/files/documents/2021-12/1991-tap-emergency-management.pdf

Aotearoa New Zealand has developed a Health Strategy for Disabled People,[14] bringing together all aspects of health for all communities of people with disability. This would be a significant achievement in an Australian context to deliver the same kind of strategic focus to the health of people with disability, including during climate events.

People with disability also experience specific negative health outcomes from climate related events, such as excessive heat. Specific measures to improve access to cooling are vital for people with disability.

In addition, the experiences of many people with disability identified significant gaps in the existing capacity of the government health responses. The Disability Royal Commission recommended after Public Hearing 5[15] that:

The Australian Government Department of Health should ensure that an appropriately resourced unit or team has specific responsibility for developing plans and programs to protect the health and wellbeing of people with disability, including during emergencies such as the COVID-19 pandemic. This unit should be responsible for coordinating health and disability responses to emergencies such as the COVID-19 pandemic. The unit should operate in addition to the Advisory Committee on Health Emergency Response to Coronavirus (COVID-19) for People with Disability and should work closely with that Committee.

It is unclear if this recommendation has been actioned but would be an appropriate recommendation to include in the development of this Strategy.

Feedback to questions

Q18. The health impacts of climate change and related events need to be included in the appropriate Targeted Action Plans under Australia's Disability Strategy, with specific actions co-designed with people with disability. In addition, consideration should be given to developing a specific health strategy for people with disability overall, and to develop a specific Climate Change Targeted Action Plan.

Independent disability advocacy organisations need additional resources to manage climate related events, including doing preventative and proactive work with people with disability in their communities before, during and after a disaster.

Any development of a National Health and Vulnerability and Adaptation Assessment and a National Health Adaption Plan must be co-designed with people with disability, families, supporters and our organisations.

Q19. The findings of the two COVID public hearings[16] from the Disability Royal Commission need to inform any nationally consistent approach to vulnerability assessment and adaption

[14] https://www.health.govt.nz/new-zealand-health-system/pae-ora-healthy-futures-all-new-zealanders/pae-ora-strategies/health-disabled-people-strategy
[15] https://disability.royalcommission.gov.au/system/files/2020-11/Report%20-%20Public%20hearing%205%20-%20Experiences%20of%20people%20with%20disability%20during%20the%20ongoing%20COVID-19%20pandemic.pdf
[16] https://disability.royalcommission.gov.au/public-hearings/public-hearing-12

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planning and be co-designed with people with disability and in harmony with the work of the National Disability Data Asset. People with disability were left out of much of the early responses to COVID because our needs were not routinely collected or measured in the health system. This needs urgent action as part of any work to monitor vulnerability, that must be done with people with disability. The Plan would be welcome, if developed carefully and with communities affected, and taking into account the recommendations from the Disability Royal Commission about COVID-19.

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https://disability.royalcommission.gov.au/public-hearings/public-hearing-5

Proposed Objective 4: Health in All Policies

A Health in All Policies needs to include and recognise the significant barriers people with disability face to accessing healthcare in the current system.

In addition, the social determinants of health for people with disability research reveals very substantial impacts of access gaps in a wide range of public services. Academics found "the environments people live, work and interact in like their housing, employment and education, have been shown to be more important for good health than having access to health services, yet these areas are often neglected in policy for people with disability."[17]

The Australian Institute of Health and Welfare[18] also found that:

'Some people with disability experience difficulties in accessing health services, such as unacceptable or lengthy waiting times, cost, inaccessibility of buildings and discrimination by health professionals. They may also experience issues caused by lack of communication between different health professionals treating them.'

A Health in All Policies approach could begin to address some of these barriers and gaps. It may also be worth considering the developing of a specific health strategy for people with disability, including linking with Australia's Disability Strategy.

The Disability Royal Commission found that people with disability were not considered in the Federal Government's response to COVID-19, identifying a significant gap in the existing Health Department. The Commission also made a number of recommendations to address this gap that should be addressed as part of this Strategy.

Feedback to questions

Q22. A Health in All Policies approach needs to align with Australia's Disability Strategy, and include the needs of people with disability with an intersectional lens.

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[17] Celia Green, Helen Dickinson, Gemma Carey & Andrew Joyce (2022) Barriers to policy action on social determinants of health for people with disability in Australia, Disability & Society, 37:2, 206-230, DOI: 10.1080/09687599.2020.1815523

[18] https://www.aihw.gov.au/reports/disability/access-health-services-disability/contents/content

Enablers

People with disability, families, supporters and organisations, including disability advocacy organisations, are already leading programs and work in community about climate change. They are also leading disaster responses, using the specific problem solving and innovative skills that people with disability excel in.

So an enabler of climate change action in the health system is the leadership of people with disability, in all aspects of the Strategy.

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Australian Government
Department of Health and Aged Care

NATIONAL HEALTH AND CLIMATE STRATEGY

Detailed submission form

This form allows you to provide responses to the full set of questions in the Consultation Paper available here.

Alternatively, you may wish to complete the briefer online survey available here.

Please submit this form in Word format to Health.Climate.Consultation@health.gov.au.

Respondent details

What is your name?
ANZCA Environmental Sustainability Network
What is your email address?
enviro-sustainability@anzca.edu.au
What is your organisation?
Australian and New Zealand College of Anaesthetists
Have you read and agreed to the Privacy Statement? (NB we will not be able to use your submission unless you tick this box)
☑ I have read and agreed to the Privacy Statement
Do you identify as Aboriginal and/or Torres Strait Islander? (Yes/No/Prefer not to say)
☐ Yes ☑ No ☐ Prefer not to say
Please select which applies to you: ☐ Individual citizen ☐ Health Service Provider ☐ Industry and Life Sciences Organisation or Representative ☐ Academic or Researcher ☐ Primary and/or Allied Health Peak or Advocacy Organisation or Representative ☐ Aged Care Service Provider ☐ First Nations Health Service Provider ☐ First Nations Community Group ☐ First Nations Peak or Advocacy ☑ Medical College or Peak professional body

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Questions for feedback from the Consultation Paper

Introduction

1. How could these objectives be improved to better support the vision of the Strategy?
Measurement – ANZCA supports government assistance in establishing uniform measurement methods and reporting. In particular, measurement should be broken down into individual health services, institutions and specific to medical specialties to enable clinicians to better direct reduction strategies. Measurement and reporting should be built into existing governance mechanisms at a health service level and, as such, become mandatory. Mitigation – strategies will be more easily identified and prioritised if measuring/reporting systems are properly established and user-friendly at a local level. In particular, individual medical specialties/units can then implement action relevant to their own contribution e.g. reduction of desflurane usage in anaesthesia. Some strategies require a system-wide approach e.g. renewable energy and such issues must be tackled separately but concurrently. Adaptation – consultation with clinical staff will help to identify vulnerable communities and specific medical conditions that are most likely to be affected by climate change. Health in All Policies – addressing and incorporating planetary health needs to become business as usual throughout every area of the healthcare system. Mandating reporting and governance, and funding staff to work on environmental sustainability policies will strengthen the response in healthcare itself. Suggested additional objective: Education - campaigns and learning materials should be developed and distributed to all staff working within healthcare. The value of hospitals as anchor institutes and healthcare staff at all levels should both be recognised as significant and vital resources and utilised accordingly to educate and inform the wider population.
2. How could these principles be improved to better inform the objectives of the Strategy?
5. Evidence-informed policymaking - this principle should take account of the urgent need for decisive action in the face of a climate crisis that is already happening. Consultation with clinical staff should occur to best inform decisions on new sustainable models of care and reduction of low-value healthcare. 6. Partnership-based working - this principle should specifically mention healthcare industries as partners that government agencies must work with. Government should require net-zero plans and sustainability credentials from all industry partners.
3. Which of the various types of greenhouse gas emissions discussed above should be in scope of the Strategy's emission reduction efforts?
The strategy should account for all types of greenhouse gas emissions. There should be recognition of scope 3 emissions as a significant contributor in emission reduction plans. Government should partner with industries to reduce emissions and require robust

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sustainability credentials alongside net-zero plans from each company. Whole-of-government influence and policy avenues should be recognised and utilised in achieving this.
4. What existing First Nations policies, initiatives, expertise, knowledge and practices should the Strategy align with or draw upon to address climate change and protect First Nations country, culture and wellbeing?
ANZCA recognises that Aboriginal and Torres Strait Islander Peoples' voices need to be heard and our actions guided by them. We do not seek to represent the views of First Nations People and encourage meaningful engagement with their communities in identifying existing First Nations policies, initiatives, knowledge, expertise and practices with which to align the Strategy.
5. What types of governance forums should be utilised to facilitate co-design of the Strategy with First Nations people to ensure First Nations voices, decision-making and leadership are embedded in the Strategy?
ANZCA recognises that Aboriginal and Torres Strait Islander Peoples' voices need to be heard and our actions guided by them. As such, we do not seek to represent the views of First Nations People and encourage meaningful engagement with their communities in co-design of this Strategy and governance structures.

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Proposed Objective 1: Measurement

6. Beyond the schemes already noted above, is your organisation involved in any existing or planned initiatives to measure and report on health system emissions and/or energy use in Australia?
While these likely fall under the umbrella of the initiatives described above, the ANZCA Environmental Sustainability Network is actively involved in supporting the development of initiatives to - measure use and leakage of nitrous oxide around Australia (not currently a widely reported metric) - measure use of anaesthetic vapours and CO_2e associated with these - measure the lifecycle impact of medical devices, medications, investigations and consumables used commonly in Australia ANZCA has developed an Environmental Sustainability Audit tool to support clinicians and services to consider ways of reducing emissions https://www.anzca.edu.au/resources/environmental-sustainability/eswg-audit-tool-(1).aspx
7. What additional data and information is required to support targeted emissions reduction efforts within health and aged care?
Expanded utilisation of existing methodologies such as EEIO studies and life cycle assessments (LCA) where appropriate to improve the validity and accuracy of data required to target emissions reduction measures through appropriate funding, resourcing and prioritising. Transparent access to current purchasing data for carbon intensive goods and medicines, such as nitrous oxide and desflurane to enable benchmarking. Medical equipment and pharmaceutical composition data to enable independent LCAs to be undertaken and / or verified - this data is presently very difficult to obtain.

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Proposed Objective 2: Mitigation

8. What do you think of these proposed focus areas for emissions reduction? Should anything else be included?
ANZCA supports the proposed focus areas. We suggest the additional focus area - food and beverages. The environmental impact of food and beverages, from the healthcare sector is significant, with emissions stemming from production, transport, packaging storage and waste. Systems should be developed to minimise waste. Food waste emissions should be minimised through appropriate composting or energy production facilities over landfill and safely redistributing uneaten food items to those in need. High-quality plant-based nutrition should be recognised as both a method of reducing emissions and encouraging recovery from illness.
9. Which specific action areas should be considered relating to the **built environment and facilities (including energy and water)**, over and above any existing policies or initiatives in this area?
• Definitive targets for transition to renewable sources of power for all healthcare facilities. • Not installing piped nitrous oxide infrastructure in new builds and removing it in existing facilities, particularly in facilities without obstetric or paediatric services. • Enhancing access and use of telehealth across all aspects of healthcare to minimise the need for patients and staff to travel.
10. Which specific action areas should be considered relating to **travel and transport**, over and above any existing policies or initiatives in this area?
• Ensure that there are adequate 'end-of-journey' facilities in all buildings in healthcare, to encourage the use of active means of transport e.g. cycling. • Adequate facilities to store and charge electric vehicles, including eRideables.
11. Which specific action areas should be considered relating to **supply chain**, over and above any existing policies or initiatives in this area?
• Targeted strategies and innovations to encourage reduced use of healthcare-related items and therapeutics, which will then also result in reduced waste. • Reduction of low-value care episodes.

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- Work with healthcare institutions, industry and regulators to maximise use of reusable equipment as opposed to single-use. Improve the feasibility and capacity of sterilisation facilities in healthcare to clean and sterilise reusable equipment.

12. Which specific action areas should be considered relating to **medicines and gases**, over and above any existing policies or initiatives in this area?

- Minimise waste of medications by minimising episodes of low-value care and reviewing clinical models of care.
- Ensure proper disposal of medicines and anaesthetic gases to avoid leaching of pharmaceuticals into waterways and venting of waste anaesthetic gases to the atmosphere.
- Scavenging of nitrous oxide and use of capture/destruction technologies for both volatile anaesthetic agents and nitrous oxide. Central units for such technology should be present in all new buildings.
- Healthcare facility gas supply infrastructure should be regularly and thoroughly monitored for leaks.

13. Which specific action areas should be considered relating to **waste**, over and above any existing policies or initiatives in this area?

- Policy levers to harmonise pharmaceutical and clinical waste disposal standards across Australia.
- Partner with organisations to safely redistribute unused food items to those in need.

14. Which specific action areas should be considered relating to **prevention and optimising models of care**, over and above any existing policies or initiatives in this area?

- Support innovation in facilitating streamlined access to test and investigation results to providers in order to mitigate duplication, excess repeated testing and inappropriate testing.

15. What can be done to involve private providers within the health system in the Strategy's emissions reduction efforts?

Adequate weighting for environmental credentials when considering contracts with private providers, including commitments to net zero emission targets should be mandatory. Appropriate environmental accreditation standards must include both public and private healthcare providers.

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16. Where should the Strategy prioritise its emissions reduction efforts?

    a. How should the Strategy strike a balance between prioritising emissions reduction areas over which the health system has the most direct control and prioritising the areas where emissions are highest, even if it is harder to reduce emissions in these areas?

    b. Which of the six sources of emissions discussed above (on pages 13 to 18 of the Consultation Paper) are the highest priorities for action?

17. What 'quick wins' in relation to emissions reduction should be prioritised for delivery in the twelve months following publication of the Strategy?

- Remove desflurane from public hospital formularies to discourage its use.
- Mandate public reporting of emissions from volatile anaesthetic gases and nitrous oxide from all healthcare facilities.
- Prohibit the venting of residual nitrous oxide, from ‘near empty’ cylinders, to the atmosphere.
- Implement a nitrous oxide mitigation strategy for all hospitals, including:
    - Ceasing the supply of piped nitrous oxide in any facility which does not offer obstetric or paediatric services (converting to cylinder supply where necessary)
    - Monitoring, detection and mitigation of nitrous oxide infrastructure leaks
    - Encouraging alternative sources of analgesia where appropriate
- Reduction and re-direction of hospital food waste away from landfill.

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Proposed Objective 3: Adaptation

18. What health impacts, risks and vulnerabilities should be prioritised for adaptation action through the Strategy? What process or methodology should be adopted to prioritise impacts, risks and vulnerabilities for adaptation action?
19. Should the Australian government develop a National Health Vulnerability and Adaptation Assessment and National Health Adaptation Plan? If yes: a. What are the key considerations in developing a methodology? b. How should their development draw on work already undertaken, for example at the state and territory level, or internationally? c. What are the key areas where a national approach will support local/jurisdictional vulnerability assessment and adaptation planning?

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20. Would there be value in the Australian government promoting a nationally consistent approach to vulnerability assessment and adaptation planning for the health system specifically, for instance by issuing guidance and associated implementation support tools for states, territories and local health systems? If yes, what topics should be covered to promote a nationally consistent approach? What examples of existing guidance (either from states/territories or internationally) should be drawn from?
21. What immediate high-priority health system adaptation actions are required in the next 12 to 24 months?

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Proposed Objective 4: Health in All Policies

22. What are the key areas in which a Health in All Policies approach might assist in addressing the health and wellbeing impacts of climate change and reducing emissions?
23. What are the most effective ways to facilitate collaboration and partnerships between stakeholders to maximise the synergies between climate policy and public health policy? What are some successful examples of collaboration in this area?

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Enablers

24. How could these enablers be improved to better inform the objectives of the Strategy? Should any enablers be added or removed?
25. For each of these enablers: a. What is currently working well? b. What actions should the Strategy consider to support delivery?

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Thank you for taking the time to complete this survey – your feedback is greatly appreciated!

Please submit this form in Word format to Health.Climate.Consultation@health.gov.au.

Australian Government
Department of Health and Aged Care

NATIONAL HEALTH AND CLIMATE STRATEGY

Detailed submission form

This form allows you to provide responses to the full set of questions in the Consultation Paper available here.

Alternatively, you may wish to complete the briefer online survey available here.

Please submit this form in Word format to Health.Climate.Consultation@health.gov.au.

Respondent details

What is your name?
[redacted]
What is your email address?
[redacted]
What is your organisation?
Melbourne Children's Campus Home - Melbourne Children's (melbournechildrens.com) ENDORSED: [redacted]
Have you read and agreed to the Privacy Statement? (NB we will not be able to use your submission unless you tick this box)
☒ I have read and agreed to the Privacy Statement
Do you identify as Aboriginal and/or Torres Strait Islander? (Yes/No/Prefer not to say)

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[redacted]

Please select which applies to you:

☐ Individual citizen
☒ Health Service Provider
☐ Industry and Life Sciences Organisation or Representative
☒ Academic or Researcher
☐ Primary and/or Allied Health Peak or Advocacy Organisation or Representative
☐ Aged Care Service Provider
☐ First Nations Health Service Provider
☐ First Nations Community Group
☐ First Nations Peak or Advocacy
☐ Medical College or Peak professional body

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Questions for feedback from the Consultation Paper

Introduction

1. How could these objectives be improved to better support the vision of the Strategy?

Suggested improvements to the vision and objectives have been detailed below:

- The Strategy should include a 'vision statement' that clearly articulates an agreed vision for the future state that we aim to achieve or work towards.
  Given the holistic nature of the intersection between climate and health, it may be useful to reference the World Health Organisation's (WHO) definition of health as "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*".

  Example vision statements:
  "A net-zero healthcare system that recognises the range of social, economic, political, cultural and environmental determinants of health."
  "A healthy, equitable and climate resilient community."

- 'Measurement' should be included as an Enabler, rather than as an Objective of the Strategy.

- With regards to 'Mitigation', evidence-based emission reduction targets should be included for various time horizons (including interim targets).

- 'Health in All Policies' should be a comprehensive approach that entails the seamless integration of health-related factors into various policy domains, encompassing diverse sectors such as transportation, urban development, energy, education, agriculture, finance, defence, and more. The primary objective is to extend the focus beyond the confines of the health sector, ensuring a holistic consideration of health implications throughout all facets of policymaking. The description for this objective should be broadened further to encompass engagements and impacts across additional sectors.
  Alternatively, if current capacity or influence for such broad integration is limited,

the objective can be appropriately tailored to address a range of factors affecting health, including social, economic, cultural, and environmental determinants.

2. How could these principles be improved to better inform the objectives of the Strategy?

The Melbourne Children's Campus generally supports the proposed principles and would support their use throughout the Strategy. Some suggested improvements have been included below.

Consider additional principles:

- '*Intergenerational Equity, Justice and Inclusion*'
  The choices we make today, whether through action or inaction, will exert a significant influence on future generations. It is imperative that we prioritize this long-term perspective as we forge ahead in formulating our strategy. The profound consequences that lie ahead must remain at the forefront of our minds during the development of this approach.

Consider revisions to existing principles:

- '*Tackling health inequities*'
  In addition to acknowledging health disparities within Australia, it is imperative to explicitly identify the most vulnerable populations and provide them with enhanced support to cope with the health challenges posed by climate change. Prioritizing these marginalized groups and ensuring their adaptation to the health impacts of climate change is of utmost importance.

- '*One Health*'
  Consider re-naming this Principle 'Planetary Health', as the focus of this strategy is anthropocentric and focuses mostly on human health (reference https://www.researchgate.net/publication/320101995_A_Comparison_of_Three_Holistic_Approaches_to_Health_One_Health_EcoHealth_and_Planetary_Health)

- '*Partnership-based working across all levels of government and beyond*'
  To genuinely achieve the goal of 'Health in All Policies,' the concept of 'Partnership-based working' must transcend vertical collaboration and encompass horizontal cooperation across various sectors. It is essential to foster collaborative efforts that span beyond traditional boundaries and work laterally across different domains. This inclusive and comprehensive approach will pave the way for successfully integrating health considerations into all policy areas, leading to a more holistic and impactful outcome.

3. Which of the various types of greenhouse gas emissions discussed above should be in scope of the Strategy's emission reduction efforts?

It is crucial to address emissions from all three scopes - Scope 1, 2, and 3 - both domestically and internationally, including emissions from other countries' jurisdictions. Additionally, we must not overlook emissions stemming from patient and visitor transport.

While measurements for Scope 1 and 2 emissions are already available in most Australian jurisdictions, equal emphasis should be placed on calculating and considering Scope 3 emissions in all procurement decisions. These Scope 3 emissions constitute the majority (60-70%) of the healthcare sector's carbon footprint and, as such, warrant meticulous evaluation in our procurement processes.

Furthermore, it is imperative to incorporate offshore Scope 3 emissions linked to pharmaceuticals and medical devices. By doing so, we can shape our procurement

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strategies to take these emissions into account, utilizing our purchasing influence to promote lower carbon products and encourage environmentally responsible pharmaceutical and manufacturing practices overseas. Such actions will contribute to a more sustainable and environmentally conscious healthcare industry.

4. What existing First Nations policies, initiatives, expertise, knowledge and practices should the Strategy align with or draw upon to address climate change and protect First Nations country, culture and wellbeing?

The Lowitja Institute has produced a discussion paper that focuses on climate change and Aboriginal and Torres Strait Islander Health. The paper highlights Aboriginal and Torres Strait Islander-led initiatives in climate change adaptation and mitigation that strengthens wellbeing and benefits the global community. This discussion paper was commissioned by the Lowitja Institute based on the need to address the health and wellbeing impacts of climate change identified by the National Health Leadership Forum – a collective partnership of national Aboriginal and Torres Strait Islander health and wellbeing organisations.

The key findings of the discussion paper identify that:

- Impacts from climate change will vary considerably across Australia.
- There are many varied direct and indirect climate change impacts on the morbidity and mortality of Aboriginal and Torres Strait Islander people.
- To date, Aboriginal and Torres Strait Islander people have not been sufficiently included in national conversations about climate change. There are gaps in research and data and most reporting on climate change does not include Aboriginal and Torres Strait Islander or local knowledge in the assessment findings.
- Many solutions are known but access to these solutions is not equally or equitably available across Australia. These issues are inextricably linked to structural and systemic racism.
- Climate change presents an opportunity for redress and empowerment of Aboriginal and Torres Strait Islander communities to lead climate action planning based on their intimate traditional and historical knowledges of Country. The discussion paper outlines best practice principles to take up this opportunity.

We recommend this discussion paper as a comprehensive resource to help inform action to address climate change and protect First Nations country, culture and wellbeing.

Source:
The Lowitja Institute Discussion Paper "Climate Change and Aboriginal and Torres Strait Islander Health"
https://www.lowitja.org.au/content/Image/Lowitja_ClimateChangeHealth_1021_D10.pdf

5. What types of governance forums should be utilised to facilitate co-design of the Strategy with First Nations people to ensure First Nations voices, decision-making and leadership are embedded in the Strategy?

The Lowitja Institute Discussion Paper "Climate Change and Aboriginal and Torres Strait Islander Health" (referenced in Question 4) highlights that establishing equitable power relationships and co-governance arrangements at multiple levels would provide Aboriginal and Torres Strait Islander communities more certainty and control in protecting Country.

Governance forums to consider utilising to facilitate co-design of the Strategy could include:

- Aboriginal health services;
- local Aboriginal land councils;

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- The Lowitja Institute https://www.lowitja.org.au/; and
- the National Health Leadership Forum https://www.nhlf.org.au/.

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Proposed Objective 1: Measurement

6. Beyond the schemes already noted above, is your organisation involved in any existing or planned initiatives to measure and report on health system emissions and/or energy use in Australia?
Yes, initiatives listed below: • National Greenhouse and Energy Report (NGER) National Greenhouse and Energy Reporting NGER (cleanenergyregulator.gov.au) • National Australian Built Environment Ratings System (NABERS) What is NABERS? | NABERS • Environmental Data Management System (EDMS/Eden Suite) managed by the DH Sustainability team • Emissions and Energy Reporting System (EERS) The Emissions and Energy Reporting System (cleanenergyregulator.gov.au)
7. What additional data and information is required to support targeted emissions reduction efforts within health and aged care?
To bolster focused emissions reduction endeavours within healthcare, there is a pressing need for Life-cycle analysis (LCA) data or databases pertaining to pharmaceuticals, medical equipment, and consumables. Such data will play a pivotal role in guiding informed decision-making during procurement processes. Additionally, it is essential to enhance data collection and ensure better data quality concerning various waste streams across the entire service cycle. By doing so, we can gain deeper insights into waste generation and disposal patterns, facilitating more effective waste management strategies. Moreover, to make environmentally conscious procurement decisions, we must avail ourselves of more extensive informational data. This data should encompass crucial aspects like product and packaging recyclability, product reusability, and decomposition characteristics. Armed with this knowledge, we can prioritize the selection of sustainable and eco-friendly products, making significant strides towards creating a greener and more responsible healthcare system.

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Proposed Objective 2: Mitigation

8. What do you think of these proposed focus areas for emissions reduction? Should anything else be included?
Energy demands particular attention as a distinct and independent focus area, rather than being combined with buildings, given its substantial contribution to healthcare's carbon footprint. Furthermore, Food should be considered as a separate focus area, unless it is already adequately addressed in Supply Chain and Waste Management initiatives. The Built Environment and Facilities must receive significant emphasis in the strategy document, considering their profound impact on our carbon footprint. The document should explore aspects such as gas, water, and electricity consumption, and the potential for local energy generation and water harnessing. Regarding Waste management, the strategy should lay a strong emphasis on waste minimization, exploring strategies to facilitate the return of waste to manufacturers and implementing efficient waste disposal methods outside the hospital precinct. By doing so, we can effectively address the challenges associated with waste generation and its environmental implications.
9. Which specific action areas should be considered relating to the **built environment and facilities (including energy and water)**, over and above any existing policies or initiatives in this area?
Both energy and water consumption necessitate dedicated attention as independent focus areas, distinct from being subsumed under buildings, primarily due to their significant contributions to healthcare's carbon footprint. Actions might include the following (all will require reportable KPIs, incentives, and target dates): • Transition to electricity from 100% renewable sources, using power purchasing agreements • Onsite renewable energy generation • All-electric hospital/clinic buildings (phase out gas) • Energy and water efficiency measures • Avoidance of piped nitrous infrastructure in all new builds • Reduction of water use in clinical practice, particularly dialysis • Develop and implement strategies to facilitate diversion of wastewater into reuse throughout all healthcare settings whilst maintaining appropriate infection control
10. Which specific action areas should be considered relating to **travel and transport**, over and above any existing policies or initiatives in this area?
It is essential to prioritize patient and visitor transport to healthcare facilities as a crucial aspect of the strategy. We must strive for improved accessibility, affordability, and reliability of public transport options, while also fostering shared patient transport alternatives. Additionally, promoting active transport and establishing corresponding infrastructure within communities and healthcare settings is vital. Incorporating electric and zero-emissions transport solutions is imperative to reduce our carbon footprint. To encourage this shift, electric vehicle charging facilities should be made available to all hospital staff, patients, and visitors.

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We also need to shift our hospital fleet to electric vehicles, and power them with 100% renewable electricity.

The Strategy could also consider the following suggestions focusing on the delivery of healthcare and the healthcare workforce:

- To enhance healthcare accessibility, virtual models of care, such as telehealth and videoconferencing, should be expanded, along with reinstating MBS item numbers for telephone consultations when clinically appropriate.

- Decentralizing healthcare from tertiary centres by empowering local health facilities and reinstating visiting specialist schemes for regional and remote communities will bring care closer to patients' homes. This approach, exemplified by RCH's MOUs with Northern and Sunshine Hospitals for inpatient paediatric care, can be replicated elsewhere.

- Expanding the Hospital in the Home models of care will offer further flexibility and convenience for patients whilst reducing environmental impacts associated with the delivery of care.

- The Strategy could look to restructure continuous medical education (CME) funding to discourage international travel for conferences, encourage virtual attendance, and allocate CME resources for ESG (environment, social and governance factors) projects that benefit the health system's sustainability. This approach aligns medical education with environmental responsibility.

11. Which specific action areas should be considered relating to **supply chain**, over and above any existing policies or initiatives in this area?

We wholeheartedly endorse the proposed actions outlined in the Strategy, emphasizing the use of policy levers as discussed in the consultation paper. Additionally, we appreciate the Strategy's recognition of the UK NH's roadmap for reducing supply chain emissions and the potential to harness the health sector's substantial purchasing power for positive impact.

To achieve a cohesive and effective approach to procurement policy at the national level, the following critical elements should be included:

- Establishing nationally consistent procurement standards to ensure uniformity and clarity in the acquisition process.
- Requiring pharmaceutical and medical device/supply companies to publicly disclose the carbon footprint of each product, fostering transparency and enabling informed procurement decisions.
- Creating a comprehensive life cycle analysis (LCA) database to aid procurement choices, facilitating a holistic evaluation of environmental impacts.

Continued research into life cycle analyses of diverse procedures, supplies, and consumables should also be a priority, promoting continuous improvement in sustainability practices.

A comprehensive review of and guidance for infection control policies is necessary to strike a balance between infection risk and sustainability considerations. This review should encompass appropriate and necessary use of gloves, dressing packs, Blueys, gowns, and face masks. Furthermore, it should consider the implications of sterile field versus clean non-sterile fields and infection control practices concerning the donation of unopened packaged food, among other relevant factors. Striking this equilibrium will

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ensure that healthcare practices align with sustainability objectives while maintaining stringent infection control measures.

12. Which specific action areas should be considered relating to **medicines and gases**, over and above any existing policies or initiatives in this area?

- The Strategy must prioritize research and policy initiatives that explore viable alternatives to nitrous oxide particularly in the paediatric and maternity settings, such as midazolam or virtual reality headsets. This approach will foster innovation and advancements in pain management.

- Additionally, in pursuit of enhancing asthma management, the Strategy should delve into the efficacy of Dry Powder Inhalers (DPIs) versus Metered-Dose Inhalers (MDIs). Evidence-based policies can lead to more effective and personalized treatments.

- Investing in cutting-edge technology and adopting efficient strategies for pharmaceutical stock management is essential to minimize waste and optimize resource utilization. This approach will contribute to a more sustainable and environmentally responsible healthcare system.

- Moreover, the Strategy should explore further ways to leverage the Pharmaceutical Benefits Scheme (PBS) to promote rational and appropriate medication use. Evidence-based guidelines and incentives can steer prescribers towards optimal choices.

- Accurate measurements, meticulous record-keeping, and benchmarking are fundamental components that the Strategy should embrace in relation to medicines and gases.

- To reduce the environmental impact of healthcare, the Strategy should expand recycling options for medication packaging, encompassing blister packs and cool storage containers. By doing so, we can actively participate in reducing plastic waste and enhancing sustainability efforts in the healthcare sector.

13. Which specific action areas should be considered relating to **waste**, over and above any existing policies or initiatives in this area?

There are two critical focal points that demand our attention:

- Minimizing waste generation at the source.
- Implementing proper waste handling practices for the waste that is generated.

Specifically, regarding waste management, the Strategy should primarily prioritize waste minimization efforts, the establishment of effective return-to-manufacturer processes, and well-planned waste disposal strategies once waste leaves the hospital premises.

To promote sustainability within the healthcare sector, it is essential to place greater emphasis on fostering a circular economy. This includes reducing reliance on disposable products, encouraging asset sharing (e.g., medical equipment, cars), promoting product reuse, and extending equipment lifespan through maintenance, refurbishment, and upcycling practices.

Embracing resource circularity, the Strategy should explore remanufacturing options for products and components, as well as enhancing recycling initiatives for materials found within disposable products. By doing so, we can move towards a more environmentally conscious and resource-efficient healthcare system.

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14. Which specific action areas should be considered relating to **prevention and optimising models of care**, over and above any existing policies or initiatives in this area?

We generally support the proposed actions related to prevention and optimising models of care in relation to their impact in minimising the carbon footprint associated with the delivery of healthcare, and in keeping children and young people healthy in the community. Suggestions for strengthening these actions have been included below.

Prevention and addressing social determinants of health:
Alleviating the disease burden and therefore reducing utilization of health services at every level will contribute towards reducing the carbon footprint associated with healthcare in the long term.

- Improved nutrition plays a crucial role, and this can be achieved by transforming hospital food sourcing practices to be more sustainable. Additionally, implementing food subsidies and enhancing school breakfast programs can promote healthier eating habits among children. Providing nutrition education to parents and managing food waste while educating about composting are essential steps. Moreover, implementing junk food bans can contribute to healthier dietary choices.
- To combat obesity and promote physical activity, ensuring financial access to sports and fostering school-based teams instead of relying solely on external private clubs can enhance participation. Making public transport more accessible and pram-friendly with ramps and no steps can encourage active commuting. Road safety measures can facilitate walking school buses and promote walking or biking to school.
- Addressing risk-taking behaviours, such as vaping and drug use, through education is vital for promoting healthier lifestyles.
- Improving the built environment is crucial for physical and mental well-being. Increasing green spaces, community gardens, and playgrounds can help reduce air pollution, enhance carbon sequestration, and alleviate the urban heat island effect.
- In terms of mental health, increasing accessibility to mental health services is paramount. Special attention should be given to the mental health of new mothers. Additionally, addressing screen time issues can positively impact mental well-being, especially among children and adolescents.

De-centralizing healthcare:
Decentralizing healthcare away from tertiary centres should be a priority.

- This can be achieved by empowering and resourcing local health facilities, enabling them to deliver appropriate care closer to patients' homes, thus reducing the need for extensive travel.
- Decentralizing healthcare will require a shared Electronic Medical Record system. Sharing of records amongst health services will improve information access across sites, eliminate duplication of investigations, and improve quality of care overall.
- Ongoing Virtual ED models and expansion of Hospital in the Home models of care should also be on the agenda, as they offer flexible and efficient alternatives to in-hospital treatments.
- Incorporating virtual models of care, such as telehealth, videoconferencing, and telephone consultations, should also be a key consideration in the Strategy. When deemed clinically appropriate, these virtual technologies can significantly improve accessibility and convenience for patients.
- The Strategy should encourage a care team approach using Telehealth, enabling patients and their families to virtually join GPs during specialist appointments. This fosters better communication, enhances GPs' skillsets, and ensures Telehealth

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accessibility for patients facing technological challenges like those in rural or regional areas, dealing with language barriers, or cultural differences.

Primary Care:
The Strategy should explore innovative care models that transition patients from high-emission acute sectors to lower-emission primary care settings. Considerations include:

- Substantial reinforcement of the primary care system, including increased funding, workforce incentives, education, and support. Public Health Networks (PHNs) can play a crucial role in facilitating this shift.
- To address the de-skilling of GPs in paediatrics due to an aging population, investing in programs to upskill GPs in paediatrics is essential. This approach aims to reduce unnecessary visits to paediatric emergency rooms and hospitals.
- Implementing shared care models and team approaches involving patients, families, specialists, and GPs can enhance communication and upskill GPs, leading to better patient outcomes.
- Strengthening Maternal Child Health Nurse and Enhanced Maternal Child Health Nurse programs can provide valuable support to parents of babies and young children.
- Empowering parents with knowledge on managing their child's medical conditions can reduce the need for specialist appointments and hospital visits.
- Incentivizing quality care, rather than quantity, for GPs through MBS levers can improve overall healthcare standards.
- To shift paediatric care into the community, outpatient paediatric healthcare programs need bolstering, particularly by funding more paediatricians in public community health centres. The current inadequacy of outpatient general and behavioural/developmental paediatric services leads to long wait times for public paediatricians, reaching up to 12 months.
- Promoting general health literacy in the community is vital to empower individuals to make informed healthcare decisions.
- A centralized web-based health hub could serve as a dependable source for public health information, offering a comprehensive and accessible resource for the community

15. What can be done to involve private providers within the health system in the Strategy's emissions reduction efforts?

- Enable private healthcare providers to engage in bulk power-purchasing agreements for 100% renewable electricity, advancing their commitment to sustainable energy sources.

- Enhance transparency in the carbon footprint impact of products used in private practice by urging medical distributors to provide comprehensive information. This disclosure will empower small and medium-sized businesses to make well-informed procurement decisions, prioritizing eco-friendly products.

- Implement financial incentives within the Medicare Benefits Schedule (MBS) billing system to discourage low-value, high-carbon healthcare practices and encourage high-value, sustainable healthcare options. This approach holds great potential for steering healthcare providers towards more environmentally responsible practices while promoting better patient care.

- Accreditation standards – the Australian Commission on Safety and Quality in Health Care (the Commission) is developing a Sustainable Healthcare Module which will apply to both public and private healthcare facilities.

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16. Where should the Strategy prioritise its emissions reduction efforts?

a. How should the Strategy strike a balance between prioritising emissions reduction areas over which the health system has the most direct control and prioritising the areas where emissions are highest, even if it is harder to reduce emissions in these areas?

b. Which of the six sources of emissions discussed above (on pages 13 to 18 of the Consultation Paper) are the highest priorities for action?

To effectively address emissions reduction within the health system, the Strategy should adopt a dual strategy. Firstly, identify areas that fall under the health system's control, focusing on those that offer the most significant environmental impact per investment (the "biggest bang for buck"). Then, target areas with the highest emissions, pursuing a "revolutionary" approach to effect transformative changes.

Concurrently, the second prong of the Strategy should involve identifying sectors with the highest emissions, even if they present greater challenges for reduction. In these areas, we will embrace an "evolutionary" approach, gradually implementing sustainable practices to achieve meaningful progress over time.

By blending both revolutionary and evolutionary tactics, we can pave the way for substantial emissions reduction and foster a more environmentally conscious health system.

17. What 'quick wins' in relation to emissions reduction should be prioritised for delivery in the twelve months following publication of the Strategy?

1) Use of 100% renewable electricity to power infrastructure and fleet vehicles
2) Reduction in waste production
3) Sustainable choices in Procurement
4) Sustainable Design Guidelines for new built environment
5) Water harvesting
6) Supporting Telehealth, videoconferencing and telephone consultation, including re-instating MBS codes for telephone consultation
7) Invest in technological program for better Pharmacy stock management

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Proposed Objective 3: Adaptation

18. What health impacts, risks and vulnerabilities should be prioritised for adaptation action through the Strategy? What process or methodology should be adopted to prioritise impacts, risks and vulnerabilities for adaptation action?
The consultation document already outlines essential measures, but we must place a stronger emphasis on education, mental health first aid and system planning to enhance resilience and preparedness. **Listening to and working in partnership with communities** It is crucial to prioritize marginalized and disengaged communities, such as First Nations, refugee/migrant populations, and disabled groups, ensuring they receive appropriate support. We can also learn valuable lessons from First Nations peoples (such as their traditional fire-management practices) as a means of reducing risk. **Mental health preparedness and education** The increasing number of climate change refugees escaping rising oceans and food and water insecurity further underlines the urgency to create more resilient communities, considering the health and mental health implications. Climate change carries the risk of poor mental health outcomes, including post-traumatic stress and transgenerational impacts. Identifying vulnerable groups, such as individuals with past trauma experiences or mental illnesses, can guide us in providing timely support and early intervention. The growing climate change concerns among children and young people, particularly regarding the future and natural disasters, require immediate attention. Frontline healthcare workers may also experience secondary trauma due to the increasing health presentations related to climate change. They should be well-informed about available treatment options as part of adaptation plans. Collecting comprehensive data sets on stress-related problems and mental well-being within communities, utilizing Census data demographics, is vital for crafting targeted responses. We should integrate climate change education and preparedness into schools and higher education centres to raise awareness and understanding of risks and help to mitigate growing rates of climate anxiety amongst children and young people. **Public health system and workforce planning**

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Effective public health system and workforce planning is crucial for addressing various challenges and ensuring a resilient healthcare system.

- Immediate response capacity during extreme events, such as thunderstorm asthma, COVID-19, and bushfires, is essential to mitigate their impact and protect public health.
- Long-term capacity and follow-up planning are necessary to anticipate and prepare for potential impacts on education, health, and employment over the next five years.
- Strategically planning for vaccines to combat new outbreaks will enhance preparedness and response capabilities.
- Empowering and strengthening peripheral and rural healthcare facilities is vital to provide equitable access to healthcare services across all regions.
- To attract healthcare professionals to rural areas, we must increase the desirability of such sites and ensure sufficient numbers of nurses and doctors are available.
- Furthermore, ensuring an adequate number of university places for nursing and medical students is crucial to meet future healthcare workforce demands.
- We can draw inspiration from British Columbia's Ministry of Environment and Climate Change Strategy and advocate for incorporating climate-health education into professional associations and universities. This training should include identifying at-risk groups and mental health symptoms associated with "climate anxiety," "eco-anxiety," and "ecological grief."

Other adaptation measures:

- To address nutrition and food shortage concerns, we should focus on improving the local food supply chain and investing in low-resource waste technology to minimize food waste and ensure efficient utilization of resources.
- Regarding heat-related challenges, we can explore adapting the timing of schooling to early morning or late afternoon, with breaks during the hottest part of the day. This adjustment can enhance the learning environment and protect students from extreme heat.

References:
https://www.frontiersin.org/articles/10.3389/fpsyt.2020.00074/full
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8464837/
https://www2.gov.bc.ca/assets/gov/environment/climate-change/adaptation/health/final_climate_and_health_backgrounder_frontline_health_care.pdf

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19. Should the Australian government develop a National Health Vulnerability and Adaptation Assessment and National Health Adaptation Plan? If yes:
    a. What are the key considerations in developing a methodology?
    b. How should their development draw on work already undertaken, for example at the state and territory level, or internationally?
    c. What are the key areas where a national approach will support local/jurisdictional vulnerability assessment and adaptation planning?

An effective plan should break free from a siloed approach as disasters do not abide by the boundaries we set. Our health sector responses need to encompass a cradle-to-grave approach to ensure the sustainability of our preparedness strategies.

A good starting point is to map and evaluate the current efforts and initiatives in place.

Recognizing that climate change disregards borders, we must address the burden of cross-border differences in legislation to facilitate collaborative efforts in reducing its impacts. This obligation extends beyond just collaborating with wealthy OECD countries; we must also work collaboratively with our regional partners.

At a national level, we can strengthen emissions reduction efforts through legislation, eliminating obfuscation and preventing the use of "creative accounting" tricks to misrepresent progress. This legislation should be applicable to all governments, regardless of their political affiliations or the regions they represent. Additionally, exploring the effectiveness of offsets is crucial to understand if they genuinely contribute to emission reductions or merely shift the burden elsewhere.

Other resources:
https://www.epa.gov/crwu/climate-resilience-evaluation-and-awareness-tool-creat-risk-assessment-application-water

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20. Would there be value in the Australian government promoting a nationally consistent approach to vulnerability assessment and adaptation planning for the health system specifically, for instance by issuing guidance and associated implementation support tools for states, territories and local health systems? If yes, what topics should be covered to promote a nationally consistent approach? What examples of existing guidance (either from states/territories or internationally) should be drawn from?
Yes. Topics may include: 1. Governance structures – roles & responsibilities 2. Risk and vulnerability assessment tool 3. Competency assessment tool 4. Data collection & reporting requirements 5. National and Global commitments 6. ROI tool to justify investment in climate adaptation and Environmental sustainability 7. Climate Resilience Evaluation and Awareness Tool - https://www.epa.gov/crwu/climate-resilience-evaluation-and-awareness-tool-creat-risk-assessment-application-water
21. What immediate high-priority health system adaptation actions are required in the next 12 to 24 months?
• Benchmarking, enhancing data collection capabilities, promoting education, and defining clear roles and responsibilities. • Adoption of a nationally consistent approach to vulnerability assessment and adaptation planning within the health system. This unified strategy will enable us to better understand and address vulnerabilities, ensuring a more resilient and prepared healthcare system.

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Proposed Objective 4: Health in All Policies

22. What are the key areas in which a Health in All Policies approach might assist in addressing the health and wellbeing impacts of climate change and reducing emissions?
The 'Health in All Policies' approach and synergies can be particularly beneficial in several key areas: 1. Energy: Prioritizing a swift transition to 100% renewable energy is essential. We must also limit new fossil fuel projects and instead maximize investments in renewable energy sources. Striving for Net Zero emissions in the healthcare sector will only be meaningful if we refrain from developing new fossil fuel projects. 2. Transport: Encouraging active transport, such as walking and cycling, offers significant health co-benefits. Additionally, investing in efficient and accessible public transport systems will contribute to a greener and healthier society. 3. Food and Agriculture: Promoting plant-based diets and taking measures to ban junk food advertising will have positive implications for public health and sustainability. 4. Finance: Currently, the government operates in financial and cost-silos, necessitating a focus on demonstrating savings in specific areas. However, a more comprehensive approach is needed to consider the broader picture and the interconnectivity of policies. It is concerning that the consultation paper makes no reference to mining and fossil fuel operations in Australia. It is vital to address the health impacts of mining and fossil fuel operations. Ignoring these effects and 'exporting' the human and environmental costs is no longer acceptable. The 'Health in All Policies' approach must confront this issue and prioritize the well-being of both people and the planet.
23. What are the most effective ways to facilitate collaboration and partnerships between stakeholders to maximise the synergies between climate policy and public health policy? What are some successful examples of collaboration in this area?
N/A

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Enablers

24. How could these enablers be improved to better inform the objectives of the Strategy? Should any enablers be added or removed?
Leadership and Governance: To drive effective change, 'Leadership and Governance' must be regarded as a distinct and prioritized Enabler, not merged with workforce and training initiatives. Before any other actions can take place, establishing a robust governance framework is crucial. This governance structure should incorporate the coordination between the National Health, Sustainability, and Climate Unit, state health sustainability units, and other relevant stakeholders. Accountability structures need to be well-defined, ensuring transparency and responsibility. Clarity regarding regulatory powers and legislative frameworks is essential to empower the governance system effectively. Additionally, involving Chief Financial Officers (CFOs) in the sustainability governance structures can bolster financial oversight and align sustainability efforts with financial planning and decision-making. **Finance and Funding:** How will the various initiatives be funded? What are the funding sources for research activities? The presence of cost-silo mentalities within departments hinders progress due to a lack of communication and collaboration. Reinvesting cost-savings into additional sustainability initiatives would be an effective approach. To ensure checks and balances, all new projects and investments must incorporate a Green House gas emissions review as part of their viability assessment. **Human Resources (as separate from the health workforce):** Further consideration for • Organisational competencies in health sector sustainability • Environmentally friendly procurement • Climate resilience.
25. For each of these enablers: a. What is currently working well? b. What actions should the Strategy consider to support delivery?
Workforce, leadership and training: • Leadership should be called out separately. **Research:** • Would benefit from mapping available data and evidence, then targeting research to fill gaps. • The medical and scientific research field has a unique opportunity to spearhead global efforts for a better climate future. Research funders can play a pivotal role in driving change by establishing clear expectations for efficiency, resiliency, and sustainability in the way research is conducted. By prioritizing environmentally conscious practices, the research community can contribute significantly to creating a more sustainable and resilient world. There is also an opportunity to set expectations in research funding for efficiency, resiliency and sustainability in the way that research is conducted.

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Communication and engagement:

- Re-phrase: Communication, engagement and sharing.

Collaboration:

-

Monitoring, evaluation and reporting:

-

Thank you for taking the time to complete this survey – your feedback is greatly appreciated!

Please submit this form in Word format to Health.Climate.Consultation@health.gov.au.

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Australian Government
Department of Health and Aged Care

NATIONAL HEALTH AND CLIMATE STRATEGY

Detailed submission form

This form allows you to provide responses to the full set of questions in the Consultation Paper available here.

Alternatively, you may wish to complete the briefer online survey available here.

Please submit this form in Word format to Health.Climate.Consultation@health.gov.au.

Respondent details

What is your name?
[redacted]
What is your email address?
[redacted]
What is your organisation?
Indigenous Allied Health Australia
Have you read and agreed to the Privacy Statement? (NB we will not be able to use your submission unless you tick this box)
☒ I have read and agreed to the Privacy Statement
Do you identify as Aboriginal and/or Torres Strait Islander? (Yes/No/Prefer not to say)
[redacted]
Please select which applies to you: ☐ Individual citizen ☐ Health Service Provider ☐ Industry and Life Sciences Organisation or Representative ☐ Academic or Researcher ☒ Primary and/or Allied Health Peak or Advocacy Organisation or Representative ☐ Aged Care Service Provider ☐ First Nations Health Service Provider ☐ First Nations Community Group ☒ First Nations Peak or Advocacy ☐ Medical College or Peak professional body

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Questions for feedback from the Consultation Paper

Introduction

1. How could these objectives be improved to better support the vision of the Strategy?
IAHA commends acknowledgement of opportunities to maximise the synergies between good climate policy and public health policy by working across policy areas to lessen the impact of climate change on the social and cultural determinants of health and wellbeing. However, in doing so, IAHA asserts that the climate and health strategy can be more ambitious and positive in its direction, including consideration of the following: • Holistic, strengths-based and human rights approaches that embed the cultural determinants and social determinants of health, including ability to promote better health and wellbeing outcomes through climate mitigation policies and improve health equity. • Genuine shared decision-making and partnerships based on respect, trust, understanding and mutual respect through a rights-based approach to climate and health strategy. • Investment to grow, support and develop the Aboriginal and Torres Strait Islander health, allied health, environmental health workforce and other relevant workforces that is culturally safe and responsive to support the capacity of individuals, families, and communities to respond in the face of a changing climate.
2. How could these principles be improved to better inform the objectives of the Strategy?
IAHA commends the guiding principles proposed. IAHA emphasises the opportunity for these principles to be meaningfully enacted, including via directing investment toward Aboriginal and Torres Strait Islander led solutions and ways of working, which have proven to be effective and positive for generations. The application of the principles of the Strategy should support new ways of working, centring the rights and aspirations of Aboriginal and Torres Strait Islander people, to achieve better outcomes and take an approach consistent with governments responsibilities under the United Nations Declaration of the Rights of Indigenous Peoples and the National Agreement on Closing the Gap. While reaffirming what is intrinsically known by Aboriginal and Torres Strait Islander people, emerging literature such as that of the Mayi Kuwayu National Study of Aboriginal and Torres Strait Islander Wellbeing on the cultural determinants of health is further strengthening the evidence base on the role of culture in the health and wellbeing of Aboriginal and Torres Strait Islander people, families and communities. In the context of climate health, IAHA asserts that the implementation of a successful strategy should be driven by culture at the core, as cultural determinants of health originate from and promote a strengths-based perspective anchored in Aboriginal and Torres Strait Islander ways of knowing, being and doing, embodying a holistic understanding of health and wellbeing. IAHA acknowledges the interplay between the cultural determinants and climate change, including the need to safeguard sites of cultural significance and care for Country, protect for traditional food systems and support cultural

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practices, with these actions likely to produce reinforcing benefits, and the negative impacts of a changing climate likely to cause harm via multiple pathways.

Some other areas which might be strengthened in the document, through further development of identified principles, may include:

- Significant focus on cultural safety for Aboriginal and Torres Strait Islander people.
- Tackling health inequities should seek to understand and address the impacts of discrimination resulting from colonisation, racism, paternalism, persistent disadvantage, systemic injustice and lack of acknowledgement of culture, given its profound influence on health and wellbeing outcomes.
- Genuine partnership with Aboriginal and Torres Strait Islander peoples, including Indigenous-led health and community services to ensure new and existing initiatives enhance and support these strengths.
- Preventative measures to include a significant focus on workforce and models of care, including by leveraging the value of the Aboriginal and Torres Strait Islander health workforce, in particular the allied health workforce, in promoting community health and wellbeing and supporting diversion from higher emitting healthcare practices and settings, for example keeping people out of hospital and within the community, reducing aeromedical retrieval or related practices.
    - Localised workforce development should be a specific focus, reducing reliance on fly-in-fly-out and drive in drive out workforces and increasing community capacity and capability.
    - More holistically considering barriers to employment, including access to climate appropriate housing and built infrastructure, which impedes the recruitment, retention and productivity of the workforce.
- A movement for climate justice that provides an opportunity to ensure climate action (or inaction) learns from the past and does not perpetuate existing inequities.

3. Which of the various types of greenhouse gas emissions discussed above should be in scope of the Strategy's emission reduction efforts?

IAHA encourages engagement with the Climate and Health Alliance as leaders in emissions reduction within health, including under the *Healthy, Regenerative and Just: Framework for a national strategy on climate, health and wellbeing for Australia* and *Sustainable Healthcare Report*.

4. What existing First Nations policies, initiatives, expertise, knowledge and practices should the Strategy align with or draw upon to address climate change and protect First Nations country, culture and wellbeing?

IAHA asserts that the Strategy should align with and draw upon the following existing First Nations policies, initiatives, expertise, knowledge, and practices, including some mainstream frameworks with specific relevance and accountabilities:

International frameworks

- United Nations' Framework Convention on Climate Change

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- United Nations Declaration on the Rights of Indigenous Peoples, that sets minimum standards and affirms basic rights that safeguards the survival, dignity, and wellbeing of Indigenous communities across the globe.

- International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights, which outlines rights to selfdetermination and adequate housing, health, food, and water that are consistent with Aboriginal and Torres Strait Islander communities.

National knowledge and practices

- Closing the Gap Report 2021 that showcases the resilience, strengths and leadership of Aboriginal and Torres Strait Islander peoples, communities and organisations throughout critical health crises in 2020: devastating bushfires and climate change, the coronavirus pandemic and the mental health emergency facing Aboriginal and Torres Strait Islander people.

- National Aboriginal and Torres Strait Islander Health Plan 2021-2031 and the National Aboriginal and Torres Strait Islander Workforce Strategic Framework and Implementation Plan 2021–2031

- The Lowitja Institute's Climate Change and Aboriginal and Torres Strait Islander Health discussion paper

- Heal Country, Health Climate

- Wiyi Yani U Thangani Report

- National Indigenous Housing Guide

- Royal Commission's Emergency Planning and Response Issues Paper

5. What types of governance forums should be utilised to facilitate co-design of the Strategy with First Nations people to ensure First Nations voices, decision-making and leadership are embedded in the Strategy?

As highlighted above, while some individual policy initiatives are beginning to incorporate aspects of climate change and sustainable development, an intersectoral and nationally consistent approach is required which should be consistent with the National Agreement on Closing the Gap.

In recognition of the existence of effective, established Aboriginal and Torres Strait Islander forums, such as the National Health Leadership Forum, local and placed based initiatives, and cultural and Nation governance structures, IAHA suggests that existing governance structures be explored and invested in first and foremost.

IAHA believes by utilising these governance forums, the co-design of the Strategy can be truly inclusive, collaborative, and informed by First Nations knowledge and priorities, which empowers them to take a leading role in shaping their own climate health future.

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Proposed Objective 1: Measurement

6. Beyond the schemes already noted above, is your organisation involved in any existing or planned initiatives to measure and report on health system emissions and/or energy use in Australia?
NIL input. Please refer to the leadership of the Climate and Health Alliance.
7. What additional data and information is required to support targeted emissions reduction efforts within health and aged care?
NIL input.

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Proposed Objective 2: Mitigation

8. What do you think of these proposed focus areas for emissions reduction? Should anything else be included?
NIL input.
9. Which specific action areas should be considered relating to the **built environment and facilities (including energy and water)**, over and above any existing policies or initiatives in this area?
NIL input.
10. Which specific action areas should be considered relating to **travel and transport**, over and above any existing policies or initiatives in this area?
NIL input.
11. Which specific action areas should be considered relating to **supply chain**, over and above any existing policies or initiatives in this area?
While IAHA acknowledges that the role of production, transport and disposal of healthrelated goods such as medicines accounts for 70 per cent of the health system's global emissions footprint, we note the opportunity in leveraging the health workforce who can influence health system emissions reduction strategies without undermining the quality of care. Examples include: • The health workforce taking a leading role in raising awareness about the health impacts of climate change and the importance of mitigating emissions. • Promoting preventative healthcare through a greater investment in and utilisation of the allied health workforce in emphasising healthy lifestyles, early detection, and regular check-ups, which require fewer resources for treating advanced or chronic conditions, ultimately reducing the overall emissions footprint associated with healthcare facilities and treatments. • Encouraging and mandating sustainable practices in healthcare facilities, including an increased focus on developing the local workforce, utilisation energy-efficient lighting and equipment, waste reduction and recycling programs, climate appropriate infrastructure design, and greener procurement of medical supplies. • Adopting telehealth practices which can decrease greenhouse gas emissions from transportation, particularly in rural or remote areas and in maintaining physical infrastructures.

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- Successful uptake of telehealth services by Aboriginal and Torres Strait Islander communities, however, requires the whole system to be equipped, ensuring Aboriginal and Torres Strait Islander people receive appropriate support, and ongoing management of their health conditions (e.g. culturally safe and responsive care, access to telehealth, including internet connectivity and infrastructure to ensure seamless communication during telehealth consultations).

12. Which specific action areas should be considered relating to **medicines and gases**, over and above any existing policies or initiatives in this area?

NIL input.

13. Which specific action areas should be considered relating to **waste**, over and above any existing policies or initiatives in this area?

NIL input.

14. Which specific action areas should be considered relating to **prevention and optimising models of care**, over and above any existing policies or initiatives in this area?

IAHA acknowledges the importance of investing in and implementing sustainable models of care. There is growing recognition of opportunities to reduce emissions through the provision of value-based care, including by avoiding overdiagnosis and overtreatment, experiences of cultural safety, racism, discrimination, and stigma across all settings impact upon institutional trust and access to care. The composition, distribution, and capabilities of the workforce drive models of care and practices.

Noting this Strategy seeks, rightfully, to strengthen the health system to be resilient to both prepare for, and be ready to respond to, stresses and shocks from climate change, IAHA argues that the health workforce, which is a great enabler in reducing emissions, is inequitably distributed within Australia with chronic staff shortages in rural and remote regions particularly. Remote areas generally rely on a transient health workforce (shortterm locum, fly or drive in and out models). Lack of quality, 'fit for purpose' housing and infrastructure impedes the recruitment and retention of staff, further magnifying these workforce pressures.

Therefore, IAHA argues that investment is needed to further grow and strengthen the diverse workforce at different points of intersection (from responding to a disaster to managing a health condition) with a focus on local workforce development. This includes Aboriginal and Torres Strait Islander allied health workforce and environmental health workforce, as they play a significant role in not just reducing emissions but also in keeping people healthy in place for as long as possible and out of the health system.

The Aboriginal and Torres Strait Islander allied health workforce, for example, is well placed to provide culturally responsive and safe care to Aboriginal and Torres Strait Islander people and families. This includes care that is holistic, culturally safe, and traumainformed to meet local community needs – from early identification to management and referral to other appropriate services. IAHA's work is reflective of this, with a strong

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focus on interdisciplinary education and exchange, promoting interprofessional exchange and
multidisciplinary ways of working. Improving health workforce education on climate and health, to equip the workforce to better understand the interplay between the two and to promote positive mitigation behaviours which protect health, wellbeing and Country. Increasing Aboriginal and Torres Strait Islander people's participation in all levels, roles and functions across systems is essential to improving outcomes. Improved social outcomes, such as educational attainment and secure employment, also improves health and wellbeing outcomes and increases ability to respond to stressors from a changing climate. The *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021 – 2031* provides an Aboriginal and Torres Strait Islander led framework to achieve this, including localised and place based opportunities. IAHA highlights however that, coordinated investment across sectors in workforce development – recognising the shared commitment and responsibility, need and benefit from investment in what is the same workforce – is essential to ensuring long-term sustainability of our systems, by positively impacting the health and wellbeing of Aboriginal and Torres Strait Islander people for current and future generations and reducing reliance on more expensive parts of our system.
15. What can be done to involve private providers within the health system in the Strategy's emissions reduction efforts?

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NIL input.
16. Where should the Strategy prioritise its emissions reduction efforts? a. How should the Strategy strike a balance between prioritising emissions reduction areas over which the health system has the most direct control and prioritising the areas where emissions are highest, even if it is harder to reduce emissions in these areas? b. Which of the six sources of emissions discussed above (on pages 13 to 18 of the Consultation Paper) are the highest priorities for action?
NIL input.
17. What 'quick wins' in relation to emissions reduction should be prioritised for delivery in the twelve months following publication of the Strategy?
NIL input.

Proposed Objective 3: Adaptation

18. What health impacts, risks and vulnerabilities should be prioritised for adaptation action through the Strategy? What process or methodology should be adopted to prioritise impacts, risks and vulnerabilities for adaptation action?
IAHA, through our wholly owned Northern Territory subsidiary company, is about to release a position statement on the relationship between housing and workforce development, particularly across Northern Australia. Housing that is adequate, safe, secure, affordable, appropriately designed and maintained, and that meets the cultural needs, preferences, and priorities of Aboriginal and Torres Strait Islander peoples is a significant factor in wellbeing. In addition to direct health impacts of housing, housing influences success in education, training and employment, behaviours (for example the relationship between energy and water security and nutrition) and social participation. Addressing housing and environmental health needs of Aboriginal and Torries Strait Islander people should be a priority. IAHA would be happy to provide a copy of the position statement upon publication.

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19. Should the Australian government develop a National Health Vulnerability and Adaptation Assessment and National Health Adaptation Plan? If yes: a. What are the key considerations in developing a methodology? b. How should their development draw on work already undertaken, for example at the state and territory level, or internationally? c. What are the key areas where a national approach will support local/jurisdictional vulnerability assessment and adaptation planning?
NIL input.

20. Would there be value in the Australian government promoting a nationally consistent approach to vulnerability assessment and adaptation planning for the health system specifically, for instance by issuing guidance and associated implementation support tools for states, territories and local health systems? If yes, what topics should be covered to promote a nationally consistent approach? What examples of existing guidance (either from states/territories or internationally) should be drawn from?
IAHA again recognises the insights captured in the Climate Change and Aboriginal and Torres Strait Islander Health Discussion Paper published via the Lowitja Institute and the leadership of the Climate and Health Alliance for specific information on vulnerability assessment and adaptation planning for the health system. IAHA believes that, at a high level, there would be significant value in promoting a nationally consistent approach to vulnerability assessment and adaptation planning for the health system, that is adaptable to place and context. A consistent approach would help ensure all states, territories and local health systems have access to the necessary tools to effectively assess and address the health inequities of Aboriginal and Torres Strait Islander people, ensuring equitable and fit-for-purpose responses.

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The following topics should be considered and addressed:

- Culturally safe and responsive practices that reflect and take into consideration the unique cultural beliefs, practices, and needs of Aboriginal and Torres Strait Islander people.
    - While the health inequities of Aboriginal and Torres Strait Islander people and communities are often identified as 'vulnerabilities', it is essential that approaches recognise the individual and collective strengths of Aboriginal and Torres Strait Islander peoples in a community development and Indigenous Nation Building approach to adaption.

- Aboriginal and Torres Strait Islander-led engagement throughout the assessment and planning processes, with active involvement of community members in decision-making when designing interventions that align with their priorities.

- Addressing specific climate-related health impacts affecting Aboriginal and Torres Strait Islander communities, such as inappropriate housing infrastructures, poor access to clean water, lack of food security and social and emotional wellbeing issues arising from climate-induced displacement and loss of cultural sites.

- Promoting capacity building within health systems through dedicated and sustainable investment in Aboriginal and Torres Strait Islander workforce development initiatives.

21. What immediate high-priority health system adaptation actions are required in the next 12 to 24 months?

IAHA argues that the following overarching principles should guide adaptation actions:

- Placing culture (cultural determinants of health) at the centre through the recognition of Aboriginal and Torres Strait Islander cultures, traditions and knowledge systems alongside Western knowledge systems to inform innovative adaptation and mitigation efforts.

- Prioritising community-led adaptation planning and decision-making, to further empower Aboriginal and Torres Strait Islander communities to define their adaptation needs, set priorities, and co-design solutions that align with their values and aspirations, that is inclusive of women, young people and elders.

    - Promoting strategies that preserve and strengthen Aboriginal and Torres Strait Islander connections to their traditional lands and environments (e.g. understanding and respecting the significance of land and water in sustaining cultural practices and wellbeing).

- Empowering Aboriginal and Torres Strait Islander people through workforce development and capacity building initiatives.

○ Adopting a multidisciplinary approach to climate adaptation, including the role of the allied health workforce, that is culturally safe and responsive. ○ Empowering Aboriginal and Torres Strait Islander organisations, including recognition of the leadership and burden which often falls to Aboriginal and

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Torres Strait Islander sector in responding to climate emergencies and community need.

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Proposed Objective 4: Health in All Policies

22. What are the key areas in which a Health in All Policies approach might assist in addressing the health and wellbeing impacts of climate change and reducing emissions?
For Aboriginal and Torres Strait Islander people where health encompasses a whole-oflife view and includes a cyclical concept of life-death-life, a Health in All Policies approach may be instrumental in addressing the underlying social, economic and environmental factors contributing to these disparities. Key areas in which a Health in All Policies approach might assist in addressing the health and wellbeing impacts of climate change and reducing emissions include: • Climate-resilient infrastructure such as access to appropriate housing that is safe and climate suitable for communities, supports education, training and employment outcomes, and information technology infrastructure (for example as an enabler access to telehealth services) that ensure continuity of care during emergencies, while providing quality care. • Disaster preparedness and response plans that take into account the unique cultural and health needs of Aboriginal and Torres Strait Islander people, with relevant workforce being culturally safe and responsive when preparing for and/or responding to disasters o Disaster preparedness and response planning also needs to ensure that triggers for the declaration of a climate related emergency is culturally safe and responds to the needs of Aboriginal and Torres Strait Islander communities. Recent flooding events and barriers to access for Commonwealth funding and support, including for the delivery of essential goods, is an example. • Food security and nutrition that is inclusive of traditional food practices and local food production. • Environmental and cultural heritage protections and rights, inclusive of lands, seas and waterways, which recognise the connection to Country of Aboriginal and Torres Strait Islander people and communities and the cultural determinants of health and wellbeing.
23. What are the most effective ways to facilitate collaboration and partnerships between stakeholders to maximise the synergies between climate policy and public health policy? What are some successful examples of collaboration in this area?
IAHA affirms that partnerships and collaboration must foster broader cross-sector action, determined by the needs of communities, as consistent with cultural and social determinants of health approaches, and through learnings from jurisdictions locally, nationally and internationally. Community development and Indigenous Nation Building approaches are also essential and align with the commitment of government to increase Aboriginal and Torres Strait Islander peoples and communities voice in decision making.

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These include but are not limited to:

- Adopting an interdisciplinary approach that is reflective of a wide range of stakeholders to ensure the connections between climate change and health are addressed.
- Encouraging the sharing of data and research findings to shape policy interventions
    - Establishing mechanisms to monitor the effectiveness of collaborative policies and programs.
- Involving local communities, including Aboriginal and Torres Strait Islander people in the decision-making processes, from inception through to monitoring and evaluation.
- Investing in workforce development, including the allied health workforce to enhance their understanding of the interlinkages between climate and health, including the provision of culturally safe and responsive care.
- Advancing the shared and cross portfolio commitments of governments at all levels – local government, states and territories, and the Commonwealth – under the National Agreement to work differently. The National Agreement should provide an avenue to avoid abdication of responsibilities and advance a more collective approach to action.

Some successful examples of collaboration in this area include:

- Climate and Health Alliance
- National Health Leadership Forum
- Healthy Environments and Lives Network

Enablers

24. How could these enablers be improved to better inform the objectives of the Strategy? Should any enablers be added or removed?

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Enabler 1: Workforce, leadership and training

IAHA commends acknowledgement of workforce, leadership and training as one of the key enablers to better inform the objectives of the Strategy. As noted elsewhere, IAHA asserts that commitment to strengthening Aboriginal and Torres Strait Islander workforce locally is critical in achieving a long-term sustainable workforce. A strong Aboriginal and Torres Strait Islander workforce is a powerful driver of change, and evidence clearly shows that an Aboriginal and Torres Strait Islander workforce more broadly delivers better outcomes for Aboriginal and Torres Strait Islander peoples.

In doing so, flexible and innovative solutions are required in education and workforce. This requires the availability of adequate and clear pathways and training in the allied health and environmental health sector. Additionally, to support the workforce to deliver culturally safe and responsive care, racism, and discrimination, including deficit approach must be addressed in all settings including education and training and in the workplace. It also requires content on climate and health to be embedded within all health workforce education and training.

IAHA in close partnership with its members and key stakeholders, operate to have more Aboriginal and Torres Strait Islander people considering, pursuing, and succeeding in education, training, and employment. IAHA achieves this through workforce reform, development and support, with particular focus on the opportunities available in health and related sectors, centring Aboriginal and Torres Strait Islander culture and worldviews. Examples include:

- Cultural supervision and mentoring, tailored to individual needs, and free of racism and discrimination.
- Personal and professional development opportunities that support interprofessional collaboration and networks.

The full implementation of the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031* will also play a crucial role in increasing access to culturally safe care, including ensuring that Aboriginal and Torres Strait Islander people are able to access health care that is responsive to their needs.

Enabler 2: Research

Issues of health equity for Aboriginal and Torres Strait Islander people extend into research and academia. This means, there is a need to invest in and support Aboriginal and Torres Strait Islander researchers to participate in coordinated climate and health research to improve the evidence base and to leverage and value knowledges and knowledge systems. While progress is being made towards research led by Aboriginal and Torres Strait Islander people, IAHA believes Aboriginal and Torres Strait Islander research organisations and researchers need to be given the opportunity to shape and lead Aboriginal and Torres Strait Islander research agenda, where they can embed the empowerment, rights and wellbeing of people and communities. This should include avenues for community identified and led research priorities.

This is also closely aligned with National Agreement Priority Reform Four – Shared Access to Data and Information at a Regional Level, which calls for Aboriginal and Torres Strait Islander partnership and shared decision making in research.

The Lowitja Institute is an example that supports the health and wellbeing of Aboriginal and Torres Strait Islander people through quality, high impact research, and by prioritising

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Aboriginal and Torres Strait Islander leadership. A unique feature of The Lowitja' Institute's process is to fund knowledge translation as part of all commissioned research projects[1].

Enabler 3: Communication and engagement

IAHA highlights that effective communication and engagement with a wide range of stakeholders needs to be context-specific and tailored to the unique needs of individuals and communities, to ensure the impacts of climate change on health and other are widely understood. Communication strategies should also ensure significant attention is given to promoting the health co-benefits of climate action.

However, in the context of Aboriginal and Torres Strait Islander people, IAHA asserts that communication and engagement based on cultural safety and responsiveness is critical, that is determined by Aboriginal and Torres Strait Islander people, communities and organisations. The pandemic response leadership from the sector has highlighted the effectiveness of this approach.

While cultural safety values, behaviours and standards must be embedded within the workplace culture across the health system and adjacent systems, there is still a significant need for consistency in reference to cultural safety to avoid conceptual confusion with similar terms such as cultural competence.

Enabler 4: Collaboration

As noted in the Strategy, it is critical to recognise that Aboriginal and Torres Strait Islander people are the holders of cultural knowledge and practice and must therefore define how the cultural determinants of health are embedded in policy and programs. This means ensuring Aboriginal and Torres Strait Islander leadership and co-design to shift current policymaking and program implementation practices.

While all governments have committed to a new era of partnership, collaboration and shared decision-making under the new National Agreement on Closing the Gap, there is still a long way for genuine relationships and partnerships to be formed, that is based on respect, trust and understanding. Again, the COVID-19 pandemic response, led by Aboriginal and Torres Strait Islander health leaders and ACCHS, is an exemplar of what can be achieved when partnerships are based on empowerment, trust and mutual respect.

Enabler 5: Monitoring and evaluation

IAHA notes the importance of monitoring and evaluation about Aboriginal and Torres Strait Islander people to be driven by priorities set by Aboriginal and Torres Strait Islander people. This includes supporting them to build their capacity and expertise in collecting, using and interpreting data in a meaningful way.

25. For each of these enablers:
    a. What is currently working well?
    b. What actions should the Strategy consider to support delivery?

[1] https://www.lowitja.org.au/content/Image/Lowitja_ClimateChangeHealth_1021_D10.pdf.

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What is currently working well?

1. Workforce, leadership and training

Co-designed in genuine partnership with Aboriginal and Torres Strait Islander people and in strong alignment with the National Agreement on Closing the Gap and the new National Aboriginal and Torres Strait Islander Health Plan, the National Workforce Plan encompasses an approach that is strengths based, preventative and holistic and acknowledges that Aboriginal and Torres Strait Islander leadership is fundamental to drive real action and change to achieve its vision.

Thank you for taking the time to complete this survey – your feedback is greatly appreciated!

Please submit this form in Word format to Health.Climate.Consultation@health.gov.au.

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ACCPA
Aged & Community Care Providers Association

National Health and Climate Strategy Consultation

Submission

31 July 2023

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About ACCPA

Aged and Community Care Providers Association (ACCPA) is the national Industry Association for aged care providers offering retirement living, seniors housing, residential care, home care, community care and related services.

ACCPA exists to unite aged care providers under a shared vision to enhance the wellbeing of older Australians through a high performing, trusted and sustainable aged care sector. We support our members to provide high quality care and services while amplifying their views and opinions through an authoritative and comprehensive voice to the government, community, and media.

Our sector serves to make better lives for older Australians, and so do we.

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1. Introduction

The Aged Care and Community Care Providers Association (ACCPA) welcomes the Government's commitment to the development of Australia's first National Health and Climate Strategy.

ACCPA also welcomes the opportunity to provide feedback to inform the development of the National Health and Climate Strategy and is pleased to note that the aged care sector has been included as an integral part of this consultation process.

According to the World Health Organisation (WHO), climate change is the greatest global health threat facing the world in the 21st century[1] with increased average temperatures contributing to more severe hot weather, storms, floods, and fires. In just over a century, ACCPA notes that Australia's climate has warmed by over 1 degree Celsius.[2] Consequently, we have seen that warmer temperatures have increased the frequency of extreme weather events, such as heatwaves, bushfires, floods, and droughts.

In addition to the impact of flooding and extreme weather events that may cause displacement, older people (many of whom have complex care needs) are more vulnerable to the effects of climate change. For example, they are more prone to dehydration, heat stress, infections and exacerbation of heart and lung disease.[3] Furthermore, the accumulated health effects from climate change not only puts pressure on the already stretched health system and aged care facilities, but also the associated workforce.

ACCPA supports action and initiatives that will address the challenges of climate change and the Government's commitment to net zero emissions by 2050.

This submission has been prepared from an aged care perspective in response to the objectives of the proposed Strategy which include:

- *Measurement* (Measure and report on health system greenhouse gas emissions, so progress in reducing emissions can be tracked and quantified);
- *Mitigation* (Accelerate the reduction of greenhouse gas emissions from the health system);
- *Adaptation* (Strengthen the resilience of the health system and communities to anticipate and respond to the health impacts of climate change); and
- *Health in All Policies* (Maximise the synergies between good climate policy and public health policy by working across policy areas to lessen the impact of climate change on the social and cultural determinants of health and wellbeing).

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[1] WHO https://www.ccacoalition.org/en/news/who-director-general-climate-change-defining-issue-public-health-21st-century
[2] BOM State of the climate 2022 http://www.bom.gov.au/state-of-the-climate/
[3] VIC Government Better Health Channel https://www.betterhealth.vic.gov.au/health/healthyliving/climate-change-and-health

2. Summary of recommendations

R1. Include older people in actions and initiatives to address climate change.
R2. Undertake a pilot project to sample a selection of aged care services and related emissions and identify possible mitigation strategies for further funding support.
R3. Allocate appropriate funding to support the development, implementation, and evaluation of the Strategy and the accompanying action plans.
R4. Develop a roadmap for the Strategy that clearly articulates a timeframe for achieving each milestone and roles and responsibilities of stakeholders tasked with implementation.
R5. Support aged care providers, through additional funding, to develop a comprehensive strategy around environmental sustainability.
R6. Consider how the design of the new in-home aged care program currently being developed by the Government might incorporate funding for older people to consider adaptation of their homes to support their health and wellbeing.
R7. Incentivise aged care providers (through providing financial supports) to pursue projects that will mitigate emissions.
R8. Provide aged care services with guidance to correctly classify and recycle wastes.
R9. Enhance prevention activity by providing more funding for allied health to support Short Term Restorative Care.
R10. Support the use of telehealth for those receiving aged care services, where clinically appropriate.
R11. Consider aged care needs as part of state/territory emergency planning.
R12. Embed the health and climate policy into the Primary Healthcare 10-Year Plan and the National Health Reform Agreement.

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3. Measuring aged care associated emissions

Older people need to be included in initiatives to address climate change to ensure that their specific needs are addressed and to support a national policy framework that sets out cross sector interventions and policies to improve the quality of life of older people.

This means the Strategy not only needs to consider the impact of climate change in the context of residential care, but also older people in the community receiving home care packages and the Commonwealth Home Support Programme (CHSP).

Importantly, the aged care sector must be supported (financially)/prepared for, to manage, the health impacts of climate change (see Recommendation 6 and 8).

While ACCPA notes that the carbon footprint attributed to health care was 7% of Australia's total[4], we are not aware of any specific data/information on the carbon footprint attributed to the Australian aged care sector.

We believe there is a need for this Strategy to address aged care greenhouse emissions specific data so appropriate mapping exercises could be conducted to identify where the gaps are, so appropriate/targeted mitigation strategies could be developed in areas that require improvement.

R1. Include older people in actions and initiatives to address climate change.
R2. Undertake a pilot project to sample a selection of aged care services and related emissions and identify possible mitigation strategies for further funding support.

4. Mitigating emissions

ACCPA recognises that health and the aged care sector are significant contributors to climate change as large consumers of energy, water, and products. They also generate huge volumes of waste.[5]

However, any mitigation strategies to reduce carbon emissions must align with the primary goals of aged care and should always be undertaken in a manner that does not undermine quality of care. For residential care, the primary goals include:[6]

- The provision of a comfortable and safe home for the person;
- The provision of aged care services necessary to meet the care needs of the person;
- Facilitating (not necessarily providing) appropriate health care for the person; and
- Giving regard to and treating every person with dignity and respect.

ACCPA supports the proposed areas of focus for the Australian health care system (as noted in the consultation paper) to reduce emissions, which include built environment and facilities;

[4] The Lancet https://www.thelancet.com/journals/lanplh/article/PIIS2542-51961730180-8/fulltext
[5] ANMF https://www.anmf.org.au/professional/professional-issues/climate-change
[6] AACC Submission to DHAC on A New Residential Aged Care Accommodation Framework Dec 2021

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travel and transport; supply chain; medicines and gases; waste; and prevention and optimising of care.

However, for this to work, ACCPA believes that the strategy will:

- need to be properly funded (such as to support aged care facilities to implement energy upgrades and/or transport subsidies for home care workers)
- need to clearly articulate a roadmap for various deliverables (with timeframes for each deliverable), as well as roles and responsibilities of stakeholders with responsibility for implementation (of action plans)
- need to be accompanied by an evaluation framework that is developed in consultation/collaboration with the relevant stakeholders to ensure regular monitoring and reporting of progress in delivering the Strategy.

Importantly, ACCPA believes that environmental sustainability in aged care is dependent on developing the necessary culture within the organisation and that aged care providers, which will need to be supported/funded in order to develop a comprehensive strategy around environmental sustainability.

R3. Allocate appropriate funding to support the development, implementation, and evaluation of the Strategy and the accompanying action plans.
R4. Develop a roadmap for the Strategy that clearly articulates a timeframe for achieving each milestone and roles and responsibilities of stakeholders tasked with implementation.
R5. Support aged care providers, through additional funding, to develop a comprehensive strategy around environmental sustainability.

5. Adaptation

In discussing adaptation in aged care, it is important to note that aged care providers, through various reforms and compliance requirements, are already being asked to facilitate innovation in care models.

To ask the sector to transition into climate adaptation will take further financial and staff resources. In order to ensure this does not detract from the valuable resources directed to resident care, aged care providers must be adequately supported to adapt to climate change (and to mitigate gas emissions), where appropriate.

5.1 Home care and CHSP providers

The Royal Commission into Aged Care Quality and Safety showed clearly that older people in Australia want to age in their home if they can. Over 1 million older people in Australia will be transitioning to the new in-home aged care program (also known as Support at Home) from 1 July 2024 (a combination of those receiving home care packages and CHSP).

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ACCPA believes the proposed Strategy should consider how the design of the new in-home aged care program (which is still under consideration by the Government) might incorporate or align with new funding or a grant program for older people to consider adaptation of their homes to support their health and wellbeing (e.g., efficient energy heating and cooling systems).

ACCPA notes there is already a home modifications component to the in-home aged care program – eligibility criteria could be adapted to allow for climate-related considerations as a decision of the Government. This approach could benefit both the older person during times of climate extremes and the visiting workforce supporting their care.

R6. Consider how the design of the new in-home aged care program currently being developed by the Government might incorporate funding for older people to adapt their homes to support their health and wellbeing.

5.2 Residential care and retirement living

ACCPA notes that there are a number of early adopters that have successfully reduced their carbon emissions. Regis, for example, has been able to reduce energy consumption by about 20% per year (saving almost 375,000kWh) by implementing energy upgrades to reduce the company's environmental footprint.[7]

NSW provider Warrigal is a leader in embedding environmental sustainability into its strategic plan and organisational culture and is the winner of multiple sustainability awards since its journey began in 2008.[8] Following an energy audit, Warrigal introduced a range of energy efficiency programs including upgrading to LED lighting and replacing older T8 fluorescent lights with less energy demanding T5s. The organisation has also installed cold water laundry systems utilising ozone technology and recommissioned their Heating, Ventilation and Air Conditioning (HVAC) systems to support more efficient energy use.

A commitment to review and identify ways to reduce energy consumption and waste, and to implement an environmental sustainability design standard for new and upgraded buildings, will be key in supporting the aged care sector in mitigating emissions.

However, incorporating design of new builds or renovations of residential aged care facilities to be energy efficient and mitigate emissions is an expensive undertaking (noting many residential aged care facilities are ageing buildings). Given the financial sustainability challenges in residential aged care, capital investment is a big consideration for Boards - the aged care sector should therefore be incentivised to pursue projects that will mitigate emissions.

Waste management represents a significant cost to the aged care sector, as well as contributing to indirect carbon emissions. ACCPA believes correctly classifying waste is a key way to reduce negative environmental impacts (a study conducted in the United States

[7] Sustainability Australia https://www.sustainability.vic.gov.au/energy-efficiency-and-reducing-emissions/in-a-business/success-stories/aged-care-homes-cut-power-bills-by-20-after-energy-upgrades

[8] Australian Ageing Agenda https://www.australianageingagenda.com.au/features/smart-choices-aged-care-goes-green/

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found that 92 per cent of waste from an operating theatre was misclassified as biohazardous and could have been disposed of in the general waste or recycling streams instead[9]).

Recycling programs are also a common aspect of efforts to increase sustainability in healthcare facilities, and are included in government plans in NSW, Victoria and the ACT, as well as guidance from the WHO's European arm.[10] To this end, aged care facilities should be supported (through guidance) to correctly classify wastes and should be incentivised to adopt recycling programs.

Additionally, health care associated emissions are increasing because of an ageing population and changes in the way care are being delivered.

One clear pathway for reducing emissions is by keeping people healthy and out of the health system through prevention, which includes taking measures to keep people healthy and avoid the onset of illness, disease, or injury. In this context, Short Term Restorative Care has been shown to improve health outcomes for older people (thus reducing the need for complex care),[11] and should be given a higher priority. Furthermore, technological innovations such as e-health, live data sharing and teleconferencing can also increase efficiency in healthcare systems, thereby alleviating environmental impacts.

R7. Incentivise aged care providers (through providing financial supports) to pursue projects that will mitigate emissions.
R8. Provide aged care services with guidance to correctly classify and recycle wastes.
R9. Enhance prevention activity by providing more funding for allied health to support Short Term Restorative Care.
R10. Support the use of telehealth for those receiving aged care services, where clinically appropriate.

5.3 Flood and weather emergencies

Importantly, and considering flooding is a key issue, ACCPA believes aged care facilities should not be built in flood prone areas, where possible.

This issue was evident in recent events in QLD, VIC, NSW and SA where vulnerable aged care residents have had to be evacuated due to flooding. In Brisbane, for example, the affected home's residents — some of whom had severe dementia — were left in rooms in the higher floors for more than 24 hours without electricity before they could be evacuated.

All aged care providers (including home care and CHSP providers) that may be impacted by flood and weather emergencies must have emergency management plans. These should consider how safe and quality care of residents will continue to be delivered, and where this

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[9] Windfeld ED and Brooks MS. Medical waste management – a review. Journal of Environmental Management 2015 ;Nov (63):98-108.
[10] World Health Organisation Regional Office for Europe. Environmentally sustainable health systems: a strategic document. Copenhagen: WHO Europe, 2017
[11] From Dr Tim Henwood's presentation on innovative approaches for SRTC in community aged care, Southern Cross Care

will occur should potential evacuation be required; and how providers will access additional disaster management supports, as required.[12]

Importantly, where appropriate, providers should be supported to continue to deliver appropriate care in accordance with their emergency risk management plan and relevant aged care programs, and provide regular advice to staff, family and care recipients.

R11. Consider aged care needs as part of state/territory emergency planning.

6. Health in All Policies

ACCPA agrees that existing inequities mean some groups are at a disproportionately increased risk of adverse health impacts from climate change. This includes the First Nations people, culturally and linguistically diverse (CALD) communities and people living in rural and remote areas.

The Strategy should emphasise the need to address the implications (impact on disadvantaged groups) through joined up policy – a Health in All Policies approach.

In addition to Transport Policy, Housing Policy, and Food, Agricultural Policy as noted in the consultation paper, ACCPA believes Climate and Health Policy should be incorporated into the Primary Healthcare 10-Year Plan, to mitigate emissions because of primary care activities.

Additionally, the policy (particularly issues relating to roles and responsibilities) should be embedded in the National Health Reform Agreement so that appropriate funding and accountability for mitigating emissions could be equitably allocated across state and territories.

R12. Embed Health and Climate Policy into the Primary Healthcare 10-Year Plan and the National Health Reform Agreement.

7. Contact

If you have any further questions or would like to discuss, please contact us at [redacted]

[12] Department of Health and Aged Care https://www.health.gov.au/sites/default/files/documents/2022/03/health-support-for-aged-care-in-flood-affected-regions_0.pdf

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31 July 2023

Department of Health and Aged Care
Email: Health.Climate.Consultation@health.gov.au

National Health and Climate Strategy

La Trobe welcomes this draft National Health and Climate Strategy (NHCS) and the opportunity to participate in this consultation.

As a university with a long history in public health research and scholarship and having recently established Australia's first Climate Change Adaptation Lab to drive inter-disciplinary research, La Trobe welcomes the opportunity to participate in this important process.

Our Department of Public Health, and its associated Research Centres, works to improve the health of individuals and of society by building the capacity of practitioners working in a range of areas, to protect and promote health in organisations, workplaces, local communities and the population more broadly. Simultaneously, we are training the future health workforce with thousands of students enrolled in our multi-campus network across Victoria. In tandem, our newly-established Climate Change Adaptation Lab is aiming to advance large-scale adaptation, action-based learning and peer knowledge exchange on climate change.

La Trobe strongly endorses the NHCS's focus on First Nations' leadership and experience as well as on the environmental determinants of health. In addition, the consultation paper usefully sets out the crucial role the health sector plays in our response to climate change impacts. It also provides an extensive list of negative health outcomes that underscore the challenges health services face under climate change. We argue that these challenges are even more significant when one considers that health sector workers are also being affected by the same impacts they are responding to - they are part of the communities they serve. **On the basis of our preliminary research, we therefore recommend that the NHCS should focus on the adaptation and the resilience of the health sector and its workers to climate change.** While this is implied in the discussion paper, we believe it should be a key objective of the strategy. Our research, which is further outlined in the submission, indicates that climate change is negatively impacting the capacity of the health system. Further research is needed to provide a better understanding of the impacts of climate change on health workers.

La Trobe welcomes in particular the 'Health in All Policies' objective, which is the kind of systemic approach that is required for climate change adaptation. While the paper goes in the right direction, we believe that health-climate change nexus should be addressed via a whole-of government approach which usefully includes the input of other departments such as the Departments of Housing and Social Services. Another key factor is the need to investigate the implications of climate change for some of the upcoming expected trajectories in health care. For instance, as with aged care, health care is shifting from care delivered in a hospital setting to being delivered at home. These shifts (including for instance accessing point of care assessments, diagnostic tests and robotic surgery) all have environmental costs and benefits that are not explored.

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Drawing on La Trobe's presence in regional Victoria, we also recommend that that the NHCS include an explicit focus on the intersections between health outcomes and rural and regional development.

Our response to select questions from the consultation paper follows. In a separate attachment, La Trobe's John Richards Centre for Rural Ageing Research explores the links between climate change and the impact on the ageing community.

La Trobe looks forward to working with the Department of Health and Aged Care towards the formulation and implementation of the NHCS strategy. Further information about any of the research and/or points raised in our submission can be provided upon request.

Yours faithfully



Attachment 1: National Health and Climate Strategy Long Template Response

NATIONAL HEALTH AND CLIMATE STRATEGY

Detailed submission form

This form allows you to provide responses to the full set of questions in the Consultation Paper available here.

Alternatively, you may wish to complete the briefer online survey available here.

Please submit this form in Word format to Health.Climate.Consultation@health.gov.au.

Respondent details

What is your name?
[redacted]
What is your email address?
[redacted]
What is your organisation?
La Trobe University
Have you read and agreed to the Privacy Statement? (NB we will not be able to use your submission unless you tick this box)
☒ I have read and agreed to the Privacy Statement
Do you identify as Aboriginal and/or Torres Strait Islander? (Yes/No/Prefer not to say)
[redacted]
Please select which applies to you: ☐ Individual citizen ☐ Health Service Provider ☐ Industry and Life Sciences Organisation or Representative ☐ Academic or Researcher ☐ Primary and/or Allied Health Peak or Advocacy Organisation or Representative ☐ Aged Care Service Provider ☐ First Nations Health Service Provider ☐ First Nations Community Group ☐ First Nations Peak or Advocacy ☐ Medical College or Peak professional bod

Questions for feedback from the Consultation Paper

Introduction

1. How could these objectives be improved to better support the vision of the Strategy?

Objective 1- Measuring health system greenhouse gas emissions

- The paper questions what we know about health system greenhouse emissions in Australia. We submit that an equally important question is to explore the ways health organisations and health professionals demonstrate or advocate for community actions to reduce greenhouse emissions. For instance ,some health organisations are already ahead of what is proposed in the strategy in their own practice and are playing a leadership role, e.g. the Australian Medical Association declared climate change as a health emergency in 2019 (https://www.ama.com.au/media/climate-change-health-emergency).
- While measuring emissions is crucial, adaptation success relies on the monitoring of climate change impacts in order to better understand how climate change works and how it is already affecting Australians and the health system. The Consultation Paper only refers to the measurement of impacts and vulnerabilities related to health services as a footnote to Objective 1: Measurement 1. The monitoring and measurement of climate change vulnerabilities, risks and impacts should be a priority within the measurement objective. Without understanding how impacts are distributed today, we cannot understand what risks we face and what adaptation is needed and possible.
- In particular, it is important to monitor the impacts on planetary health, health and aged care services, and other sectors that play an important role in human health. This should be an essential function of the proposed national Centre for Disease Control.

Objective 2 – Mitigation

- Beyond accelerating the reduction of greenhouse emissions from the health system, mitigation should also entail 'ways to influence the wider communities to reduce greenhouse gas emissions'

Objective 4 – Health in all policies (HiAP)

- This Objective reflects the systemic thinking that is needed and is welcomed. Given that adaptation is needed to enable health and wellbeing, an HIAP approach is a route for adaptation. That is, HIAP should be approached as a way of inserting not only health but the enabler of positive health outcomes – climate change adaptation of all social and environmental determinants of health - into all policies. More broadly, human health and wellbeing could be usefully positioned as the ultimate objective of climate change adaptation, offering a vision and focus for all adaptation efforts. In other words, the National Climate and Health Strategy could be a beacon for adaptation across the Australian Government.

- More specifically, HIAP needs to include an explicit focus on the intersections between health and rural and regional development. These intersections are twofold:

- Access to health services by rural and regional residents and how it may be affected by climate change needs consideration: Ageing populations in regional areas in conjunction with hotter summers can be expected to increase demand for health services (Israelsson

[1] Footnote 8: While our proposed Objective 1 is focused on measuring health system greenhouse gas emissions, we recognise there are many other measurement challenges related to climate change and health – such as measuring environmental exposures and vulnerability indicators related to the resilience of health services to climate change. These are listed under Objective 3 on adaptation.

et al., 2022), and along with other extreme events, such as floods and fires, make accessing services more difficult. Telehealth may provide an alternative in some circumstances, but also has implications for the second intersection: the health workforce.

- The health workforce: Health care and community services has become the major industry of employment across rural and regional Australia (Li et al., 2022), therefore how the sector responds to the urgent need for climate change mitigation and adaptation has implications for regional communities. For example, the inclusion of scope 3 emissions associated with clients accessing services in targets has spatial implications due to the distances required for regional people to access services. If scope 3 emissions are not omitted, the likely outcome is a concentration of employment in major cities. Similarly, for adaptation, a focus on resilient regional communities as a result of a resilient health care system may also lead to a more equitable spatial distribution of employment in the sector.

- HIAP is an important objective, but equally important is the related objective of "One Health or Planetary Health". We have to define health as one for the entire planet, not just about health of human beings. The Australian Veterinary Association also recognises climate change as a global emergency.

2. How could these principles be improved to better inform the objectives of the Strategy?

Principle 1 - First Nations leadership

- La Trobe strongly endorses and welcomes this principle. Linked to Principle 2, it is important to recognise the inequality of climate change impacts on health, especially for First Nations people. Those who are socioeconomically disadvantaged are disproportionately impacted by climate change although they contribute less to carbon emission.

Principle 2 – Tackling health inequities

- The principles of health promotion should be followed, which include "Enable, Mediate, Advocate". We need to mobilise the whole society to respond to the challenges of climate change. The role and functions of the health system are not limited to the health care sector and the patients who seek help from health care. The health system should advocate and lead community responses to climate change.

Principle 3 – Population health and prevention

- Issues relating to the prevention of disease and maintenance of health should be included in 'health promotion'.

Principle 4 – One Health

- We welcome the inclusion of "One Health" as a principle and the systems thinking that it requires. It underlines the ecological relations that connect human and natural systems, the need for improved environmental sustainability as part of a health strategy, and the need for a global health lens. In advancing this boundary-crossing approach, it is important that Australia does so through international collaborations.

Principle 5 – Evidence-informed policymaking

- La Trobe strongly endorses this point and also welcomes the recognition that "we must also be willing to take action on a prudent and precautionary basis in the face of

uncertainty and incomplete information". Indeed, there are many areas that require further research.

Principle 6 - Partnership-based working across all levels of government and beyond

- It is important to ensure that "communities" also covers various industries and workplaces. It is preferable to make their inclusion explicit.

3. Which of the various types of greenhouse gas emissions discussed above should be in scope of the Strategy's emission reduction efforts?

4. What existing First Nations policies, initiatives, expertise, knowledge and practices should the Strategy align with or draw upon to address climate change and protect First Nations country, culture and wellbeing?

As outlined in the response of the John Richards Centre for Rural Ageing Research (see Attachment 2), we welcome the fact that the NHCS acknowledges the importance of learning from Indigenous knowledge to address the impact of climate change on health. In keeping with the First Nations' understanding of good health, this response recognises that connections to community are important for the health and wellbeing of ageing populations. For older people in rural areas, distance can be a significant barrier to their participation in community activities.

5. What types of governance forums should be utilised to facilitate co-design of the Strategy with First Nations people to ensure First Nations voices, decision-making and leadership are embedded in the Strategy?

Proposed Objective 1: Measurement

6. Beyond the schemes already noted above, is your organisation involved in any existing or planned initiatives to measure and report on health system emissions and/or energy use in Australia?

No

7. What additional data and information is required to support targeted emissions reduction efforts within health and aged care?

- Measuring emissions must first entail a robust understanding of where emissions are being generated and why, which requires in turn a robust understanding of how parts of our interconnected systems are linked.

- As in other sectors, the big challenge for health sector emissions reduction is tackling Scope 3 (supply chain) emissions. There is a natural synergy between a focus on interconnected supply chains and networks, and the boundary-crossing approaches of HIAP and One Health. Research on the linkages envisaged through HIAP and One Health could improve our understanding of how the health sector functions in practice, and is imbricated in infrastructural systems and other sectors, which in turn could help inform analysis of how the health sector is contributing to and could help reduce emissions. Furthermore, a systems analysis of health system parts and practices would be useful to

understand where and how the system is most exposed, sensitive and vulnerable to direct and indirect climate change impacts.

Proposed Objective 2: Mitigation

8. What do you think of these proposed focus areas for emissions reduction? Should anything else be included?
9. Which specific action areas should be considered relating to the **built environment and facilities (including energy and water)**, over and above any existing policies or initiatives in this area?
10. Which specific action areas should be considered relating to **travel and transport**, over and above any existing policies or initiatives in this area?
11. Which specific action areas should be considered relating to **supply chain**, over and above any existing policies or initiatives in this area?
12. Which specific action areas should be considered relating to **medicines and gases**, over and above any existing policies or initiatives in this area?
▪ The disposal of unused medications is also a risk for greenhouse gas emissions. ▪ Pharmacists need to be trained on ways to reduce medications waste i.e. stock management, rotating stock, monitoring hoarding by patients and creating ways for their safe disposals.
13. Which specific action areas should be considered relating to **waste**, over and above any existing policies or initiatives in this area?
▪ Identify policies to reduce medications hoarding and safe disposal of medications
14. Which specific action areas should be considered relating to **prevention and optimising models of care**, over and above any existing policies or initiatives in this area?
▪ Review duplication of care provided to patients by both primary and secondary care
15. What can be done to involve private providers within the health system in the Strategy's emissions reduction efforts?
16. Where should the Strategy prioritise its emissions reduction efforts? a. How should the Strategy strike a balance between prioritising emissions reduction areas over which the health system has the most direct control and prioritising the

areas where emissions are highest, even if it is harder to reduce emissions in these areas?

b. Which of the six sources of emissions discussed above (on pages 13 to 18 of the Consultation Paper) are the highest priorities for action?

17. What 'quick wins' in relation to emissions reduction should be prioritised for delivery in the twelve months following publication of the Strategy?

Proposed Objective 3: Adaptation

18. What health impacts, risks and vulnerabilities should be prioritised for adaptation action through the Strategy? What process or methodology should be adopted to prioritise impacts, risks and vulnerabilities for adaptation action?

- The National Health and Climate Strategy Consultation Paper sets out some of the many health impacts and risks society faces under climate change, and the crucial role the health sector plays in responding to and preventing them. At the same time, the health system itself is being impacted by climate change. The degree to which and ways in which it is being stressed and disrupted by climate change in turn negatively affect human health outcomes. This is not only because the increased demand for health services creates a relative deficit in supply, but because the same pressures are concurrently directly affecting that supply - reducing the capacity of the health system in a myriad of ways.

- A key way that the health system is being affected and transmits impacts onto society is because health systems workers are being hampered by climate related stressors and disruptions. That is, workers in the health sector are being affected by the same impacts they are responding to - they are part of the communities they serve. Our research report, Climate Impacts At Work: Supporting a climate-ready workforce (Denham & Rickards, 2022), surveyed more than 1,100 members of six Victorian unions about how climate change was affecting them, their work and the organisations that employ them. In total, 192 members of the Health and Community Services Union responded to the survey, including allied health providers, carers, mental health nurses and other hospital workers. A direct impact on the health system and its work is that 63% of workers reported that they had experienced difficulties with clients due to climate, and more than half of the respondents reported reduced productivity. Reduced productivity is also linked to tiredness and fatigue (74%), reduced sleep quality (58%) and headaches (53%) due to climate change. In addition, 39% of the workers indicated that climate change was impacting on their mental health. It was not only through health impacts that work was affected, 42% reported transport disruptions, affecting their ability to attend work. More significant for workers is that 2% had lost their jobs as a result of climate impacts, and 11% had their working hours reduced. Other impacts included blackouts, OH&S incidents, impacts to buildings and equipment, and supply chain disruptions. The strong indication from this research is that for health workers to fulfil their role in helping the community respond to climate change, they need to be made resilient first. Much like any other emergencies, health needs to save itself before it can save others.

- There is a clear need to focus on the adaptation and resilience of the health sector and its workers. This is implied within the discussion paper, but in our view, this needs to be made a primary objective of the strategy.

- The research cited in this submission is preliminary, indicating that climate change is impacting on the capacities of the system, but far more research is needed to provide a better understanding of climate change impacts on health workers. This includes research across Australia, to reflect the localised nature of climate impacts, as well as additional members of the health workforce: doctors, nurses, paramedics, and ambulance workers. It also includes research into neglected elements of the health system. This includes social and environmental determinants of health that are emphasised by the Health in All Policies framework, including the infrastructural and systemic interdependencies of the health system and the many SMEs and NGOS involved.
- One of the neglected implications of recognising that health outcomes are shaped by many sectors is that "the health workforce" also necessarily expands. Thus the workers and systems that need to be adapted to climate change include those outside the formal health sector. The health sector needs to play a key role in helping advocate for adaptation in other sectors and leading adaptation more widely. This includes but is not limited to recognising workplaces as themselves a social and environmental determinant of workers' health and therefore, a need to adapt OHS and human resources management across all sectors to climate change.

- A second key way the health system is at risk of climate change is via its systemic interdependencies, notably its reliance on the functional reliability of numerous other sectors: transport (passable roads and bridges), energy (electricity and gas – most backup generators only last short periods), water and sewerage, finance and ICT, to name a few. Over longer time frames, the sector is highly reliant on the education sector to educate and train workers, and the environment sector to help maintain environmental determinants of health. In other words, the HIAP vision of health at the centre of multiple sectors needs to be converted into a map of interdependencies and possible climate change-related vulnerabilities. That is, inadequate adaptation and disaster response in the sectors it relies on will stress and disrupt the health system and thus health outcomes, triggering feedbacks into the other systems that rely on healthy humans to work in them. Research is badly needed on this issue.

19. Should the Australian government develop a National Health Vulnerability and Adaptation Assessment and National Health Adaptation Plan? If yes:
    a. What are the key considerations in developing a methodology?
    b. How should their development draw on work already undertaken, for example at the state and territory level, or internationally?
    c. What are the key areas where a national approach will support local/jurisdictional vulnerability assessment and adaptation planning?

- As indicated above, there is a need to develop conceptual frameworks for understanding climate change impacts and their effect on the health care system, and to address the intersections of health with other sectors and policies.

- More broadly, HIAP and One Health underscore the need to better understand human health in systemic and interconnected ways. For example the links to agriculture through food security and in some circumstances zoonotic diseases, highlight the need for frameworks to support systemic health research. There is important work being done on extreme events and natural hazards, such as the Natural Hazards Research Australia, but

less on the complex ways that climate change will impact on the health and care needs of Australians in their day-to-day lives in less extreme circumstances.
20. Would there be value in the Australian government promoting a nationally consistent approach to vulnerability assessment and adaptation planning for the health system specifically, for instance by issuing guidance and associated implementation support tools for states, territories and local health systems? If yes, what topics should be covered to promote a nationally consistent approach? What examples of existing guidance (either from states/territories or internationally) should be drawn from?
21. What immediate high-priority health system adaptation actions are required in the next 12 to 24 months?
▪ To enable people to cope with the next disasters, it is vital to relieve pressure on the health system workforce (increase funding, staff ratios) as quickly as possible and accelerate existing disaster recovery processes. Only by avoiding the worst of climate related disaster stress will we be in a position to do the hard work of long-term adaptation and mitigation.

Proposed Objective 4: Health in All Policies

22. What are the key areas in which a Health in All Policies approach might assist in addressing the health and wellbeing impacts of climate change and reducing emissions?
▪ As indicated above, there are three main aspects of HIAP that open up important opportunities for climate change action: ▪ 1. Use the systems thinking of HIAP to map interconnections with other sectors/systems/supply chains and use this in turn to identify and address emissions and exposure, sensitivity and vulnerabilities to climate-related stresses and disruptions ▪ 2. Piggyback adaptation to HIAP to help embed adaptation (as an enabler of health) into all policy areas ▪ 3. Position human health and wellbeing, and their social and environmental determinants, as the ultimate focus of climate change adaptation in order to focus and galvanise adaptation efforts across sectors and evaluate adaptation success.
23. What are the most effective ways to facilitate collaboration and partnerships between stakeholders to maximise the synergies between climate policy and public health policy? What are some successful examples of collaboration in this area?
The first step would be identifying important key stakeholders.

Enablers

24. How could these enablers be improved to better inform the objectives of the Strategy? Should any enablers be added or removed?
▪ Instead of talking about Enablers, we recommend talking about 'system building'. According to the World Health Organization, this should cover Governance; Health Financing; Human Resources for Health; Service Delivery; Medical Products, Vaccines, and Technologies; and Health Information Systems. For each building block, we could then discuss "enable, mediate, advocacy" for adequate response to the health challenges of climate change. ▪ We agree it is important to map the current existing research and it is very important to identify current gaps.
25. For each of these enablers: a. What is currently working well? b. What actions should the Strategy consider to support delivery?

Thank you for taking the time to complete this survey – your feedback is greatly appreciated!

Please submit this form in Word format to Health.Climate.Consultation@health.gov.au.

Attachment 2: JRC response to the National Health and Climate Strategy Consultation paper



The John Richards Centre for Rural Ageing Research welcomes the opportunity to provide a submission in response to the National Health and Climate Strategy.

The National Health and Climate Strategy acknowledges the importance of learning from Indigenous knowledge to address the impact of climate change on health. In keeping with the First Nations' understanding of good health, this response recognises that connections to community are important for the health and wellbeing of ageing populations (Feist et al., 2010). For older people in rural areas, distance can be a significant barrier to their participation in community activities. However, technology is increasingly providing solutions for connecting rural older people with their communities (Feist et al., 2010; Wilding et al., 2022).

Within the context of climate change, however, as with environmental disasters, technology such as mobile phone networks can have limits. In any case, many older people living in rural areas experience digital disadvantage (Park, 2017) and for some older people, anxiety around technology can be a barrier to connection, rather than an enabler (Kim et al., 2023). In terms of achieving good health for older Australians, particularly in rural areas, community needs to be real as well as virtual. Climate change strategies therefore need to consider supporting geographical communities at the local level, to become resilient.

The Strategy recognises that actions need to be taken to build the resilience of communities, however, it does not offer a definition for the highly contested term, 'resilience'. In supporting the notion of building resilience, this response considers the following definition:

> *Community resilience is the existence, development, and engagement of community resources by community members to thrive in an environment characterised by change, uncertainty, unpredictability, and surprise. Members of resilient communities intentionally develop personal and collective capacity that they engage to respond to and influence change, to sustain and renew the community, and to develop new trajectories for the communities' future* (Magis, 2010, p. 402).

Critically, older adults have a significant role to play in building resilient communities, through their knowledge and lived experience as well as through leadership roles, and their contributions have important implications for public health (Madsen et al., 2019).

As recognised by the Objectives of the Strategy, the resilience of communities as well as the resilience of the health system are important to responding to the health impacts of climate change. Resilience in the context of public health has been defined as "the capacity for populations to endure, adapt and generate new ways of thinking and functioning in the context of change, uncertainty or adversity" (Seaman et al., 2014). Through a resilience lens, the development of strong communities benefits public health, and resilience in health systems needs to be considered across the contexts of culture, economics, governance

and infrastructure (Seaman et al., 2014). The importance for all levels of government to build partnerships with communities as part of the response to climate change is recognised in the Principles of the Strategy.

Stronger communities which aim to achieve good health for older people must not only be resilient, but they must also be inclusive. The relationship between age-friendly and resilient communities has been recognised by the New York Academy of Medicine in their study investigating the needs and roles of older adults during Hurricane Sandy, which was conducted with a view to improving disaster preparedness and responses for older adults (Goldman et al., 2014). In that dementia-friendly initiatives address the inclusion of people living with dementia, they may also be seen to contribute to building stronger communities. Strong, inclusive communities are especially important for older people, given that a growing number of older adults wish to remain in their communities, or 'age in place' (Rose et al., 2023).

Older farmers in rural areas also desire to 'age on farm' (Hadmin, 2023), as farmers experience a relationship to the land that contributes to their health and wellbeing (Lamb, 2023). While climatic challenges can weaken community resilience in rural agricultural areas (O'Meara, 2019), for farmers, connections to their community facilitate a sense of belonging which contributes to rural resilience (McManus et al., 2012). Strategies to support older people to age in place, and farmers to age on farm are therefore important.

Supporting older people to continue to live in their communities should therefore be a priority for both building resilient communities and a resilient health system. As recognised by the Strategy, keeping people healthy contributes to the reduction of unnecessary emissions, as does the implementation of sustainable models of care. Community-based care can help achieve healthcare sustainability goals, as the delivery of healthcare in a community setting typically generates fewer emissions than the high resource use of hospitals (Sherman et al., 2023). In addition, patient experiences in community-based care can be more positive than in acute care settings (Sherman et al., 2023). Community-based care can therefore play an important role in a climate health strategy. Importantly, however, workforce shortages in rural areas need to be addressed, identifying opportunities for influencing place-based social processes which currently impact retention rates (Cosgrave et al., 2019). In addition, older people living in rural areas rely heavily on informal support networks and community care programs (Hodgkin et al., 2022), the sustainability of which needs to be assessed.

As the Strategy recognises, older people can be especially vulnerable to climate change for several health-related reasons. It is important however, not to view older adults as being vulnerable in general and in need of assistance, rather, from a resilience perspective, older adults – while supported by services and agencies as needed – should be viewed as having much to contribute to building community resilience (Madsen et al., 2019). The Strategy also recognises that many older people live alone and have limited social support networks. Older people who live in rural communities experience disadvantage and are at risk of social isolation (Winterton & Warburton, 2011), and a focus on building resilient communities which address disadvantage as a barrier to inclusion should be part of a health and climate strategy.

Part of a resilient community approach includes equitable access to the services and amenities of a community (Anderson et al., 2022). The Strategy recognises that active transport may be difficult in remote areas. While many councils have adopted walking and cycling strategies, active transport may not be possible for many older people and people with disabilities, and most councils recognise of the continued need for public and community transport to support mobility for older people. A study which

investigates how the access, and equity of access, of three communities were impacted following transportation network disruptions recommends that a broader view of the transportation network's role be adopted in preparation for and responses to disruptions and natural hazards (Anderson et al., 2022). This should be considered.

Lastly, the Strategy recognises the need for housing which offers thermal comfort, lowers energy costs, and increases community connectedness. These factors are all important to many older people who are isolated in their communities, who are susceptible to weather extremities, and for whom energy costs may currently be an economic burden. Importantly, aged care homes should be included in housing policies, and houses for older people should be co-designed or co-created, to ensure that the needs of older people are addressed (Soebarto, 2022).

In closing, some of the issues raised in this response have been or are being addressed by various initiatives, and supplementary information is provided below.

Thank you for the opportunity to respond to the National Health and Climate Strategy Consultation paper.

Supplementary information (links)

La Trobe University, Helping Older Farmers Age in Place
https://www.latrobe.edu.au/news/articles/2023/release/helping-older-farmers-age-in-place

Verily Connect, an Australian Government initiative
La Trobe University, Swinburne University, Flinders University, University of Newcastle, and University of Saskatchewan (Canada). Funded by the Australian Government Department of Health under the Dementia and Aged Care Services (DACS) funding round.
https://verilyconnect.org.au/about/?type=1

Heathcote Dementia Alliance, various projects including Care Cabins, the design of which is informed by Passive House (design principles), Off the Grid (solar power), Assistive Technology, and published design principles for dementia.
https://heathcotedementia.org/projects

Dementia-friendly communities which adopt a whole-of-community approach to reducing the stigma and supporting community members living with dementia.
https://www.alzheimerswa.org.au/consultancy-services/dementia-friendly-communities/

Ageing in place, a community-managed approach to home care using self-managed home care packages and support provided by a local workforce.
https://www.cotaqld.org.au/program-and-services/concluded-programs/ageing-in-your-community/

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Australian Government
Department of Health and Aged Care

NATIONAL HEALTH AND CLIMATE STRATEGY

Detailed submission form

This form allows you to provide responses to the full set of questions in the Consultation Paper available here.

Alternatively, you may wish to complete the briefer online survey available here.

Please submit this form in Word format to Health.Climate.Consultation@health.gov.au.

Respondent details

What is your name?
[redacted]
What is your email address?
[redacted]
What is your organisation?
Australian Psychological Society
Have you read and agreed to the Privacy Statement? (NB we will not be able to use your submission unless you tick this box)
☒ I have read and agreed to the Privacy Statement
Do you identify as Aboriginal and/or Torres Strait Islander? (Yes/No/Prefer not to say)
[redacted]
Please select which applies to you: ☐ Individual citizen ☐ Health Service Provider ☐ Industry and Life Sciences Organisation or Representative ☐ Academic or Researcher ☒ Primary and/or Allied Health Peak or Advocacy Organisation or Representative ☐ Aged Care Service Provider ☐ First Nations Health Service Provider ☐ First Nations Community Group ☐ First Nations Peak or Advocacy ☐ Medical College or Peak professional body

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31 July 2023

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Environmental Health and Climate Change Branch
Office of Health Protection
Australian Government, Department of Health and Aged Care

Emailed to: Health.Climate.Consultation@health.gov.au

Dear Environmental Health and Climate Change Branch members,

APS Response to the National Health and Climate Strategy

The Australian Psychological Society (APS) is pleased to provide a response to the National Health and Climate Strategy consultation. The impacts of climate change are a particular interest of the APS, as detailed in our Position Statement: *Psychology and Climate Change*[1]. Psychologists are experts in human behaviour and use evidence-based psychological interventions in many aspects relevant to the mitigation of and adaptation to the effects of climate change.

The APS has an established history of working collaboratively with the Australian, State and Territory governments and other agencies to help address major social, emotional and health issues for local communities and ensure healthcare is equitable and accessible to all. We would like to extend our collaboration with Government to assist in the implementation of the National Health and Climate Strategy to ensure that its implementation is as immediately impactful as possible.

As with all our work at the APS, we consider this in light of the Sustainable Development Goals (SDGs)[2]. Undoubtedly, of particular relevance is SDG 13 which aims to "Take urgent action to combat climate change and its impacts"[3] but this work also critically interacts with SDG 3 which aims to "ensure healthy lives and promote well-being for all at all ages"[4].

In addition to the overall recommendations below, we have provided targeted responses to some of the questions in the long response survey. For brevity, we have omitted the questions which are outside the scope of the APS.

Upon consideration of the *National Health and Climate Strategy Consultation Paper (the Consultation Paper)*, the APS recommends:

- **Strengthening the urgency and individual responsibility of the strategy –** climate change has been identified as the biggest threat to global health in the 21st century[5]. As can be seen in the Intergovernmental Panel on Climate Change (IPCC) AR6 Climate Change 2023 Synthesis Report[6], we are at a critical juncture where immediate action has the potential to prevent catastrophic impacts which will be felt for potentially thousands of years into the future. The IPCC identified a low sense of urgency as a key barrier to adaption[6] which has

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ABN 23 000 543 788

been a strong point of advocacy for the APS[1]. Throughout the *Consultation Paper*, the language to describe climate change and articulate its effects is often written in the future tense and with subjunctive mood – which reinforces the notion that it is something abstract and happening in time as opposed to an urgent need that is happening now. The necessity of immediate action must be clearly communicated.

- **Highlighting the strong, multi-faceted interactions between the effects of climate change and mental health and wellbeing:** it is well established that there are both direct and indirect impacts of climate change on mental health[7,8]. The effects of climate change need to be elevated and prioritised in the Strategy as more evidence becomes available. They underpin many other aspects of health, wellbeing and an individual's capacity to contribute to the broader community.

- **Integrating the strategy with other sectors and initiatives:** As acknowledged in the Consultation Paper, the success of the strategy depends on a 'health in all policies approach'. Further to this, to prevent duplication of efforts and the Strategy operating in a 'silo', it is essential that the strategy and initiatives are integrated with the work from other sectors and organisations. As a member of the Climate and Health Alliance, the APS strongly advocates for the adoption of the *Healthy, Regenerative and Just' Framework* to underpin a holistic approach.[9] This framework sets out actions and responsible stakeholders to support communities to mitigate and adapt to the effects of climate change. We support the IPCC in their statement that "Maladaptation can be avoided by flexible, multi-sectoral, inclusive, long-term planning and implementation of adaptation actions, with co-benefits to many sectors and systems[6(p. 19)]".

- **Including psychological science to support initiatives to motivate and promote behaviour change:** climate change adaptation and mitigation can be facilitated by all levels of government working toward a common goal. At a national level, psychologically informed and evidence-based initiatives which support pro-environmental behaviour should be supported [1,see 10].

- **Supporting the psychologists and mental health professionals affected by climate change:** recent research shows that since 2019, 31% of psychologists have been personally affected by climate-related disasters[11]. In these situations, psychologists often have a role to support the community while also having lived experience of the disaster themselves. Dual roles are particularly common in rural and remote areas. Psychologists need systemic and organisational support to engage in committed self-care and to be trained and professionally supervised to manage these roles in the community[11].

- **Growing the psychological workforce to sufficient meet demand and prepare for the future:** The APS is cognisant of the current workforce shortages across the entire mental health sector[12]. Governments need to work together to implement policies and initiatives that grow the psychology workforce to ensure the chronic undersupply of psychologists does not continue. In previous submissions and correspondence [e.g 13], the APS has called on governments to (1) appropriately fund advanced psychology university courses, (2) support paid psychology placements and their coordination, and (3) provide adequate provisions for supervisors (including training). The APS thanks the Government for initial support in some of these initiatives, but more is needed to ensure the workforce has the scale to support Australia in the challenging times ahead.

- **Equipping Australians to be more resilient to the effects of climate change**: the scale of the impacts of climate change require a public health, preventative approach to provide Australians with the psychological tools and resources to be resilient to climate change

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impacts[1]. Ideally, this should be facilitated at a community level to distribute the responsibility beyond health professionals.

- **Ensuring psychological expertise is incorporated into the Strategy's governance structures:** psychologists have an evidence-informed understanding of many aspects that are critical to the success of the Strategy.

The APS looks forward to working collaboratively with the Environmental Health and Climate Change Branch as the Strategy is implemented. If any further information is required from the APS I would be happy to be contacted through my office [redacted]

Yours sincerely

[redacted]

[redacted]

Questions for feedback from the Consultation Paper

Introduction

1. How could these objectives be improved to better support the vision of the Strategy?
Overall, the objectives are clear and direct, however, written in a high-level sector/systemic focus which may minimise the personal impact for any individual in the system. Ideally, it should include something aspirational that evokes hope and connection. If the Strategy is to genuinely engage with mitigating and improving the health of Australians (specifically including mental health), it must be pitched in a way that is more ambitious, with specific objectives and timeframes for action. We acknowledge that details regarding initiatives may be developed later, however, it is important that the urgency and conceptualisation of the Strategy in terms of reaching particular targets is clear. We also wish to draw attention to the following: • **Measurement** – in addition to reporting on the health system emissions, health professionals' knowledge, confidence, and use of strategies to address the effects of climate change should also be measured. However, importantly we note the current high administration burden on psychologists[11]. Importantly, any data that is collected is used to inform and refine the Strategy and related initiatives and is not considered an end 'objective' in itself. • **Social determinants of health** – as psychologists, our members are keenly aware of the impact that housing, infrastructure, displacement, and workplace conditions can have on health by impacting mental health (page 3)[14]. Despite these factors being affected by climate change, addressing such social determinants of health is not directly in the scope of the Strategy. • **Importance of integration** – At this stage, it is not clear how the objectives of the Strategy align with strategies and initiatives of other sectors, and other initiatives undertaken at a National level. It seems as though the Strategy has been conceptualised in isolation. Much more emphasis is needed to embed the Strategy in broader changing ecosystems to ensure that efforts are not duplicated and benefits are complementary and amplified by other sectors and work already underway.
2. How could these principles be improved to better inform the objectives of the Strategy?
Overall, the APS supports the principles in their current form, however, there is an opportunity to emphasise the impact that climate change has on mental health *and wellbeing*, in addition to physical health. Ideally this should be incorporated into Principle 3. While we support Principle 6, partnership-based work needs to be genuinely co-produced, not designed by one party for another to enact[15]. Co-production gives ownership to all parties in all parts of the planning, design, delivery, and evaluation of the strategy. If done effectively, this provides the greatest opportunities for joint success. As previously mentioned, greater emphasis must be placed on the necessity for urgent action and rapid adaptation to new information as it becomes available must be designed

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to be incorporated into the Strategy[6]. Collaboration and strong working relationships will be essential to this ability to nimbly adapt.

4. What existing First Nations policies, initiatives, expertise, knowledge and practices should the Strategy align with or draw upon to address climate change and protect First Nations country, culture and wellbeing?

Being guided by our First Nations people, knowledges and wisdom is crucial. Non-Indigenous Australia can learn from First Nations people's knowledges about living in harmony with the land, seas, and sky.

Although we acknowledge that the *Consultation Paper* includes the importance of working with First Nations people, we believe that much greater attention is required. This could be through a distinct arm of the Strategy or, ideally, in a dedicated strategy which is co-produced utilising the expertise, leadership, and knowledges of First Nations people and communities. This should be part of a national conversation regarding their mental health and wellbeing.

The unique impact of colonisation means that First Nations people are not the same as other vulnerable groups. There must be deep recognition of the intergenerational trauma[16] and ongoing disenfranchisement that they experience in Australian society.

We must acknowledge that many of the social determinants of health are not uniform across communities. Interaction with the criminal justice system,[17] racism and discrimination,[18] disconnection from country, service inequalities, educational outcomes, and health outcomes, are some of the many factors that may in-part explain part why our First Nations people are particularly vulnerable to the effects of climate change. These must be addressed appropriately in order to see tangible progress.

In addition to the plans listed in the Consultation Paper, we suggest the following sources be drawn upon:

- National Strategic Framework for First Nations people's Mental Health and Social and Emotional Wellbeing 2017-2023[19]
- Intergenerational trauma and mental health.[16]

5. What types of governance forums should be utilised to facilitate co-design of the Strategy with First Nations people to ensure First Nations voices, decision-making and leadership are embedded in the Strategy?

It is essential that the Strategy consultation hears and learns from First Nations people to develop appropriate governance forums. This is not for the APS to determine, however, as previously mentioned, the APS considers it essential to work with partners using a genuine co-production framework[15].

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Proposed Objective 3: Adaptation

18. What health impacts, risks and vulnerabilities should be prioritised for adaptation action through the Strategy? What process or methodology should be adopted to prioritise impacts, risks and vulnerabilities for adaptation action?

The health impacts, risks and vulnerabilities due to climate change are severe, broad, and current or imminent[6]. The Strategy focusses on healthcare systems which we know have been chronically under-supported long before the impacts of recent bushfires, floods, drought, and a global pandemic[11]. If healthcare is already under pressure, then innovative, systemic, and comprehensive reform will be needed to adequately prepare for future needs due to the impacts of climate change.

The impacts of climate change on mental health and wellbeing are pervasive. As it is currently conceptualised, the Strategy does not appropriately acknowledge the underlying relationship mental health and wellbeing have with social determinants of health outcomes such as housing, connection to country, heat, food and water and energy security[14]. Acute and potentially chronic health impacts include climate and eco anxiety and/or solastalgia [11,20,21] , as well as the trauma associated with surviving a disaster[7,8,11].

Although this is not a comprehensive list, we would identify the following groups as particularly vulnerable to negative mental health and wellbeing impacts as a result of climate change [see also 1]. Particular attention must be paid to people who experience intersectional disadvantage.

- **First Nations people**: as previously described, the unique impact of colonisation means that First Nations people are not the same as other vulnerable groups. There must be deep recognition of the intergenerational trauma[16] and ongoing disenfranchisement that has been created in Australian society.
- **Rural and remote Australians**: rural and remote Australians are more likely to have experienced different forms of disasters[21] and are more likely to rely on the land and climate for income. Together, this means that rural and remote Australians are particularly vulnerable which is further exacerbated by inequities in healthcare spending, access and support[21,22].
- **Children and young people**: Children and young people are more likely to develop climate change related mental ill-health than adults [see 23]. Stress associated with the effects of climate change[1] have the potential to affect sleep and concentration which can in turn affect academic performance and educational outcomes[14].
- **Women and families:** women are disproportionately affected by impacts on housing and social networks post-disaster and this often leads to a decreased capacity for paid employment[14,24] [see also 25]
- **People already experiencing poor mental and physical health**[7]:

19. Should the Australian government develop a National Health Vulnerability and Adaptation Assessment and National Health Adaptation Plan? If yes:
    a. What are the key considerations in developing a methodology?
    b. How should their development draw on work already undertaken, for example at the state and territory level, or internationally?
    c. What are the key areas where a national approach will support local/jurisdictional vulnerability assessment and adaptation planning?

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The APS would support the development of a National Health Vulnerability and Adaptation Assessment and National Health Adaption Plan if it is targeted and complements other initiatives rather than adding additional administration burdens on the already stressed health sector.

As will be later described, the success of such a plan will require 'grass roots' initiatives and participation that engages Australians at the local and community level. Local adaption will be required to ensure that initiatives are suitable.

20. Would there be value in the Australian government promoting a nationally consistent approach to vulnerability assessment and adaptation planning for the health system specifically, for instance by issuing guidance and associated implementation support tools for states, territories and local health systems? If yes, what topics should be covered to promote a nationally consistent approach? What examples of existing guidance (either from states/territories or internationally) should be drawn from?

As a national organisation, the APS, in principle, supports national consistency to best support clear and simplified communication and operationalisation. However, we are also aware that the effects of climate change may necessitate differential approaches across jurisdictions so a 'one-size fits all' philosophy may be inappropriate. The best balance between consistency and local appropriateness will be most effectively informed by a well conceptualised and facilitated consultation process.

In the APS *Position Statement: Psychology and climate change*, we recommend that: "Governments and education providers should develop and implement national curricula on climate change, covering the science of climate change, its psychological and social dimensions, and solutions to it"[1(p. 6)]. We also support the recent Deeble Issues Brief which recommended the establishment of national guidelines to counter misinformation regarding climate change on social media[23].

21. What immediate high-priority health system adaptation actions are required in the next 12 to 24 months?

Given the urgency needed for action, Australians must be prepared as much as possible for impending climate change impacts. This includes (a) providing every Australian with the psychological tools and resources to build resilience in preparation for future climate change impacts, (b) building the capacity of psychologists and other mental health professionals to be best equipped to support communities in the wake of disasters, and (c) ensuring we are not duplicating efforts with other initiatives.

(a) Building Australians' resilience using a preventative approach

The scale and broad impacts of climate change mean that the health system and health professionals in isolation will be unable to address the psychosocial impacts of climate change. Evidence suggests that proactive investment in 'cohesive communities' is helpful to buffer the effects of disasters[26]. The Strategy must take a preventative and health promotion approach to mental health and wellbeing, that equips each community with networks of people with skills, such as psychological first aid and peer support[1]. These initiatives focus on strengthening Australian community networks to be able to locally customise responses to efficiently prepare for and respond to the impacts of climate change. In this way, it is not just the role of the health professional to build health and wellbeing, it is the responsibility of whole communities.

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(b) Supporting our psychologists:

As outlined in a recent report *Australian Psychologists in the Context of Disasters: Preliminary Report on Workforce Impacts and Needs*[11], there are ten key ways that we can enable psychologists to be best placed to support our communities:

Systems and policy

1. Increase the capacity of the psychology workforce by training more psychologists.
2. Increase the availability and accessibility of mental wellbeing support for psychologists.
3. Prepare psychologists to navigate future disasters by developing and providing training and practice guidelines specific to disasters, including managing personal impacts.
4. Reduce barriers of time and cost for psychologists to access supervision and professional development.
5. Support psychologists to be able to deliver adequate doses of treatment, aligned with best practice guidelines.

Organisations and workplaces

6. Formally recognise the importance of professional development, supervision, and peer support, and develop and promote clear processes to facilitate access.
7. Encourage a workplace culture that supports self-care, flexible work arrangements, and job autonomy for all psychologists.
8. Streamline systems to reduce administration requirements and prioritise specialist administrative support.

Self-employed practitioners

9. Develop guidance specifically for individual private practitioners regarding work structure, job design, and psychosocial hazard reduction and mitigation.

All psychologists

10. All psychologists should include selfcare as part of their continuing professional development.

(c) Ensure efforts are complementary:

To be most effective in a system that is already under stress, the Strategy should complement and not duplicate efforts already underway for example *Our Stories Beyond the Disaster - National Disaster Mental Health and Wellbeing Framework*[14] and the *National suicide prevention strategy for Australia's health system: 2020–2023*[27].

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Proposed Objective 4: Health in All Policies

22. What are the key areas in which a Health in All Policies approach might assist in addressing the health and wellbeing impacts of climate change and reducing emissions?
The APS endorses the 'Health in All Policies' approach as it acknowledges the interconnected impacts that policies can have on mental and physical health. However, as previously described, this necessitates an ambitious, integrated, and broad ranging strategy to maximise the multiplicative impact of climate change mitigating and adapting initiatives.

23. What are the most effective ways to facilitate collaboration and partnerships between stakeholders to maximise the synergies between climate policy and public health policy? What are some successful examples of collaboration in this area?

As previously described, we strongly advocate for genuine co-production to facilitate co-ownership of all components of the design, implementation, refinement and evaluation of an iniative[15]. We have an example of collaboration – the Disaster Response Network (DRN). The DRN is a network of APS psychologists who donate their time to support frontline workers and communities following disasters. During the last 14 months, we have completed 532 deployments providing wellbeing checks on frontline and emergency workers across the country. The success of the network has been dependent on successful collaboration between national co-ordination organisations and local, community-based partners, supporting each other to help affected Australians. We appreciate the support of the Government and its recent announcement to provide additional funding for this collaboration.

Enablers

24. How could these enablers be improved to better inform the objectives of the Strategy? Should any enablers be added or removed?
25. For each of these enablers:
    a. What is currently working well?
    b. What actions should the Strategy consider to support delivery?

The APS endorses the conceptualisation of the enablers and consider them all important in the success of the Strategy.

Enabler 1: Workforce, leadership and training – we welcome the opportunity to deliver additional continuing professional development offerings to psychologists to help prepare Australians to cope with the multiplicitous effects of climate change as well as overcome the trauma and devastation of disasters. This could be as a microcredential to complement and extend already existing formal qualifications in the context of lifelong learning. We have members with expertise in climate and health and we would be pleased to partner with the Government to operationalise this enabler.

Enabler 2: Research – as an evidence-informed profession, research is essential to our registration and practice. In addition, we have many members who are psychological scientists whose work underpins many professional contexts and applications. Evidence suggests that additional research is necessary to understand the full impacts of climate change on mental health[7,8]. We are conscious that the outcome of the Universities Accord[28] should be considered to maximise the opportunities for research to have the best impact in this field.

Enabler 3: Communication and engagement – this is essential to ensure that the general public understands the urgency and importance of the strategy and the broader context in which it is conceptualised.

Enabler 4: Collaboration – as previously discussed, collaboration must be genuine co-production. This is particularly important when working with First Nations people's and different ways of being and doing must be respected and integrated in the Strategy to ensure that there is shared success.

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Enabler 5: Monitoring and evaluation – ongoing monitoring and evaluation is essential to the success of the Strategy. However, simply collecting data regarding the performance of the initiatives of the Strategy is insufficient – data must be integrated and utilised. The Strategy should underpin a living and learning culture that adapts to the needs of Australians as new information is received. This is essential if the Strategy is going to be responsive to the necessary timeframes to make a significant impact.

Thank you for taking the time to complete this survey – your feedback is greatly appreciated!

Please submit this form in Word format to Health.Climate.Consultation@health.gov.au.

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Australian Council of Social Service

Submission to National Health and Climate Strategy

Department of Health and Aged Care

31 July 2023

About ACOSS

The Australian Council of Social Service (ACOSS) is a national voice in support of people affected by poverty, disadvantage and inequality and the peak body for the community services and civil society sector.

ACOSS consists of a network of approximately 4000 organisations and individuals across Australia in metro, regional and remote areas.

Our vision is an end to poverty in all its forms; economies that are fair, sustainable and resilient; and communities that are just, peaceful and inclusive.

Climate change impacts and a poorly managed transition to a net zero economy disproportionately impacts people experiencing socio-economic disadvantage and/or other vulnerabilities to climate change impacts (e.g. people with disability and/or pre-existing health conditions, people in regional or remote areas, people with limited or no English, First Nations communities, etc.).

A rapid transition to net zero emissions, consistent with limiting global warming to 1.5 degrees C, is therefore critical to reducing the impact on people facing disadvantage. This will require Australia prioritising emission reductions this decade and aiming for net zero emissions by 2035.

However, to achieve benefits for everybody, the transition to net zero emissions must be fair and inclusive. Putting people with the least at the centre of policy design means we can rapidly reduce emissions, poverty, and inequality in Australia.

Summary

ACOSS welcomes the Federal Government's development of a National Health and Climate Strategy. A national strategy is crucial to plan and coordinate actions to prevent and address the impacts of climate change on population health and wellbeing. Given the interconnections between disadvantage and the social, cultural, economic and environmental determinants of health, which are likely to be exacerbated by climate change, the Strategy could be a crucial policy lever to reduce inequality and disadvantage in ways that actively reduce health risks and promote community resilience to climate change impacts.

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As the consultation paper points out, rapidly worsening climate change is creating more extreme temperatures, severe weather events and sea level rise, with serious impacts on human morbidity and mortality, as well as implications for air pollution, food and water security, and changes in infectious disease patterns that also impact on human health. People experiencing poverty and disadvantage are already being impacted first, worst and longest because they have fewer resources to cope, adapt and recover from such impacts. Their risks are heightened if actions to address climate change and its health impacts are not fair and inclusive.

The proposed Strategy presents an opportunity to address climate change and improve health and wellbeing outcomes for all, especially for those experiencing financial and social disadvantage.

The consultation paper outlines some positive proposals for the Strategy to address the current and potential risks of climate change to health. However, there are some shortfalls, as outlined in our submission and summarised below.

The Strategy does not but should articulate a vision for the health of the Australian population that sets a policy direction. We welcome the proposed principles to guide the Strategy and recommend strengthening and expanding on these.

We generally support the proposed mitigation and adaptation objectives but consider the Strategy should extend its scope beyond the health system and health sector. That is, to reflect prevention and population health approaches that recognise the social, economic, cultural and environmental determinants of health that are likely to be greatly affected by climate change. For example, improving access to quality housing with good energy performance for people on low income will lower greenhouse gas emissions, lower their energy costs (thereby reducing poverty) and improve their resilience to temperature extremes, with direct and significant impacts for health. Similarly, having reliable access to clean energy as an essential service and access to clean transport options reduce emissions, reduce poverty and have positive health outcomes. Increasing income support reduces poverty and is a resilience measure that provides people on low income with more resources to cope, adapt and respond to climate impacts We propose measures that recognise these interactions and aim to reduce emissions and/or increase resilience to achieve positive health outcomes for all.

As climate change impacts population health outcomes and widens existing health inequities across many sectors, we strongly support the proposed 'health in all policies' framework. We recommend the Strategy articulate how this will be led, coordinated and policy alignment achieved.

We support the proposal for mitigation of greenhouse gas emissions as one of the four Strategy objectives but given the severe threat of climate change to health, recommend it aim for and support a more ambitious national emission reduction target, in keeping with climate science and our international obligations.

We support the intended engagement with First Nations communities and people on the Strategy and suggest engagement processes be elaborated.

We broadly support the enablers proposed in the consultation paper but suggest strengthening and adding to these.

Our recommendations are summarised below and elaborated in the discussion.

Recommendation 1 - Adopt prevention and population health approaches that recognise the significant health impacts resulting from the impacts of climate change on the social, cultural, economic and environmental determinants of health and the health system, with a particular focus on healthy homes, access to clean energy as an essential service, access to clean transport options, adequate income support and food and water security. Prevention and population health approaches should aim to improve health outcomes for the entire population by reducing health risks and strengthening resilience.

Recommendation 2: Add an overarching vision for the Strategy, for example: "Healthy and climate-resilient people and communities are served by an accessible, resilient, zero emissions health system by 2035."

Recommendation 3: Have Strategy objectives better reflect desired health outcomes in dealing with climate change, that are fair, equitable and inclusive.

Recommendation 4: Establish Strategy principles as outlined in the consultation paper but strengthen principles 1 and 2, and add three new principles (the right to health for all within and across generations; the right to inclusive and representative health planning and policy making; and uphold First Nations peoples' collective rights to sovereignty and to self-determination).

Recommendation 5: Have the Strategy aim for and support a more ambitious national target to achieve net zero emissions by 2035, in keeping with climate science and Australia's international obligations to pursue limits of global warming to 1.5 degrees C, that reduces our contribution to climate change and its adverse health impacts.

Recommendation 6: Support First Nations-led approaches to health and climate change via their engagement and representation at all levels in decision-making that affects them (including with National Aboriginal Community Controlled Health Organisation [NACCHO], National Aboriginal and Torres Strait Islander Housing Association [NATSIHA], First Nations Clean Energy Network and others), facilitated through adequate resourcing, information and meaningful participation pathways. Substantially invest in delivering essential services to First Nations communities.

Recommendation 7: Support high priority prevention and population health mitigation actions over the next 12-24 months, including: improve energy performance of low-income homes; introduce fuel efficiency and emissions standards for health sector fleets; promote low emission transport options for health staff and patients; rapidly phase out all fossil fuel projects and accelerate clean energy investment; prioritise energy affordability and equity, and reduce energy hardship (including through legislated national objectives); commit to full employment and invest in strategic workforce planning (including for health workforce); and reduce poverty by increasing income support. All mitigation options should be codesigned with communities, especially those experiencing financial and social disadvantage.

Recommendation 8: Have the proposed National Health Vulnerability and Adaptation Assessment assess vulnerability across and within communities and be informed in an ongoing way by communities (with facilitated avenues for participation by people experiencing disadvantage), their advocates and key organisations working on climate and health (e.g. Climate and Health Alliance

and Doctors for the Environment, and peak organisations like Disability Advocacy Network Australia and NACCHO). The National Health Adaptation Plan should prioritise adaptation and resilience building for people and communities experiencing financial and social disadvantage.

Recommendation 9: Support high priority prevention and population health adaptation actions over the next 12-24 months, including improving: energy performance of low income homes; access to reliable clean low emissions energy; water and food security; capacity of and engagement with communities and the community sector around preparedness and response to disasters; health sector and community responses to heatwaves; health sector workforce capacity; provision of and access to health services in regional and remote areas. All adaptation options should be codesigned with communities, especially those experiencing financial and social disadvantage.

Recommendation 10: Have the Department of Health and Aged Care lead coordinated implementation of this framework across different tiers of government and government portfolios. The framework should adopt preventative and population health approaches.

Recommendation 11: Strengthen four of the proposed enablers and add two new enablers (one on establishing a fairness, equity and inclusion framework for government action on climate change, and one on committing adequate long-term and sustainable funding for health responses to climate change and its impacts).

Recommendation 12: Include a glossary to clarify terminology and definitions.

Discussion

ACOSS welcomes the opportunity to provide feedback on the Department of Health and Aged Care's National Health and Climate Strategy consultation paper to inform its proposed objectives, principles, enablers. We suggest that the consultation process would benefit from a longer period to allow for further examination of related research and wider consultation with health and community sector organisations, as well as First Nations and culturally and linguistically diverse (CALD) stakeholders, people with disability, regional and remote, and other stakeholders.

ACOSS welcomes the development of a National Health and Climate Strategy. We recognise that rapidly worsening climate change is creating more extreme temperatures, severe events and sea level rise, and has implications for air pollution, food and water security and changes in infectious disease patterns which all impact on human health. People experiencing poverty and disadvantage are already being impacted first, worst and longest by climate change because they have fewer resources and options to cope, adapt and recover from such impacts. They will be placed further at risk if strategies to address climate change and its health impacts are not fair and inclusive.

ACOSS sees that the proposed Strategy presents an opportunity to address climate change, improve the health and wellbeing outcomes for all, and reduce poverty and inequality. That includes for people experiencing socio-economic disadvantage and/or other vulnerabilities to climate change impacts. To do this, there needs to

be deliberate intent to reduce financial and social disadvantage as part of broader prevention and population health approaches.

In general terms, we consider the consultation paper outlines some positive proposals to address current and potential risks posed by climate change to health. However, there are shortfalls that we recommend addressing, as outlined below.

Positioning - ACOSS calls for the Strategy to adopt preventative and population health approaches, and an overarching vision

The consultation paper is primarily focused on how the health system and health sector are affected by and can address climate change. ACOSS considers this to be too narrow a focus that does not reflect a broader definition of health that recognises its social, cultural, economic and environmental determinants.

We propose that the Strategy adopt prevention and population health approaches that address these broader determinants of health, and which aim to improve health and wellbeing for the entire population. Prevention and population health approaches would recognise and facilitate opportunities to maximise the health co-benefits of carefully designed climate mitigation and adaptation actions. For example, improving access to quality housing with good energy performance for people on low income will lower greenhouse gas emissions, have direct impacts on their health and improve their resilience to temperature extremes.

The consultation paper does not articulate an overall vision of what it hopes to achieve. We propose a vision that speaks to a healthy and equitable Australian community, which is resilient to climate change impacts, and is served by a health system that produces net zero emissions.

Recommendation 1: Adopt prevention and population health approaches that recognise the significant health impacts resulting from climate change impacts on the social, cultural, economic and environmental determinants of health and the health system, with a particular focus on healthy homes, access to clean energy as an essential service, food and water security, and access to clean transport options. Prevention and population health approaches should aim to improve health outcomes for the entire population by reducing health risks and strengthening resilience.

Recommendation 2: Add an overarching vision for the Strategy, for example: "Healthy and climate-resilient people and communities are served by an accessible, resilient, zero emissions health system by 2035."

Objectives – ACOSS calls for more detail to reflect desired health and equity outcomes

The consultation paper proposes 4 objectives for the Strategy around: (1) measurement; (2) mitigation of emissions; (3) adaptation; and (4) health in all policies.

1. How could these objectives be improved to better support the vision of the Strategy?

In general, ACOSS supports the four proposed objectives but consider they could be more detailed to better reflect what is desired in terms of health, fairness, equity and inclusion outcomes in dealing with climate change.

The objectives around measurement of emissions, mitigation and adaptation strategies should allow for strengthening of targets based on tracking data, climate science and our international obligations.

We support the proposal to adopt a 'health in all policies' approach that aims to maximise the synergies between climate and public health policies. This should place an emphasis on prevention that seeks to minimise health risks resulting from changes to the climate and environment, particularly health risks for those experiencing financial and social disadvantage. For example, homes with good energy performance for people on low income will reduce emissions but also reduce energy poverty and prevent indoor temperature extremes as climate changes, both of which will improve health outcomes. Ambitious fuel efficiency standards will promote uptake of electric vehicles, reducing greenhouse gas emissions and air pollution, and thereby reduce the incidence of respiratory illness, cardiovascular disease and cancer.

Recommendation 3: Have Strategy objectives better reflect desired health outcomes in dealing with climate change that are fair, equitable and inclusive (as per text in bold below):

- *Measurement*: Measure and report on health system greenhouse gas emissions, so progress in reducing emissions can be tracked, quantified **and strengthened where needed to reduce emissions as quickly as possible, thereby reducing our contribution to climate change and its adverse impacts on health**.
- *Mitigation*: Accelerate the reduction of greenhouse gas emissions from the health system**, as well as through a range of prevention and population health mitigation measures, to achieve net zero by 2035 in line with limiting global warming to 1.5 degrees C. Strategies must be informed by engagement with communities to understand their lived experience and benefit from their knowledge, particularly for people experiencing financial and social disadvantage.**
- *Adaptation*: Strengthen the resilience of the health system and communities to anticipate and respond to the health impacts of climate change, **prioritising resilience of people experiencing financial and social disadvantage**. **Strategies must be informed by engagement with communities to understand their lived experience and benefit from their knowledge.**
- *Health in All Policies:* Maximise the synergies between good climate policy and public health policy by working across policy areas **at national, state**

and territory and local government levels, to prevent and lessen the impact of climate change on the social, **economic, environmental** and cultural determinants of health and wellbeing.

Principles - ACOSS calls for strengthening and expanding proposed principles

The consultation paper proposes six principles to inform the objectives:

- First Nations leadership
- Tackling health inequities
- Population health and prevention
- One Health
- Evidence-informed policymaking
- Partnership-based working across all levels of government and beyond.

2. How could these principles be improved to better inform the objectives of the Strategy?

ACOSS generally supports the six principles proposed but recommends strengthening the first two and adding three more.

First Nations leadership: Principle 1 states that "First Nations' knowledge and experience must be central to decision-making on climate and health policy at all levels." ACOSS strongly supports this principle and recommends adding "equipping First Nations people with resources, capacity and pathways to be self-determining in climate and health policy making". This recognises existing barriers to meaningful engagement with First Nations communities and workers. We also recommend reference to upholding the Government's Closing the Gap goal in relation to health.

Tackling health inequities: We strongly support Principle 2 "Tackling health inequities" but consider that this should be further detailed. This principle is expressed from a deficit viewpoint, referring to community "vulnerabilities and lack of capacity", rather than acknowledging health inequities often result from barriers to health and health care, such as poverty and social disadvantage, which are a result of structural inequities and policy failures. As expressed in the consultation paper, this principle does not recognise the considerable knowledge and capacity held within disadvantaged communities (including within First Nations and migrant and refugee communities, people with disability, people experiencing poverty, etc) that should be supported to inform and lead policy to improve fairness and equity. We recommend this principle also be expanded to include intra and intergenerational justice.

Additional three principles: ACOSS recommends adding three principles:

- *The right to health for all*, within and across generations (as expressed in the UN Sustainable Development Goal 3: Ensure healthy lives and promote well-being for all, at all ages), as a basic premise of the Strategy.

- *The right to inclusive and representative decision making,* centring those with the greatest health needs and at greatest risk. This reflects a strengths-based approach that recognises knowledge and expertise within communities (e.g. within First Nations communities, migrant and refugee communities, among people with disability, etc.) that facilitates community-informed and led policy and decision-making to tackle health issues and inequities.
- *First Nations peoples' collective rights to sovereignty and to self-determination over their lands, resources, cultures and communities.* This recognises that First Nations' people should be able to determine if, when and how resource development projects (including fossil fuel projects) on their lands and territories should proceed to avert adverse health and other consequences for communities.

Recommendation 4: Establish principles as outlined in the consultation paper but strengthen principles 1 and 2, and add three principles:

- *Principle 1*: Include "equipping First Nations people with the resources and opportunities to be self-determining in climate and health policy making, and reference relevant Closing the Gap commitments".
- *Principle 2*: Include intra and intergenerational justice, recognise financial and social disadvantage as barriers to health and health care, and facilitate opportunities for the significant knowledge and understanding held by communities to inform ways to tackle health inequities and health issues.
- *Add principle*: The right to health for all, within and across generations.
- *Add principle*: The right to inclusive and representative health planning and policy making that centre in decision-making those with the greatest health needs and at greatest risk of climate change impacts.
- *Add principle*: Uphold First Nations peoples' collective rights to sovereignty and to self-determination over their lands, resources, cultures and communities.

GHG emissions sources - ACOSS calls for a more ambitious Australian emissions reduction goal

The consultation paper proposes three sources of emissions to target for reduction:

- Scope 1 emissions (direct emissions)
- Scope 2 emissions (energy-related indirect emissions)
- Scope 3 emissions (other indirect emissions).

3. Which of the various types of greenhouse gas emissions discussed above should be in scope of the Strategy's emission reduction efforts?

ACOSS considers that all three types of sources should be considered within the scope of the Strategy.

The science indicates an ever-worsening climate emergency that will impact first, worst and longest on people with fewer resources and options to cope, adapt and recover. ACOSS proposes the Strategy reflects the current science and our obligations under the Paris Agreement to keep global warming to below 1.5 degrees above pre-industrial levels. That is, the Strategy should aim for a more ambitious national emissions reduction goal of reducing emissions to 43% below 2005 levels by 2030, and to achieve net zero national emissions by 2035 (rather than the current timeframe of 2050).

Recommendation 5: Aim for and support a more ambitious national target to achieve net zero emissions by 2035, in keeping with current climate science and Australia's international obligations to pursue limits of global warming to 1.5 degrees C, thereby reducing our contribution to climate change and its adverse health impacts. Revise this goal as new scientific data and understanding of the climate risk become available.

First Nations' health and climate change - ACOSS supports First Nations-led approaches

ACOSS strongly supports the consultation paper's inclusion of climate change impacts on First Nations peoples' health and wellbeing, given their unique connections with Country; existing gaps in health outcomes between First Nations and other Australian population groups; and specific challenges they face around social and other determinants for health. We support reference to the strengths of First Nations cultures, knowledge and cultural practices as holding solutions to the impact of climate change on their health and wellbeing.

We support the Strategy's having aims to progress the Closing the Gap commitments and Priority 7 of the National Aboriginal Health Plan 2021-2031:

- support and grow the First Nations environmental health workforce
- support community driven housing and infrastructure solutions
- take action to improve food security
- support disaster and pandemic planning, preparedness and recovery at the national and community levels.

We strongly support the proposal to grow the First Nations environmental health workforce, and we acknowledge the importance of delivering culturally appropriate health services.

We add to this a call for substantial government investment in delivering essential services to First Nations communities (particularly in regional and remote locations), including: sufficient quality housing that is climate resilient; water security; and reliable, safe and clean energy supply.

We note that many First Nations communities are facing health and other threats from Australia's continued investment in and approval of fossil fuel projects on their lands and territories. These projects not only contribute to long term climate change impacts and disasters, they also have immediate impacts on air and soil quality, water and food security, damage to cultural sites and artifacts, ecological

damage, that have associated impacts on health and wellbeing. The rapid development of renewable energy projects on First Nations' lands has the potential to replicate the experience of fossil fuel projects. ACOSS recommends that the Strategy acknowledge these issues through inclusion of principles around First Nations peoples' rights to sovereignty and self-determination over their own lands, resources, cultures and communities.

4. What existing First Nations policies, initiatives, expertise, knowledge and practices should the Strategy align with or draw upon to address climate change and protect First Nations country, culture and wellbeing?
5. What types of governance forums should be utilised to facilitate co-design of the Strategy with First Nations people to ensure First Nations voices, decision-making and leadership are embedded in the Strategy?

ACOSS considers that First Nations peoples, leaders, researchers, services and health workers are best placed to advise on the best policies, initiatives, expertise, knowledge and practices to address climate change, and the types of governance forums to facilitate co-design. We call for First Peoples' engagement and representation in decision-making at all levels. This must be facilitated through adequate information, resourcing and meaningful pathways for First Nations peoples, leaders, researchers, services and health workers to co-design the Strategy and assist with its implementation at all levels.

Recommendation 6: Support First Nations-led approaches to health and climate change via:

- First Peoples' engagement and representation in health and climate decision-making at all levels (including National Aboriginal Community Controlled Health Organisation [NACCHO], National Aboriginal and Torres Strait Islander Housing Association [NATSIHA], First Nations Clean Energy Network and others), facilitated through adequate resourcing, information and meaningful participation pathways.
- Substantial government investment in delivering essential services to First Nations communities (particularly in regional and remote locations), such as quality housing, food, water and clean energy.

Proposed Objective 1: Measurement - ACOSS supports accurate and regular measurement of emissions

The consultation paper discusses the need for robust, regularly updated, consistent and sufficiently granular estimates of current emissions levels, drawing on facility-level data and other sources. The paper references:

- The Government's National Greenhouse and Energy Reporting scheme that focuses on scope 1 and 2 emissions
- The voluntary Climate Active program for organisations that includes scope 1, 2 and 3 emissions
- The Powering Australia plan that aims to reduce public sector emissions to net zero by 2030, focussing on scope 1 and 2 emissions.

6. Beyond the schemes already noted, is your organisation involved in any existing or planned initiatives to measure and report on health system emissions and/or energy use in Australia?
7. What additional data and information is required to support targeted emissions reduction efforts within health and aged care?

ACOSS acknowledges the critical nature of accurate and transparent measurement of greenhouse gas emissions, and their mitigation, within the health system. We agree with the call for measurement to be "robust, regularly updated, consistent and sufficiently granular" – and stress the need for a consistent approach across health systems and jurisdictions, and the open sharing of data to allow for research within and outside of government.

We express our concern that voluntary programs for measurement and reporting can be subject to greenwashing and under- or over-reporting. Where avenues can be created for transparency, independent review and public reporting of emissions, they should be.

Proposed Objective 2: Mitigation - ACOSS calls for the Strategy to support population health and health system mitigation measures to achieve a fast transition

The consultation paper has as its Objective 2 – "the mitigation of health system greenhouse gas emissions, in a manner that does not undermine quality of care". The consultation paper discusses emissions reduction being achieved through the Government's Powering Australia plan to boost the uptake of renewable energy, as well as through more specific initiatives to reduce emissions in built environment facilities, travel and transport, supply chain, medicines and gases, waste, prevention and optimising models of care.

8. What do you think of these proposed focus areas for emissions reduction? Should anything else be included?
9. Which specific action areas should be considered relating to the built environment and facilities (including energy and water), over and above any existing policies or initiatives in this area?
10. Which specific action areas should be considered relating to travel and transport, over and above any existing policies or initiatives in this area?
11. Which specific action areas should be considered relating to supply chain, over and above any existing policies or initiatives in this area?

12. Which specific action areas should be considered relating to medicines and gases, over and above any existing policies or initiatives in this area?
13. Which specific action areas should be considered relating to waste, over and above any existing policies or initiatives in this area?
14. Which specific action areas should be considered relating to prevention and optimising models of care, over and above any existing policies or initiatives in this area?
15. What can be done to involve private providers within the health system in the Strategy's emissions reduction efforts?
16. Where should the Strategy prioritise its emissions reduction efforts?
    - How should the Strategy strike a balance between prioritising emissions reduction areas over which the health system has the most direct control and prioritising the areas where emissions are highest, even if it is harder to reduce emissions in these areas?
    - Which of the six sources of emissions discussed above (on pages 13 to 18 of the consultation paper) are the highest priorities for action?
17. What 'quick wins' in relation to emissions reduction should be prioritised for delivery in the twelve months following publication of the Strategy?

ACOSS strongly supports reducing emissions fast to limit our contribution to climate change and avoid worsening inequality. However, strategies also need to be fair and inclusive to ensure that people with the least have improved health outcomes, and to avoid worsening poverty and disadvantage.

We support the consultation paper's proposed areas of focus for the Australian health system to reduce emissions. Additionally, we propose the Strategy support a range of prevention and population health mitigation measures, as outlined below.

Recommendation 7 Focus the Strategy on high priority prevention and population health actions over the next 12-24 months, including:

Built environment and facilities:

- Improve energy performance of homes via electrification, rooftop solar and energy efficiency (e.g. fund energy performance retrofits of low income homes, introduce new building standards of zero carbon homes by 2025; introduce mandatory disclosure of building energy performance when sold and leased, by 2025; mandate minimum energy efficiency performance standards for rental properties, by 2025; phase out use of gas in existing homes and ban gas in new homes)

Travel and transport:

- Introduce standards for health sector fleets to transition to electric and zero emissions vehicles where possible
- Introduce ambitious fuel efficiency standards
- Provide facilities and supports for active, shared and public transport, including for health staff
- Prioritise policies for people on low income to access electric vehicles

Energy production and supply chain:

- Rapid phase out of fossil fuel projects, no new projects and no expansion of existing projects; and rapidly reduce fossil fuel exports
- No subsidies, rebates or tax credits for fossil fuels extraction, production, and use
- Accelerate clean energy investment

Energy as an essential (and life-saving) service:

- Establish national objectives for energy affordability and equity, and to reduce energy hardship
- Federal Government to work with states and territories to reform:
    - Energy concessions/rebates
    - Ban disconnections for those who can't pay
    - Improve energy hardship and payment difficulty frameworks
    - Improve accessibility of information for consumers about energy market
    - Shift subsidies off bills

Employment and workforce:

- Commit to full employment, integrating climate change and labour related objectives:
    - Invest in research and development in industries that reduce emissions and ease climate impacts
    - Commit to lifting workforce participation to ease labour shortages and include people still excluded from paid work
    - Have Jobs and Skills Australia lead strategic workforce planning at national, industry and regional levels; invest in TAFE to provide skills and training

Other:

- Reduce poverty as a resilience measure (i.e. so people have the resources necessary to cope, adapt and recover from climate -related health impacts) by increasing income support:
    - Research and communicate the value of emissions reduction and resulting population health outcomes and prevention
    - Codesign mitigation options with consumers.

Proposed Objective 3: Adaptation - ACOSS supports national vulnerability and adaptation assessment, and health adaptation planning

The consultation paper sets out the need for Australia to adapt to inevitable climate change impacts, including those that have already taken place. It proposes climate risk assessment and adaptation planning, identifying priority actions and developing emergency prevention, response and recovery actions.

18. What health impacts, risks and vulnerabilities should be prioritised for adaptation action through the Strategy? What process or methodology should be adopted to prioritise impacts, risks and vulnerabilities for adaptation action?

19. Should the Australian government develop a National Health Vulnerability and Adaptation Assessment and National Health Adaptation Plan? If yes:

    - What are the key considerations in developing a methodology?
    - How should their development draw on work already undertaken, for example at the state and territory level, or internationally?
    - What are the key areas where a national approach will support local/jurisdictional vulnerability assessment and adaptation planning?

20. Would there be value in the Australian government promoting a nationally consistent approach to vulnerability assessment and adaptation planning for the health system specifically, for instance by issuing guidance and associated implementation support tools for states, territories and local health systems? If yes, what topics should be covered to promote a nationally consistent approach? What examples of existing guidance (either from states/territories or internationally) should be drawn from

21. What immediate high-priority health system adaptation actions are required in the next 12 to 24 months?

ACOSS recognises that the capacity for individuals and communities to adapt to the health impacts of climate change is greatly compromised if they experience financial and social disadvantage. Reducing disadvantage is a resilience measure in and of itself, and improving equity provides individuals and communities with greater capacity to adapt to changing climate conditions.

We have identified below key risks and vulnerabilities associated with financial and social disadvantage, and associated health impacts, that should be prioritised for adaptation action through the Strategy.

Health impacts:	*Risk and vulnerability factors*:

• impacts of extreme heat (e.g. on respiratory, chronic and neurological conditions) • impacts of extreme cold • respiratory impacts of air pollution (e.g. from bushfires) • death, injury and trauma from extreme events • poor and/or insufficient nutrition due to food insecurity exacerbated by disruptions to food supply and higher food prices as a result of climate change • increases in disease due to poor water quality and/or lack of hygiene • inability to store/keep medicines cool • impacts on ecological toxicology • increases or shifts in tropical disease • risks to reproductive and maternal health, and children's early years of disasters and extreme events (e.g. causing higher incidences of preterm birth, growth restriction, low birth weight, increased stillbirth rates, and newborn complications), in addition to pre-existing health risks for groups experiencing disadvantage • increases in family violence during and following disasters, with ramifications for long term health of victim survivors	• experience of homelessness • poor quality and inefficient housing • lacking insurance or being under insured • lack of transport options • food and water insecurity • access to energy that is unreliable, and or polluting energy (e.g. gas, diesel) • poor access to health services • poverty • living with disability • living with chronic health conditions • gender and sexual orientation • age • language and cultural barriers to accessing health care and information • location (e.g. regional and remote areas with limited access to health and other services, regions at high risk of disasters or extreme weather) • existing trauma and/or mental health issues • experiences of domestic or family violence

ACOSS supports the consultation paper's proposal for a National Health Vulnerability and Adaptation Assessment that adopts a nationally consistent approach. This work should assess vulnerability across and within communities. We recommend it be informed in an ongoing way by communities themselves (with facilitated avenues for participation by people experiencing disadvantage), as well as by key organisations, such as the Climate and Health Alliance and Doctors for the Environment, and peak organisations representing specific groups, like Disability Advocacy Network Australia and National Aboriginal Community Controlled Health Organisations, which have detailed information about the needs and priorities of the people they advocate for.

The National Health Adaptation Plan should prioritise adaptation and resilience measures for people experiencing financial and social disadvantage, who are likely to experience climate change impacts first, worst and longest.

Recommendation 8: Have the proposed National Health Vulnerability and Adaptation Assessment assess vulnerability across and within communities, and be informed in an ongoing way by communities

(with facilitated avenues for participation by people experiencing disadvantage), their advocates and key organisations working on climate and health (e.g. Climate and Health Alliance, Doctors for the Environment, and peak organisations like Disability Advocacy Network Australia and NACCHO). The National Health Adaptation Plan should prioritise adaptation and resilience building for people and communities experiencing financial and social disadvantage.

ACOSS identifies a range of high priority population health adaptation actions that the Strategy should focus on in the next 12-24 months, indicated below.

Recommendation 9: Support high priority population health adaptation actions over the next 12-24 months, including:

- Improve energy performance of low-income housing (i.e. through energy efficiency, electrification and renewable energy sources)
- Improve quality and supply of low-income housing that has high energy performance
- Improve access to reliable, clean, low emissions energy, particularly for rural and remote First Nations communities
- Improve water and food security for rural and remote communities
- Build capacity of and engagement with communities and the community sector around preparedness and response to disasters, and deliver accessible information and communication strategies around preparation for and response to disasters
- Prepare responses to heatwaves (including health advice, places to shelter, health responses)
- Build health sector workforce capacity, including Aboriginal and Torres Strait Islander health workforce.
- Increase provision of health services in regional and remote areas.

Proposed Objective 4: Health in All Policies - ACOSS supports implementation of this framework

The consultation paper proposes establishing governance, leadership and accountability mechanisms that support government agencies to recognise and understand the health and health equity impacts of their policies and find ways to collaborate to design and implement joint public policy for improved health and wellbeing outcomes. This approach is reflected in the national Preventative Health Strategy 2021 – 2030 that considers climate change. It also includes proposals to develop a National Climate Risk Assessment, and to establish an Australian Centre of Disease Control.

22. What are the key areas in which a Health in All Policies approach might assist in addressing the health and wellbeing impacts of climate change and reducing emissions?

23. What are the most effective ways to facilitate collaboration and partnerships between stakeholders to maximise the synergies between climate policy and public health policy? What are some successful examples of collaboration in this area?

ACOSS supports the adoption of a Health in All Policies framework as an approach to benefit health, avoid health risks and advance equity. There are clear connections between climate change, health, water and food security, housing, energy, transport, infrastructure, urban planning, environment, and disaster management that impact on health outcomes. Taking action in these policy areas will benefit from a joined-up approach.

Successful implementation of the Strategy will require a coordinated approach across different tiers of government and government portfolios. The Department of Health and Aged Care should lead this approach and detail how coordination and alignment of policy will be achieved (e.g. dialogue and policy coordination between Departments of Health and Aged Care and Social Services to ensure access to adequate social security for positive health outcomes). This could be through the existing Health Ministers meeting routinely considering climate change issues and engaging and consulting with Ministers for related portfolios (such as DEECCW, Mental Health, Social Services, Resources, Emergency Services, Planning, and Infrastructure).

Recommendation 10: The Department of Health and Aged Care should lead a coordinated approach to the Health in All Policies framework across different tiers of government and government portfolios.

Enablers - ACOSS calls for strengthening the enablers and adding two around equity and funding

The consultation paper identifies five **enablers** to serve as a foundation for action in the health system to tackle climate change:

- Workforce, leadership and training
- Research
- Communication and engagement
- Collaboration
- Monitoring and reporting.

24. How could these enablers be improved to better inform the objectives of the Strategy? Should any enablers be added or removed?

25. For each of these enablers:

- What is currently working well?
- What actions should the Strategy consider to support delivery?

ACOSS supports the enablers proposed but recommends strengthening these. For example, we note that women dominate the health care and social assistance workforce, at comparatively low rates of pay. Healthcare will take on additional

significance due to climate change, requiring additional skills of workers, increased demand on workers, and potentially greater risks to workforces, all of which should be reflected in fair pay, conditions and support.

We propose adding two enablers around equity mechanisms and funding:

- Australia currently has no mechanism requiring climate change policies and actions to be fair, equitable or inclusive. Enacting legislation requiring a fairness, equity and inclusiveness lens be applied to all climate change action would support the equity principle proposed for this Strategy and many population health actions.
- The consultation paper does not specify funding commitments for implementation of Strategy actions. We call for a commitment to adequate long term and sustainable funding for proposed responses under the Strategy.

Recommendation 11: Strengthen four of the proposed enablers:

- *Workforce leadership and training*: Policy levers and funding be used to build a health workforce knowledgeable about climate change impacts, that increases accessibility to health care for people experiencing financial and social disadvantage. Increased demands on and risks to the health workforce resulting from climate change should be reflected in fair pay, conditions and support.
- *Research:* Investments in climate change and health research include examining risks related to disadvantage, and opportunities for mitigation and adaptation.
- *Communication and engagement:* Communicate and engage meaningfully with communities and individuals experiencing financial and social disadvantage, and their advocates, about the health risks of climate change, and build capacity for mitigation and adaptation.
- *Collaboration*: Establish governance structures for regular collaboration with all stakeholders in health planning and policy making to require representation by people experiencing disadvantage and their advocates.

Add two enablers around equity mechanisms and funding:

- *Fairness, equity and inclusion framework for climate change action*: Legislate a fairness, equity and inclusion framework for government action on climate change (e.g. through amendment of the Climate Change Act).
- *Funding*: Commit to adequate, long term and sustainable government funding for health responses to climate change and its impacts.

Glossary

Different organisations and sectors have different interpretations of the same terms. The Strategy would benefit from including a glossary for clarification. For example, a "just transition" to a clean economy has been used by some to focus on fair employment outcomes for workers, but by others to speak more broadly of fair outcomes for workers and communities (including those experiencing disadvantage). For some, the term "climate resilience" implies a 'giving in' to

the inevitability of climate change impacts and insufficient emphasis on mitigation strategies, while for others it refers to planning for inevitable changes that will take place, to prevent harmful impacts.

Recommendation 12: Include a glossary to clarify terminology and definitions.

Acknowledgements

ACOSS prepared this submission in consultation with members of the ACOSS Climate and Energy, and Health Policy Networks.

Contact

[redacted]

Australian Government
Department of Health and Aged Care

NATIONAL HEALTH AND CLIMATE STRATEGY

Detailed submission form

This form allows you to provide responses to the full set of questions in the Consultation Paper available here.

Alternatively, you may wish to complete the briefer online survey available here.

Please submit this form in Word format to Health.Climate.Consultation@health.gov.au.

Respondent details

What is your name?
Dr Alex Pavli
What is your email address?
apavli@snhn.org.au
What is your organisation?
Sydney North Health Network Sydney North Health Network (SNHN) is a primary health network covering nine local government areas in Sydney's North. We were the first primary health network to develop a Climate and Health Strategy (2020) which seeks to embed climate and health across our organisation's five key priority areas – 'Community Activation', 'System Transformation', 'Member and Provider Support', 'Commissioning', and 'An exceptional organisation'. We fully support the development of a National Climate and Health Strategy, and are grateful for the opportunity to provide feedback on the proposed priorities.
Have you read and agreed to the Privacy Statement? (NB we will not be able to use your submission unless you tick this box)
☒ I have read and agreed to the Privacy Statement
Do you identify as Aboriginal and/or Torres Strait Islander? (Yes/No/Prefer not to say)
☐ Yes ☒ No ☐ Prefer not to say
Please select which applies to you: ☐ Individual citizen ☐ Health Service Provider ☐ Industry and Life Sciences Organisation or Representative ☐ Academic or Researcher

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☒ Primary and/or Allied Health Peak or Advocacy Organisation or Representative ☐ Aged Care Service Provider ☐ First Nations Health Service Provider ☐ First Nations Community Group ☐ First Nations Peak or Advocacy ☐ Medical College or Peak professional body

Questions for feedback from the Consultation Paper

Introduction

1. How could these objectives be improved to better support the vision of the Strategy?
SNHN supports the four objectives of 'measurement', 'mitigation', 'adaptation' and 'health in all policies' and believes these broadly encompass the changes required. In particular, we support the objective of 'health in all policies', as reducing the carbon impact of the healthcare sector, and adapting to the health impacts of climate change, will both require close collaboration across different policy areas.
2. How could these principles be improved to better inform the objectives of the Strategy?
SNHN supports the principles of 'First Nations Leadership', 'Tackling Health Inequalities', 'Population Health and Prevention', 'One Health', 'Evidence Informed Policy Making', and 'Partnership Based working across all levels of government and beyond'. SNHN recommends also including the principle of 'intragenerational and intergenerational equity' as outlined in the Climate and Health Alliance (CAHA)'s Framework for a national strategy on climate, health and well-being for Australia.
3. Which of the various types of greenhouse gas emissions discussed above should be in scope of the Strategy's emission reduction efforts?
SNHN strongly recommends that scope 1, 2 and 3 emissions are all included in the Strategy's emission reduction efforts. Research from the United Kingdom suggests that a significant source of emissions are anaesthetic gases and metered dose inhalers (scope 1), as well as the supply chain (including pharmaceuticals) and staff commute (scope 3) and patient travel. Including all these sources will be important to effectively reduce emissions.
4. What existing First Nations policies, initiatives, expertise, knowledge and practices should the Strategy align with or draw upon to address climate change and protect First Nations country, culture and wellbeing?
SNHN strongly supports embedding First Nations leadership and cultural knowledge within the Strategy.

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SNHN recommends drawing on knowledge of traditional practices including cultural burning. We recommend further supporting and expanding Indigenous Ranger programs and restoring degraded land, for example through work that is conducted by Bush Heritage Australia.

SNHN also recommends promoting understanding of First Nations cultural knowledge in day-to-day activities, including communicating the benefits of local species as bush foods and medicines. For example, local councils could mandate the planting of local species to promote greater public awareness of the benefits of these plants, and to provide homes and food for native wildlife, and also use the plants to educate the community on traditional cultural practices, in a similar way to this native rooftop farm. Social prescribing programs could be based around this model, for example, healthcare providers could refer to social prescribing programs which could serve to promote exercise, reduce stress and impart cultural knowledge.

The National Strategy should also focus on providing culturally safe workplaces through the health sector.

5. What types of governance forums should be utilised to facilitate co-design of the Strategy with First Nations people to ensure First Nations voices, decision-making and leadership are embedded in the Strategy?

SNHN recommends facilitating stakeholder consultation workshops with First Nations community members, First Nations peak bodies including the National Aboriginal Community Controlled Health Organisation (NACCHO) and National Centre for Indigenous Excellence (NCIE) as well as traditional owner groups.

SNHN recommends a focus on long-term engagement with community with ongoing feedback, including on the outcomes of any consultation processes.

SNHN suggests that the Strategy could consider how legislation including Native Title legislation promotes the health and wellbeing of First Nations people and the wider Australian community more broadly, and explore how traditional owners balance, for example, promoting economic opportunities for the community through land development, with protecting country and connection to country.

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Proposed Objective 1: Measurement

6. Beyond the schemes already noted above, is your organisation involved in any existing or planned initiatives to measure and report on health system emissions and/or energy use in Australia?
SNHN is participating in a program run by Willoughby, North Sydney and Kuringai councils called the 'Better Business Partnerships program' which involves annual monitoring of our own energy consumption and petrol and gas use. We have also promoted this program to private practices in our region including general practices, pharmacies and residential aged care facilities. SNHN is planning to offer private general practices within our area a subsidised service to calculate their own carbon footprints and to compare emissions annually. The Central and Eastern Sydney Primary Health Network has developed a Green Practice Checklist to assist general practices and allied health practices reduce their environmental footprint.
7. What additional data and information is required to support targeted emissions reduction efforts within health and aged care?
Detailed information on the carbon impact of clinical care is required, including services provided (such as pathology, imaging, allied health services) and medicines prescribed, as well as staff, patient and visitor transport. This will help to target strategies to sources of highest emissions. A detailed and accurate carbon footprint of an Australian general practice, a pharmacy, an allied health clinic, and a residential aged care facility in the community would be useful to help target actions. Further research on the carbon impact of low value care would be useful, as well as further information on the effectiveness of preventative health programs (such as social prescribing) in reducing emissions.

Proposed Objective 2: Mitigation

8. What do you think of these proposed focus areas for emissions reduction? Should anything else be included?
SNHN agrees with the proposed areas of emissions reduction including 'built environment', 'travel and transport', 'supply chain', 'medicines and gases', 'waste', 'preventing and optimising models of care'. A focus on minimising low value care is also very important and we suggest it be included. This could include educating the public on the importance of minimising low value care to reduce emissions and protect the environment.

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Incentivising the use of renewable energy should include not only hospitals and residential aged care facilities as mentioned in the consultation paper, but also practices in the community including general practices, pharmacies, allied health and specialist practices.

9. Which specific action areas should be considered relating to the **built environment and facilities (including energy and water)**, over and above any existing policies or initiatives in this area?

The development of new models of providing healthcare which have emerged in the COVID pandemic, including telehealth and group health education sessions via teleconference, should be considered in relation to this issue. Further use of these services, where appropriate, could reduce the need for the development of new buildings and facilities.

10. Which specific action areas should be considered relating to **travel and transport**, over and above any existing policies or initiatives in this area?

In addition to using policy levers to promote the use of electric vehicles, SNHN recommends actions to promote staff, patients and visitors walking, cycling and taking public transport to health services. It is worth noting that in rural and remote areas, public transport options are often not available.

Consideration should also be given to the reduced emissions from staff working from home (e.g. psychologist, health administrators), and reduced patient travel due to the option of telehealth, and we recommend this be included in carbon footprinting calculations where possible.

It is also important to discuss air travel within the healthcare sector in the Strategy. Many healthcare employees attend conferences by air travel and the carbon impact of air travel should be included in measurements. Incentives to reduce air travel should be considered.

11. Which specific action areas should be considered relating to **supply chain**, over and above any existing policies or initiatives in this area?

SNHN supports CAHA's recommendation to have nationally consistent procurement standards for the healthcare sector, including both public and private sectors.

12. Which specific action areas should be considered relating to **medicines and gases**, over and above any existing policies or initiatives in this area?

SNHN supports the listed actions, including working with stakeholders in primary care to reduce dispensing of pressurised MDIs. SNHN has already commenced work educating general practitioners and pharmacies in our region and we have a planned educational webinar outlining the carbon impact of respiratory inhalers. There is also information on the carbon impact of respiratory inhalers on our website.

13. Which specific action areas should be considered relating to **waste**, over and above any existing policies or initiatives in this area?

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SNHN supports the listed actions in relation to waste including greater medical equipment re-use and recycling. With regards to medical equipment re-use and recycling, SNHN recommends exploring ways to incentivise the sterilisation of medical equipment at general practices (such as skin biopsy and minor surgery kits, and cervical screening speculum) as we have received comments from practices that it is very complicated to sterilise medical equipment and meet accreditation standards, and so many practices use single use items instead. Supporting practices to sterilise medical equipment is important, including fostering collaboration between general practices and hospitals to facilitate use of sterilisation systems at hospitals.

We support reducing medical emissions through the reduction of paper waste through promoting electronic methods of data collection and communication, including e-scripts, electronic discharges and specialist letters from hospitals to general practices. However, with regards to reducing emissions from paper waste, it is necessary to consider the impact of e-waste and include this in healthcare sector carbon footprint calculations. It is also important to consider e-waste disposal in the Strategy including computers, phones, cartridges and toners.

14. Which specific action areas should be considered relating to **prevention and optimising models of care**, over and above any existing policies or initiatives in this area?

SNHN strongly recommends optimising models of care and social prescribing, including blue and green prescribing. As earlier discussed, this could target several priorities of the Strategy at once. For example, social prescribing to a 'bush foods' garden could encourage people to be outside and improve vitamin D levels, get exercise, improve social connectedness, while also promoting awareness and understanding of caring for country. A program such as this would also work to reduce waste and emissions by avoiding the emissions associated with prescribing blood pressure or cholesterol medications.

15. What can be done to involve private providers within the health system in the Strategy's emissions reduction efforts?

Highlighting the financial savings and improved staff morale to be gained from emissions reduction will be important involving private providers in the Strategy's emissions reduction efforts.

In a qualitative study of a general practices who had taken steps to improve their environmental sustainability, many interviewees mentioned that financial savings were a strong motivator to make sustainable changes.

The research also demonstrated the importance of having leaders in private general practices who had an interest in climate and the environment. Offering climate and health training to leaders in private practices (such as practice owners and managers) could help encourage engagement with the Strategy's emissions reductions efforts.

Working with key stakeholders to include emissions reduction and environmental sustainability in accreditation standards will also be a strong motivator in private practice. For example, working with the Royal Australian College of General Practitioners to include emissions reductions in their accreditation standards.

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It is recommended that practices are supported through financial incentives to make changes such as putting solar on roofs or switching to renewable energy.

16. Where should the Strategy prioritise its emissions reduction efforts?

    a. How should the Strategy strike a balance between prioritising emissions reduction areas over which the health system has the most direct control and prioritising the areas where emissions are highest, even if it is harder to reduce emissions in these areas?

    b. Which of the six sources of emissions discussed above (on pages 13 to 18 of the Consultation Paper) are the highest priorities for action?

The strategy should focus its efforts simultaneously on 'prevention and optimising models of care' which is crucial to the system transformation required for a low carbon healthcare system, but will take longer to implement, as well as key carbon hotspots suggested from existing literature, which are 'medicines and gases', 'supply chain' and 'travel and transport'.

17. What 'quick wins' in relation to emissions reduction should be prioritised for delivery in the twelve months following publication of the Strategy?

SNHN suggests the following 'quick wins':

- An accurate and comprehensive summary of Australia's current healthcare footprint, with ongoing annual review to better target initiatives, determine priority areas and review progress
- Consider restricting the use of highly potent anaesthetic gases and metered dose inhalers, where possible
- Support for private practices to transition to renewable energy, including for those renting their premises
- Establishment of procurement standards which are consistent across Australia (as outlined in the CAHA framework), and for public and private practice
- Support education in general practice and community care about the carbon impact of respiratory inhalers
- Dedicated funding to climate and health research, including for primary care
- Consider requiring all health service providers, including private practices such as general practices, to report annually on their scope 1, 2 and 3 emissions with funding to support this

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Proposed Objective 3: Adaptation

18. What health impacts, risks and vulnerabilities should be prioritised for adaptation action through the Strategy? What process or methodology should be adopted to prioritise impacts, risks and vulnerabilities for adaptation action?
SNHN recommends that the Strategy focus on preparing for heatwaves as a priority, given the significant increased associated mortality, as well as climate related disasters including bushfires and flooding. We recommend educating the public on the risks of heat waves and how to prepare, and developing robust systems to support the vulnerable, including people who are homeless, people who are socially isolated, and the elderly and children, who are most at risk in heatwaves, and also require support to evacuate during bushfires and floods. We recommend psychological and peer support and ensuring all healthcare workers are paid for their time responding to disasters. Providing resources to the public so that they can be informed of their climate related disaster risks would be very useful. For example, a very simple online tool where an individual could look up their location and see their risks, how likely such an event is (e.g. flood, bushfire), and then a link to an individual preparedness plan.
19. Should the Australian government develop a National Health Vulnerability and Adaptation Assessment and National Health Adaptation Plan? If yes: a. What are the key considerations in developing a methodology? b. How should their development draw on work already undertaken, for example at the state and territory level, or internationally? c. What are the key areas where a national approach will support local/jurisdictional vulnerability assessment and adaptation planning?
SNHN recommends that the Australian government develop a National Health Vulnerability and Adaptation Assessment and National Health Adaptation Plan. This will provide a nation-wide assessment of vulnerable populations and potential system weaknesses which can then be further expanded at the state and local level as required. For example, a national assessment could provide information on gaps in co-ordination between the state-funded hospital system and federally funded general practice. The methodology is recommended to include reviews of the literature, stakeholder consultations as well as climate models and empirical research. We recommend including a review of policies and programs across Australia to determine what is working well and to share examples of success. Their development should draw on work already undertaken, for example the World Health Organization 'Protecting Health from Climate Change: Vulnerability and Adaptation Assessment.' A national approach and guidance will likely result in faster progress to understand these risks and best prepare for them. It will also facilitate information sharing at the local level and comparison of what is working well and what is not working so well (for example for areas with similar vulnerable groups or facing similar threats).

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We recommend making the information available to the public to help increase preparedness for climate related health risks, and having a national approach will ensure that all Australians have access to this information.

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20. Would there be value in the Australian government promoting a nationally consistent approach to vulnerability assessment and adaptation planning for the health system specifically, for instance by issuing guidance and associated implementation support tools for states, territories and local health systems? If yes, what topics should be covered to promote a nationally consistent approach? What examples of existing guidance (either from states/territories or internationally) should be drawn from?
Yes, as discussed above, a nationally consistent approach to vulnerability assessment and adaptation planning would be valuable to facilitate collaboration and communication between states, territories and local health systems. Meetings to discuss vulnerabilities would have a common framework and reference point from which to base discussions. It would also facilitate information sharing regarding which strategies are working to prepare populations and minimise risk. It would also be useful to have very clear guidance on the roles and responsibilities of different groups in disasters, including health, local council and emergency services, and to promote collaboration. Some aged care services are assessing and preparing local vulnerable populations for disasters, but there is not yet widespread awareness of such actions.
21. What immediate high-priority health system adaptation actions are required in the next 12 to 24 months?
- Ensuring all health services (including private practices such as general practices and pharmacies) have in place a disaster preparedness plan to manage climate related disasters including heat waves, bushfires and floods - Accurate information for health services and individuals about their likely climate related risks at their particular location - Ensuring all general practices have completed disaster preparedness training - Ensuring that local community aware of health risks posed by heat waves, and how to prepare, particularly for those at risk and for those with chronic health conditions - Ensure primary health networks and primary care are involved in emergency preparedness planning to ensure access to primary care is not unnecessarily disrupted following a disaster

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Proposed Objective 4: Health in All Policies

22. What are the key areas in which a Health in All Policies approach might assist in addressing the health and wellbeing impacts of climate change and reducing emissions?
SNHN strongly supports using a Health in All Policies approach which will likely assist in the key areas of urban planning, protection of the environment and transport. Poor urban planning with areas with a lack of trees and shade causes significantly increased temperatures, for example in Western Sydney. The healthcare sector could work closely with departments of planning to ensure adequate tree coverage to avoid the heat island effect. Having safe, open areas in which to exercise is also key to having a healthy lifestyle and reducing the burden of diseases relating to overweight and obesity. Creating environments to promote active commuting such as walking and cycling is also central to facilitating exercise and enabling low carbon models of care. Similarly, working with the transport sector to expand access to public transport and incentivise its use will facilitate co-benefits in terms of more exercise and less air pollution. As noted in CAHA's framework under 'thriving ecosystems', environmental protection will be a key area to reduce the health impacts of climate change. Deforestation is a key driver of climate change, and protecting existing forests will help to protect the health of all Australians.
23. What are the most effective ways to facilitate collaboration and partnerships between stakeholders to maximise the synergies between climate policy and public health policy? What are some successful examples of collaboration in this area?
Facilitating ongoing semi-regular meetings with stakeholders from health organisations (Local health districts, primary health networks) and councils and state and federal government departments on climate and health

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Enablers

24. How could these enablers be improved to better inform the objectives of the Strategy? Should any enablers be added or removed?
SNHN agrees with the listed enablers: 'workforce leadership and training', 'research', 'communication and engagement', 'collaboration', and 'monitoring and evaluation'. Other enablers to be considered include emphasising financial savings of low carbon healthcare models, as well as the improved recruitment and retention that sustainable action can promote, particularly for the private sector. We recommend a stronger emphasis on collaboration be considered to include collaboration between all levels of government, between public and private health sectors, primary care and hospitals, across all states and territories and across policy areas.
25. For each of these enablers: a. What is currently working well? b. What actions should the Strategy consider to support delivery?
All of these enablers could be further enhanced, particularly in relation to primary care. For example, with regards to research, there is minimal research on the climate impact of primary care in Australia. SNHN recommends dedicated funding for climate and health e.g. within NHMRC funding, including for primary care.

Thank you for taking the time to complete this survey – your feedback is greatly appreciated!

Please submit this form in Word format to Health.Climate.Consultation@health.gov.au.

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Central Australian
Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823

Submission to the Australian Government's development of a National Health and Climate Strategy

July 2023

Executive Summary

(Note responses below to the 'Questions for Feedback' in the National Health and Climate Strategy Consultation Paper. Please refer to the body of this submission for details and additional information)

The dimensions of the challenge

Questions for feedback # 3: Which of the various types of greenhouse gas emissions discussed above should be in scope of the Strategy's emission reduction efforts?

The scope of the *National Health and Climate Strategy* should be widened to include the effects on the health of First Nations people of all Australian greenhouse gas emissions whatever their source (including those originating outside the health system) and that it includes policies and actions to rapidly and substantially reduce these accordingly.

Principles for action

Questions for feedback # 2: How could these principles be improved to better inform the objectives of the Strategy?

Action to mitigate the effects of climate change, or assist Aboriginal communities to adapt to it, must recognise the rights to self-determination of Aboriginal peoples as established under international agreements to which Australia is a signatory, including the United Nations Declaration on the Rights of Indigenous Peoples.

Health effects of climate change in Central Australia

Questions for feedback # 18: What health impacts, risks and vulnerabilities should be prioritised for adaptation action through the Strategy? What process or methodology should be adopted to prioritise impacts, risks and vulnerabilities for adaptation action?

The National Health and Climate Strategy should commit to the following investments to minimise the adverse health effects of climate change:

- addressing the social and economic determinants of health
- increasing the resources for comprehensive primary health care under Aboriginal community control
- increasing investment in health infrastructure
- substantially improving community housing, food security and water quality
- advocating for and establishing appropriate regulatory and taxation regimes

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Aboriginal health in Aboriginal hands.

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Importance of community controlled primary health care

Questions for feedback # 4: What existing First Nations policies, initiatives, expertise, knowledge and practices should the Strategy align with or draw upon to address climate change and protect First Nations country, culture and wellbeing?

The *National Health and Climate Strategy* should explicitly recognise Aboriginal community-controlled organisations, especially Aboriginal community-controlled health services, as preferred providers for government funded services to address the health effects of climate change, in recognition of their greater service effectiveness, their higher levels of employment of Aboriginal people, and their formal structures for involving Aboriginal communities in decision-making.

Limiting the amount the climate changes (mitigation)

Questions for feedback # 22: What are the key areas in which a Health in All Policies approach might assist in addressing the health and wellbeing impacts of climate change and reducing emissions?

In order to mitigate the amount the climate changes as a result of human activity, and to meet the Government's own commitments, the National Health and Climate Strategy should recommend:

- banning any further fossil fuel developments, including Hydraulic Fracturing ('fracking')
- investing in sustainable renewable power (e.g. solar) especially in remote communities with appropriate backup systems
- recognising and investing in Aboriginal traditional ecological knowledge
- adopting an economic paradigm that is focused on public health and the reduction of inequality

Reducing the negative effects of climate change (adaptation)

Questions for feedback # 21: What immediate high-priority health system adaptation actions are required in the next 12 to 24 months?

Significant infrastructure funding for the Aboriginal community controlled health service sector is required to ensure clinics and staff housing are in a position to continue to provide comprehensive primary health care services to Aboriginal communities to address the accelerating health effects of climate change. This should include specific funding for sustainable infrastructure (solar, transition to electric vehicles etc), along with ongoing funding for sustainability action positions within ACCHSs

Climate change, health, and Closing the Gap

Questions for feedback # 5: What types of governance forums should be utilised to facilitate co-design of the Strategy with First Nations people to ensure First Nations voices, decision-making and leadership are embedded in the Strategy?

The co-design of the National Health and Climate Strategy as it relates to Aboriginal communities should be progressed at a national level through the partnership structures established and agreed under the Partnership Agreement on Closing the Gap.

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Questions for feedback # 23: What are the most effective ways to facilitate collaboration and partnerships between stakeholders to maximise the synergies between climate policy and public health policy? What are some successful examples of collaboration in this area?

At a national level, the Closing the Gap partnership structures are the most appropriate forums for collaboration and partnerships to ensure a public health perspective is at the forefront of any response to climate change as it affects Australia's First Nations.

At the level of the Northern Territory, this should take place through the already established successful Forums:

- the Northern Territory Executive Council on Closing The Gap / Aboriginal Affairs, and
- the Northern Territory Aboriginal Health Forum.

Actions by Central Australian Aboriginal Congress

Questions for feedback # 6: Beyond the schemes already noted above, is your organisation involved in any existing or planned initiatives to measure and report on health system emissions and/or energy use in Australia?

See attached Sustainability Report (December 2022) prepared for Central Australian Aboriginal Congress.

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About Us

Central Australian Aboriginal Congress (Congress) is a large Aboriginal community controlled health service based in Alice Springs. We are one of the most experienced organisations in the country in Aboriginal health, a national leader in primary health care, and a strong advocate for the health of Aboriginal[1] people. Since the 1970s, we have developed a comprehensive model of primary health care that includes:

- multidisciplinary clinical care;
- health promotion and disease prevention programs; and
- action on the social, cultural, economic and political determinants of health and wellbeing.

This submission is provided from the perspective of the Aboriginal communities of Central Australia. However, much of what is included in this submission is applicable across regional and remote Australia.

[1] The Congress Board of Directors prefers the term 'Aboriginal' as the most appropriate in the Central Australian context to refer to Australia's First Peoples.

The dimensions of the challenge

QUESTIONS FOR FEEDBACK # 3: Which of the various types of greenhouse gas emissions discussed above should be in scope of the Strategy's emission reduction efforts?

The scope of the *National Health and Climate Strategy* should be widened to include the effects on the health of First Nations people of all Australian greenhouse gas emissions *whatever their source* (including those originating outside the health system) and that it includes policies and actions to rapidly and substantially reduce these accordingly.

- Climate change caused by the emissions of greenhouse gases from human activity is an established scientific fact supported by a consensus of scientists working in the field. The global effects of climate change are already being felt through increased temperatures; more intense and more frequent bushfires; droughts; more severe storms; a warming and rising ocean; loss of animal and plant species; reduced food crops yields; and poverty and displacement [1].
- In this context, the Australian Government's promise to reduce national emissions by 43% below 2005 levels by 2030, and to achieve net zero national emissions by 2050 is a modest yet welcome commitment. Similarly the development of a *National Health and Climate Strategy* is welcome, as are any attempts to mitigate the emissions of greenhouse gases from the Australian health sector.
- However, the focus of the Strategy on reducing the emissions of greenhouse gases from the Australian health sector alone is misguided. The health effects of climate change are not just driven by the emissions from the health sector, which contributes only a small fraction (7%) of Australia's total CO_2 emissions [2].
- The scale of the effects of health system emissions compared to those from other Australian sources can be brought into focus by using research estimating the global excess mortality that can be expected to result from CO_2 emissions [3]. This suggests that every 4,434 tons of CO_2 emitted in 2020 can be expected to cause one excess death globally during the period from 2020 to 2100. Note that this is only *temperature-rated mortality* and does not include the many other potential causes of mortality caused by climate change.
- This allows us to calculate that the emissions from the Australian health system over one year can be expected to contribute over 8,000 excess global temperature-related deaths during 2020 to 2100, assuming that emissions stay at the current level. Of course, these expected excess deaths are *global* as the effects of emissions contribute to global climate change, not just to the climate of the nation where they were emitted.

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- As Australia has 0.3% of the world's population, we can come to an approximate estimate of 3 Australian deaths during the period 2020 to 2100 per year of health sector emissions, or just under 800 Australian deaths for thirty years of operation of the Australian health system. See *Figure 1*.
- To understand the scale this mortality cost of carbon, using the same methodology we can estimate that (for example) the burning of coal from all proposed and approved mines in Queensland's Galilee Basin will lead to an additional 200,000 temperature-related deaths globally per year of operation during the period 2020 to 2100, or approximately 19,000 additional Australian deaths for thirty years of operation. Note that for the purpose of the mortality associated with coal mines, it is irrelevant whether the coal is burned in Australia or elsewhere on the planet: it can be expected to lead to the same number of excess deaths of Australian citizens.

Figure 1: Comparison of the effect of CO_2 emissions on excess temperature-related mortality, 2020 – 2100 between the Australian health system and an example fossil-fuel development

Australian Health System	Comparison: Galilee Basin Coal	
3,577,200	857,000,000	tons of CO_2 emitted per year of operation [2, 4]
4,343		tons of CO_2 leading to 1 excess temperature-related death globally 2020-2100 [3]
8,236	197,329	Excess global temperature-related deaths per year of operation, 2020-2100
3	634	Approximate excess Australian temperature-related deaths per year of operation, 2020-2100
793	19,010	Approximate excess Australian temperature-related deaths over 30 years of emissions, 2020-2100
4.2%	100%	Relative impact on excess temperature-related mortality

- We can therefore estimate that excess temperature-related mortality from emissions from Australia's health system would only be 4.2% of that expected from just one large fossil-fuel mining development in Australia. It should also be noted that:
  - excess temperature-related deaths will be suffered disproportionally by First Nations globally and Aboriginal and Torres Strait Islander communities in Australia (see *Figure 2* below)
  - the health system will *save* many lives during the 21st century thus offsetting the mortality caused by its emissions; other sources of emissions such as coal mines do not have this effect.

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Principles for action

QUESTIONS FOR FEEDBACK # 2: How could these principles be improved to better inform the objectives of the Strategy?

Action to mitigate the effects of climate change, or assist Aboriginal communities to adapt to it, must recognise the rights to self-determination of Aboriginal peoples as established under international agreements to which Australia is a signatory, including the *United Nations Declaration on the Rights of Indigenous Peoples.*

- Through their diverse cultures, Aboriginal peoples have cared for and sustainably regulated the natural ecosystems of this continent for tens of thousands of years. However, the process of colonisation in Australia has profoundly undermined their ability to care for Country.
- The deregulated non-Aboriginal economic system and its unrestrained pursuit of profit is now causing irreparable damage to the living systems that sustain life in the Northern Territory, across Australia, and around the world.
- Climate change is a fundamental threat to the planet's living systems and to all human societies. It poses particular threats to the health and wellbeing of vulnerable peoples, including the Aboriginal nations of the Northern Territory.
- These threats are not in the future – they are happening now. If they are not to become ever more serious, climate change must be tackled immediately. This means all governments taking immediate and effective action to:
  - mitigate the effects of climate change in particular by reducing greenhouse gas emissions, and
  - assist communities, especially vulnerable communities such as Aboriginal nations – to adapt to the effects of climate change.
- Aboriginal people did not create climate change, but they are amongst those who are most affected by it. Accordingly, action to mitigate the effects of climate change, or assist Aboriginal communities to adapt to it, must recognise the rights to self-determination of Aboriginal peoples as established under international agreements to which Australia is a signatory, including the *United Nations Declaration on the Rights of Indigenous Peoples* [5], which states:

  Article 23: Indigenous peoples ... have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions;

  Article 29: Indigenous peoples have the right to the conservation and protection of the environment and the productive capacity of their lands or territories and resources. States shall establish and implement assistance programmes for indigenous peoples for such conservation and protection, without discrimination.

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Climate change in Central Australia

- The effects of climate change are already being felt. In Central Australia they will – or are expected to – include [6-9]:
    - increased temperatures, with average temperatures expected to increase by 4.1^{O}C by 2090 unless action to reduce emissions is taken;
    - more hot days, with the number of days per year over 35^{0}C estimated to increase from around 90 currently to an estimated 118 by 2030 and 180 by 2070) – noting that the average number of days of extreme heat between 2018-21 *are already matching previously predicted values for 2050* under a scenario where emissions are not reduced until that year;
    - more variable rainfall (for example, more average rainfall but greater variation of wet and dry periods and continuing droughts); and
    - more extreme weather events such as storms, floods, bushfires, cold snaps, and heatwaves.
- Aboriginal people recognise climate change and its effects on the ecosystem in Central Australia [6]:

    I think it is changing, sometimes hotter, sometimes colder. Weather more mixed up. Not hot all the time in summer, cold in winter. People talking about this now, now everything's changing, one day hot, one day cold. (Ltyentye Apurte ranger)

    Blossom flowers come on at different times. Atwakeye (Wild Orange) should be flowering at Christmas time, but they are coming early. Other things come late or early, but are all mixed up. (Longterm resident of Ltyentye Apurte)

    In the old days, the stars and the weather lined up. (Eastern Arrernte elder)

Aboriginal communities at risk from climate change

- Climate change is affecting everyone. However, just as ill-health is not distributed evenly across society, the negative effects of climate change are posing greater risks to some populations than others. Populations at particular health risk include those living in poverty; those with pre-existing poor health; those in remote areas; and those living in poor housing. The following table shows how Aboriginal people in the Northern Territory are particularly vulnerable due to these factors.

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Figure 2: Increased climate change health risks for Aboriginal communities in the Northern Territory

Vulnerable Population [10-12]	Aboriginal population in the Northern Territory
Living in poverty	Median total personal income for Aboriginal people in the Northern Territory is a quarter of that for non-Aboriginal people ($281 compared to $1,072 per week) [13] In very remote areas, Aboriginal incomes are falling, and the income gap to non-Aboriginal people widening [14]
Pre-existing low levels of health (especially respiratory / cardio-vascular disease, alcohol/drug issues or other mental health issues)	In 2014–15, a fifth (18%) of Aboriginal people in the Northern Territory self-assessed their health as only as fair or poor [15] Aboriginal Territorians die from respiratory disease at 2.7 times the rate for non-Indigenous Australians and at higher rates than Aboriginal people elsewhere in Australia [15] More than one in five (22%) of Aboriginal Territorians report high or very high levels of psychological distress compared with 8% for non-Indigenous Australians [15] The life expectancy gap is still 13.5 years for Aboriginal Territorians compared to non-Indigenous Australians [16]
Living in remote areas	In the Northern Territory, almost four out of five Aboriginal people live in Remote (21%) and Very remote areas (58%) [15] Three quarters (75%) of those living in very remote areas are Aboriginal [15]
Living in poor housing	A third (33%) of Aboriginal Territorians live in houses that need 1 or more extra bedrooms, six times the rate (5%) for non-Aboriginal people [13]

- While climate change affects everyone's health, Aboriginal people in the Territory are disproportionately at risk due to the burden of disadvantage and poor health that they already carry as a result of colonisation.

Health effects of climate change in Central Australia

QUESTIONS FOR FEEDBACK # 18: What health impacts, risks and vulnerabilities should be prioritised for adaptation action through the Strategy? What process or methodology should be adopted to prioritise impacts, risks and vulnerabilities for adaptation action?

The *National Health and Climate Strategy* should commit to the following investments to minimise the adverse health effects of climate change:

- addressing the social and economic determinants of health
- increasing the resources for comprehensive primary health care under Aboriginal community control
- increasing investment in health infrastructure including staff housing
- substantially improving community housing, food security and water quality
- advocating for and establishing appropriate regulatory and taxation regimes

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- For Aboriginal people health is *not just the physical well-being of an individual but includes the social, emotional and cultural well-being of the whole community* [17]. This definition:

  > *... recognises the importance of connection to land, culture, spirituality, ancestry, family and community, how these connections have been shaped across generations, and the processes by which they affect individual wellbeing. It is a whole-of-life view, and it includes the interdependent relationships between families, communities, land, sea and spirit and the cyclical concept of life–death–life*. [18]

- Accordingly, the disruption and damage to the living world that climate change creates is in itself a harm to the health of Aboriginal people as it undermines the relationships to land and sea that are at the heart of Aboriginal wellbeing. In Aboriginal culture the human spirit is one with the physical environment from which it was formed. An insult to the physical environment creates human illness in and of itself.

- There are also a range of direct effects on population health that climate change is creating. These include the following [10, 11, 19-22]

  a. *increased sickness and mortality* due to heat stress with Aboriginal people particularly vulnerable due to poorer underlying health in general and higher rates of cardio-respiratory disease in particular

  b. *increased food insecurity and malnutrition* with remote Aboriginal communities particularly vulnerable due to pre-existing poverty and poor access to healthy food, and expected increases in prices of food and damage to ecosystems that disrupts access to traditional foods

  c. *increased risk from infectious disease* and increased range of some vector-borne diseases. Remote Aboriginal communities are particularly vulnerable to food- and water-borne disease

  d. *poorer social and emotional wellbeing / mental health*, with increasing temperatures contributing to greater stress and higher rates of suicide. For Aboriginal people, social and emotional wellbeing is also undermined by damage to Country and disruption of cultural practices

  e. *poorer respiratory health* due to increased smoke from bushfires and/or dust

  f. *reduced fresh water supply* (both quantity and quality) due to changed rainfall and increased evaporation rates as well as potential contamination from mining and other extraction industries

  g. *increased potential for social conflict* due to displacement of populations (climate refugees) for example due to changing temperatures or sea level rise elsewhere.

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- In addition, climate change will increasingly reduce the capacity of the health system to respond to the health needs of communities in the Northern Territory because of [10, 11, 19]:

  a. *increased difficulty in recruiting and retaining health staff*, especially to remote areas affected by increased temperatures and more extreme weather events

  b. *increased health facility infrastructure costs* to ensure health buildings and staff accommodation are appropriately insulated and cooled

  c. *reduced productivity of health staff* due to heat stress and sickness.

Importance of community controlled primary health care

QUESTIONS FOR FEEDBACK # 4: What existing First Nations policies, initiatives, expertise, knowledge and practices should the Strategy align with or draw upon to address climate change and protect First Nations country, culture and wellbeing?

The *National Health and Climate Strategy* should explicitly recognise Aboriginal community-controlled organisations, especially Aboriginal community-controlled health services, as preferred providers for government funded services to address the health effects of climate change, in recognition of their greater service effectiveness, their higher levels of employment of Aboriginal people, and their formal structures for involving Aboriginal communities in decision-making.

- Addressing the health challenges being caused by climate change in Aboriginal communities will require increased investment in comprehensive primary health care that seeks to treat ill health; promote good health and; and tackle the social and economic drivers of poor health. For First Nations people, this investment needs to be directed through the Aboriginal community controlled health service (ACCHS) sector.
- ACCHSs have a range of inter-linked structural advantages in delivering services and hence improved outcomes compared to non-Indigenous services (government or private). These structural advantages include:

  a. *a holistic approach to service delivery*, including through addressing the social determinants of child and family wellbeing, based on a lived understanding of the Aboriginal conception of health

  b. *culturally responsive services*: Aboriginal community-controlled health services are able to provide their care within a culturally responsive setting, based on local knowledge, an Aboriginal governance structure and workforce, and strong relationships with the communities that they serve

  c. *better access*, based on community engagement and trust: a strong practice of community engagement founded on strong relationships with the community, in turn based on a sense of ownership and history.

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Aboriginal people consistently prefer to use Aboriginal organisations such as ACCHSs over mainstream services giving them a strong advantage in addressing access issues, particularly when dealing with culturally sensitive issues relating to sexuality, pregnancy, childbirth and addiction

d. *Aboriginal governance:* individuals and communities are encouraged and enabled to participate in decisions on service delivery, including though formal governing Boards, including a high proportion of Aboriginal women in governance positions

e. *an Aboriginal workforce:* community-controlled services are significantly better at attracting, training and retaining Aboriginal staff leading to greater cultural appropriateness of services as well as benefits through providing employment and capacity building in the Aboriginal community, especially for Aboriginal women

f. *high levels of accountability:* Aboriginal community-controlled health services are highly accountable to their funders for the services they provide through robust data collection and a reporting regime which is above the requirements of mainstream health and wellbeing services.

- The greater effectiveness of ACCHS in delivering health outcomes has been recognised by numerous studies and is embedded in Australian Government policy, including the *Closing the Gap Agreement* [23].

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Limiting the amount the climate changes (mitigation)

QUESTIONS FOR FEEDBACK # 22: What are the key areas in which a Health in All Policies approach might assist in addressing the health and wellbeing impacts of climate change and reducing emissions?

In order to mitigate the amount the climate changes as a result of human activity, and to meet the Government's own commitments, the *National Health and Climate Strategy* should recommend:

- banning any further fossil fuel developments, including Hydraulic Fracturing ('fracking')
- investing in sustainable renewable power (e.g. solar) especially in remote communities
- recognising and investing in Aboriginal traditional ecological knowledge
- adopting an economic paradigm that is focused on public health and the reduction of inequality

- Limiting the amount or rate of climate change involves reducing the levels of heat-trapping greenhouse gases in the atmosphere: continuing current emissions rates is likely to lead to a 4°C of warming by 2100 [21]. All governments will need to implement substantial cuts in greenhouse gas emissions if catastrophic effects on human health are to be avoided.

- Urgent and sustained action is required order to meet the Australian Government's commitment to reduce national emissions by 43% below 2005 levels by 2030, and to achieve net zero national emissions by 2050. In regards specifically to the health of Australia's First Nations, the *National Health and Climate Strategy* should recommend:

  a. *banning any further fossil fuel developments, including Hydraulic Fracturing ('fracking')* as they are incompatible with reducing greenhouse gas emissions and poses a range of other environmental threats to the health

  b. *investing in sustainable renewable power* (e.g. solar) especially in remote communities, including well-resourced systems for maintenance and back up

  c. *recognising and investing in Aboriginal traditional ecological knowledge* to manage Country and reduce the release of greenhouse gases for example through Ranger programs to manage fire regimes, feral animals etc.

  d. *adopting an economic paradigm that is focused on public health and the reduction of inequality*, rather than the unrestrained pursuit of private profit and the exploitation of the natural world.

Reducing the negative effects of climate change (adaptation)

QUESTIONS FOR FEEDBACK # 21: What immediate high-priority health system adaptation actions are required in the next 12 to 24 months?

Significant infrastructure funding for the Aboriginal community controlled health service sector is required to ensure clinics and staff housing are in a position to continue to provide comprehensive primary health care services to Aboriginal communities to address the accelerating health effects of climate change. This should include specific funding for sustainable infrastructure (solar, transition to electric vehicles etc), along with ongoing funding for sustainability action positions within ACCHSs

- The *National Health and Climate Strategy* should commit to the following investments which can be expected to help minimise the adverse health effects outlined above:

  a. *addressing the social and economic determinants of health* that increase the vulnerability of Aboriginal communities to the health effects of climate change. This includes action on poverty, lack of appropriate education, employment, and housing (see next point) and action to *reduce inequality*

  b. *increasing the resources for comprehensive primary health care* under Aboriginal community control, including social and emotional wellbeing services, to respond at the grassroots level to increased health risks posed by climate change and provide a centre for coordinated action and advocacy on health needs

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c. *increasing investment in health infrastructure* to ensure that all clinics and staff housing are fit for purpose in the context of increasing temperatures and more extreme weather

d. *substantially improving community housing*, to ensure that public housing and houses in Aboriginal communities meet the needs of Aboriginal families facing increasing temperatures (improved insulation, air-conditioning, and water) supply; that construction specifications are updated and enforced; and that increased maintenance is provided

e. *advocating for and establishing appropriate regulatory and taxation regimes* to ensure that government both address inequality and has the revenue to invest in transitioning to a low carbon economy and which ensure that the effects of climate change are not felt disproportionately by poor and marginalised communities.

- In regard to *increasing investment in health infrastructure* above, as our peak body the National Aboriginal Community Controlled Health Organisation (NACCHO) has been advocating [24], the sector is critically in need of infrastructure upgrades. The effects of climate change add to this need, to ensure that clinic buildings and staff housing are appropriately insulated, cooled, and constructed to a standard that ensures that they will continue to be able to provide their vital services to Aboriginal communities, particularly those in remote and regional Australia.

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Climate change, health, and Closing the Gap

QUESTIONS FOR FEEDBACK # 5: What types of governance forums should be utilised to facilitate co-design of the Strategy with First Nations people to ensure First Nations voices, decision-making and leadership are embedded in the Strategy?
The co-design of the *National Health and Climate Strategy* as it relates to Aboriginal communities should be progressed at a national level through the partnership structures established and agreed under the *Partnership Agreement on Closing the Gap*.
QUESTIONS FOR FEEDBACK # 23: What are the most effective ways to facilitate collaboration and partnerships between stakeholders to maximise the synergies between climate policy and public health policy? What are some successful examples of collaboration in this area?
At a national level, the Closing the Gap partnership structures are the most appropriate forums for collaboration and partnerships to ensure a public health perspective is at the forefront of any response to climate change as it affects Australia's First Nations. At the level of the Northern Territory, this should take place through the already established successful Forums: • the Northern Territory Executive Council on Closing The Gap / Aboriginal Affairs, and • the Northern Territory Aboriginal Health Forum.

- Numerous government funding programs in Aboriginal health and wellbeing have failed due to lack of engagement with Aboriginal stakeholders and collaboration with other government agencies.
- The *Partnership Agreement on Closing the Gap* [23] was negotiated and agreed to by the Coalition of Peaks and the Council of Australian Governments in March 2019. The Partnership Agreement provides an historic opportunity for Aboriginal and Torres Strait Islander Peoples and governments to work together as true partners with equal participation and shared decision-making across all levels of government.
- Accordingly, the co-design of the National Health and Climate Strategy as it relates to Aboriginal communities should be progressed at a national level through the partnership structures established and agreed under the *Partnership Agreement on Closing the Gap*.
- The Closing the Gap partnership structures are also the most appropriate for the national collaboration and partnerships to ensure a public health perspective is at the forefront of any response to climate change as it affects Australia's First Nations. At the level of the Northern Territory, however, there are two highly successful collaborative forums already in place which should be used to determine policy and program priorities:
    a. *The Northern Territory Executive Council on Closing The Gap / Aboriginal Affairs.* The Council has membership from NT Chief Minister and Cabinet, the NIAA, the Local Government Association of the Northern Territory (LGANT) and the Aboriginal Peak Organisations Northern Territory (APONT). Its role is to oversee the coordination and implementation of the National Agreement on Closing the Gap.
    b. *The Northern Territory Aboriginal Health Forum*, a peak-level partnership with considerable public health expertise and a long history of successful collaboration between the Northern Territory and Australian Departments of Health, the National Indigenous Australians Agency (NIAAA), the NT PHN and Aboriginal Medical Services Alliance Northern Territory (AMSANT).

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Actions by Central Australian Aboriginal Congress

QUESTIONS FOR FEEDBACK # 6: Beyond the schemes already noted above, is your organisation involved in any existing or planned initiatives to measure and report on health system emissions and/or energy use in Australia?

See attached *Sustainability Report (December 2022)* prepared for Central Australian Aboriginal Congress.

- Transitioning to a low-carbon economy is an extremely significant challenge for Australia and the global community, made worse by decades of limited action. As such, it is governments who must lead the adaptation and mitigation

efforts: this responsibility cannot be transferred to individuals, to First Nations, to businesses or to non-government organisations independent of government legislation, regulation and resourcing.

- Nevertheless, health organisations have a particular responsibility to ensure minimise the harmful effects of their operations, including with respect to climate change mitigation. Accordingly, Congress has formed a Sustainability Committee to implement an environmental sustainability framework across its operations, including includes buildings and facilities, procurement and purchasing, waste management, energy and water use and transport.
- The Sustainability Committee recently commissioned a report to establish baseline data for the organisation regarding greenhouse gas emissions. Results from the audit will inform a longer-term *Environmental Sustainability Action Plan* identifying short, medium and long term areas for action.
- Note that this reporting is voluntary as the Congress' emissions are under the threshold for mandatory reporting required under the *National Greenhouse and Energy Reporting Act*.
- A copy of the report accompanies this submission, and may be useful to inform similar activities in other ACCHSs and/or First Nations organisations and/or large primary health care services.
- In addition the Sustainability Committee conducted a Congress Staff Sustainability Survey in late 2022. Some key points from the Survey include:

  a. 91% of staff believed that it was important for Congress to take action to be an environmentally-sustainable organisation

  b. the issues of most concern to staff were :

     - Climate change (81%),
     - Rubbish/waste and recycling (79% and 76% respectively),
     - Renewable energy (79%),
     - Fracking (73%)
     - Access to healthy food at affordable prices (71%)

  c. staff perceived that the most important sustainability issues for Congress to take action on were

     - Waste: Reducing and recycling waste (88% + 81%); and purchasing sustainable products/procurement (67%)
     - Energy: Investing in energy efficient building infrastructure (92%) and environmentally sustainable energy sources (77%)
     - Community: supporting communities to be more sustainable (75%)
     - Water: more efficient use of water (70%)
     - Transport: Sustainable transport options (60%)

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- Congress is taking the following actions:
    - Installing solar systems including a system with battery backup at two sites in Alice Springs, and developing plans for further investments in solar.
    - Constructing a new Health Hub facility in Alice Springs that has a sustainable design and will be a Green Star certified building.
    - Transiting our vehicle fleet to electric and hybrid vehicles (noting a current, and likely future, challenge being a lack of electric vehicle charging stations in remote regions to support this transition).
    - Monitoring the driving habits of our staff to encourage more sustainable driving by reducing the speeds vehicles drive at.
    - Introducing fleet management software to better manage our vehicle fleet.
    - Reducing the amount of air travel taken by staff.

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Australian Government
Department of Health and Aged Care

NATIONAL HEALTH AND CLIMATE STRATEGY

Detailed submission form

This form allows you to provide responses to the full set of questions in the Consultation Paper available here.

Alternatively, you may wish to complete the briefer online survey available here.

Please submit this form in Word format to Health.Climate.Consultation@health.gov.au.

Respondent details

What is your name?
[redacted]
What is your email address?
[redacted]
What is your organisation?
Northern Territory Department of Health
Have you read and agreed to the Privacy Statement? (NB we will not be able to use your submission unless you tick this box)
☒ I have read and agreed to the Privacy Statement
Do you identify as Aboriginal and/or Torres Strait Islander? (Yes/No/Prefer not to say)
[redacted]
Please select which applies to you: ☐ Individual citizen ☒ Health Service Provider ☐ Industry and Life Sciences Organisation or Representative ☐ Academic or Researcher ☐ Primary and/or Allied Health Peak or Advocacy Organisation or Representative ☐ Aged Care Service Provider ☐ First Nations Health Service Provider ☐ First Nations Community Group ☐ First Nations Peak or Advocacy ☐ Medical College or Peak professional body

To be approved

Questions for feedback from the Consultation Paper

Introduction

1. How could these objectives be improved to better support the vision of the Strategy?
Consider making **leadership and governance** a fifth objective, as the complex, system wide, integrated and urgent nature of the situation requires new ways of collaborating, redefining shared authority and facilitating effective shared decision making and action at the necessary pace (not as an enabler, but as a specific pillar to drive action - translation of policy into practice).
2. How could these principles be improved to better inform the objectives of the Strategy?
Nil. Principles are appropriate and supported as is.
3. Which of the various types of greenhouse gas emissions discussed above should be in scope of the Strategy's emission reduction efforts?
All three scopes should be included in the scope of this Strategy.
4. What existing First Nations policies, initiatives, expertise, knowledge and practices should the Strategy align with or draw upon to address climate change and protect First Nations country, culture and wellbeing?
In line with the first principle of First Nations leadership: • the role of Aboriginal Health Practitioner in remote communities could be clarified and elevated to a more lead role. Years ago, community health care models were more Aboriginal Health Worker led, however this has diminished and become more nurse led over time. • there could be better acknowledgement and integration of traditional medicines as options for Aboriginal clients. • it would be powerful to take a strength based (versus deficit-based) and holistic (land / health / community) approach to community health models. This would enable health system language, priorities and healthcare design to align with traditional First Nations worldview of health. • integrate First Nations knowledges in the preventative health context, particularly in relation to bush foods and behaviours which are based on the holistic, patient/planet health. • support use (or integration) of traditional healing knowledges (and effective traditional medicines) into mainstream healthcare for patient choice. Note, this may also be an opportunity to incorporate other traditional medicines which are low emissions and high value (eg prescribing medical Qigong or TaiChi or acupuncture in some countries).
5. What types of governance forums should be utilised to facilitate co-design of the Strategy with First Nations people to ensure First Nations voices, decision-making and leadership are embedded in the Strategy?
The NT Aboriginal Health Forum would be the most appropriate governance forum for engaging with the Strategy.

Tuesday approved

Building relationships directly with First Nations people and communities would also enable First Nations' peoples' voices and worldviews being part of the design, prioritisation and decision-making.

Proposed Objective 1: Measurement

6. Beyond the schemes already noted above, is your organisation involved in any existing or planned initiatives to measure and report on health system emissions and/or energy use in Australia?

The NT Government is introducing an emissions framework and developing an associated emissions tool to report on annual emissions commencing in 2023/24.

7. What additional data and information is required to support targeted emissions reduction efforts within health and aged care?

Nil comment.

Proposed Objective 2: Mitigation

8. What do you think of these proposed focus areas for emissions reduction? Should anything else be included?

All proposed focus areas are supported.

Also, **technology** is proposed as an additional focus area, because it represents both a growing contributor to, and solution for, the waste and emissions problems.

In the context of buildings/facilities, it would be helpful to define/categorise initiatives as 'new' solutions/approaches versus 'modifications to current' to help target engagement, participation and accountability.

Questions:

- please clarify where chemicals fit, noting that these could be for cleaning or for therapeutic purposes (eg radiation)?
- please clarify where blood and blood products fit?

9. Which specific action areas should be considered relating to the **built environment and facilities (including energy and water)**, over and above any existing policies or initiatives in this area?

Mandatory public reporting for emissions for building performance.

Establish a national Energy Efficiency Infrastructure Transition Fund to accelerate the transition to low emissions infrastructure upgrades, because existing infrastructure allocations give priority to urgent clinical needs.

Strengthen national healthcare facility design and construction standards for new healthcare building design including guidance on integration of land/site features into

To be approved

design (focussing on optimising patient outcomes and minimising energy needs), supported by a transition strategy (which includes developing industry capacity to meet the standards). In support of this, one of the participants in the internal NT Health consultation sessions shared research by Ulrich (1999) which showed that patients who had a view of nature/greenery had better health outcomes than those without (https://www.researchgate.net/publication/304109537_Effects_of_gardens_on_health_outcomes_theory_and_research)

Also, consider guidance on integration of public health infrastructure with public transport infrastructure.

10. Which specific action areas should be considered relating to **travel and transport**, over and above any existing policies or initiatives in this area?

It would be valuable to have:

- national clarity and consistency on which types of health system travel types fall into which Scope emissions to support nationally consistent effort and reporting (eg independent patient travel to appointments, government funded patient travel, government funded staff air travel, government funded staff road travel, staff travel to work, etc).
- more fit-for-purpose funding models and/or behavioural economics approach to support greater engagement in effective virtual care models (for patient, clinician and health system)

Question:

- In the NT there are 52 charging stations for 1.42 million km^2 in the NT. Will Commonwealth incentivise private providers installing EV infrastructure?

11. Which specific action areas should be considered relating to **supply chain**, over and above any existing policies or initiatives in this area?

Establish a role of national Transition Broker in the Department of Health and Aged Care to drive accelerated resource circularity in relation to the health supply chain, specifically for high volume health supplies (for more detail go to Circular Economy Webinar Video.mp4 time reference is between 1hr 3min – 1hr 7min).

12. Which specific action areas should be considered relating to **medicines and gases**, over and above any existing policies or initiatives in this area?

Opportunities to achieve significant gains in this area include:

1. National definition of pharmaceutical waste and associated strategy to reduce it
2. National benchmarks / requirements for pharmaceutical companies not to include damaging elements in their products, plus accountability in relation to expiry dates
3. Develop an environmental criteria around PBS assessment
4. Elevate/integrate Choosing Wisely nationally (targeting the top 10 medicines and other areas such as low value diagnostics)
5. Develop national (evidence based) protocols for administration of medicines which support reducing waste such as oral rather than intravenous where clinically indicated
6. Implement other strategies to reduce low value medicines
7. Stop incentivising excessive supply via PBS subsidies
8. Address medicine packaging (with link to national regulation) including consideration of excess packaging (ie not all medicines need to be in tamper proof packaging)

9. Build consumer and clinical awareness to shift expectations to help reduce excess packaging (ie extra packaging gives the impression of sterility, but it is not actually sterile)

Research opportunity: need to demonstrate stability of dry powder inhalers in tropical, humid zones.

13. Which specific action areas should be considered relating to **waste**, over and above any existing policies or initiatives in this area?

Focus on suppliers: implement initiatives and/or standards which support suppliers and industry to transition away from plastics and other damaging packaging and single-use products

Focus on waste infrastructure (particularly in regional and remote areas): invest in the development of technologies which enable small locations to increase their materials repurposing/recycling to reduce landfill.

Develop national standards re health waste management (specifically in an emergency context, eg pandemic) which takes into consideration environmental impact.

14. Which specific action areas should be considered relating to **prevention and optimising models of care**, over and above any existing policies or initiatives in this area?

There is an opportunity for the Commonwealth to create national clarity and consistency around national health emissions and waste data. This could be in the form or guidelines or standards which identify:

- which data is most powerful/effective in measuring and driving change
- ways which data integrity can be ensured
- ways in which the data could be leveraged for optimal value

Other options which were raised for national leadership were:

- applying research about the value of plant based foods into practice in hospital dietary standards
- introduction of a 'sugar tax' (or similar) which decreases both the demand and supply of sugary products to support improved health across the spectrum (but in particular renal, dental and obesity)
- higher profile and integration of advanced care planning and goals of care for chronic conditions as a focus to minimise unnecessary hospitalisations and the emission/cost intensive last 1000 days of life
- a tool and/or mechanism for vulnerable individuals to be supported in their own individual emergency response planning and embed these into models of care and emergency and disaster planning to enable those individuals to have greater power over their location and movements in an emergency situation
- applying a national funding model and framework for virtual healthcare models to optimise uptake and effectiveness nationally

Potential case study - ED Liaison Team Mental Health model in Katherine – has saved $1.5million in Careflight transfers to Darwin along with reducing emissions and further patient distress through effective early intervention.

Not approved

15. What can be done to involve private providers within the health system in the Strategy's emissions reduction efforts?

The nature of the NT context (small population distributed over vast distances) results in significant private market failure which means there is a very small private health sector in the NT. Any incentives or support mechanisms to involve private providers in emissions reduction efforts should be made available to all health providers in the NT (or the already inequitable receipt/distribution of private funding which other jurisdictions receive via their private providers to provide health care to their populations will be exacerbated).

In terms of involving private providers in emissions reduction efforts, private hospitals could be supported (through a transition period) to meet the same national standards as public hospital in relation to environmental sustainability standards.

16. Where should the Strategy prioritise its emissions reduction efforts?

    a. How should the Strategy strike a balance between prioritising emissions reduction areas over which the health system has the most direct control and prioritising the areas where emissions are highest, even if it is harder to reduce emissions in these areas?

    b. Which of the six sources of emissions discussed above (on pages 13 to 18 of the Consultation Paper) are the highest priorities for action?

    a. The focus should be on targeting effort for the greatest impact. This may not always be reduction of carbon emissions. It is important to avoid carbon tunnel vision and factor in biodiversity (as no amount of emissions reductions will bring extinct plant and animals species back to life).
    Health agencies have a lead role to play in promoting understanding of the integration of planetary health and human health for cultural, system, policy and economic reform.

    b. Prioritising action on these sources of emissions should be determined by data.

17. What 'quick wins' in relation to emissions reduction should be prioritised for delivery in the twelve months following publication of the Strategy?

Solar panels on all public health infrastructure via a national building/solar program or supported via private power agreements.

Encourage peak bodies to introduce CPD points related to sustainability in healthcare.

Based on existing research in relation to whole of life emissions profiles of healthcare products and services, support operational decision making (perhaps by way of industry standards) which enable organisations to more easily determine which option has the lowest emissions/impact on the planet (eg re-usable versus single use items).

Proposed Objective 3: Adaptation

18. What health impacts, risks and vulnerabilities should be prioritised for adaptation action through the Strategy? What process or methodology should be adopted to prioritise impacts, risks and vulnerabilities for adaptation action?

Tropical areas of Australia are the most vulnerable to climate change in terms of exposure to heat, water security (and water quality) and disease.

The following areas should be prioritised for adaptation action:

1. [redacted]
2. Water quality
3. Liveability – consider impacts of relocating climate refugees when the northern and desert parts of Australia become unsuitable for human habitation due to extreme heat (or for mental and psychosocial wellbeing in the more immediate term)
4. Workforce vulnerability – this also contributes to the urgency for effective virtual health models of care and funding mechanism
5. Heat related illness
6. Vector borne disease
7. Chronic disease impact – respiratory health impacts from increased dust/smoke pollution
8. First Nations – dislocation from land, language and cultural practices (additionally, if First Nations people need to relocate from their Country they not only lose their connection to Country which exacerbates health problems, but if they relocate to someone else's Country that can create tensions and social unrest which has happened in a number of communities in the past).

19. Should the Australian government develop a National Health Vulnerability and Adaptation Assessment and National Health Adaptation Plan? If yes:
    a. What are the key considerations in developing a methodology?
    b. How should their development draw on work already undertaken, for example at the state and territory level, or internationally?
    c. What are the key areas where a national approach will support local/jurisdictional vulnerability assessment and adaptation planning?

Yes, the Australian government should develop a National Health Vulnerability and Adaptation Assessment and National Health Adaptation Plan.

a. Needs to identify health service vulnerability as well as population vulnerability.

b. Work has already been undertaken in this area by the National Climate Change Adaptation Research Facility (NCCARF) and the Greener NHS, Sustainable Development Unit in the UK

c. A national approach would be valuable in:
   - Natural hazard assessment
   - Emergency preparedness and response
   - Identification, funding and design of new health and aged care services
   - A national surveillance system and indicators

20. Would there be value in the Australian government promoting a nationally consistent approach to vulnerability assessment and adaptation planning for the health system specifically, for instance by issuing guidance and associated implementation support tools for states, territories and local health systems? If yes, what topics should be covered to promote a nationally consistent approach? What examples of existing guidance (either from states/territories or internationally) should be drawn from?

Yes, this could support local decision making, carbon farming and national liveability ratings.

By drawing from existing guidance and issuing a nationally consistent approach, the Commonwealth can ensure that vulnerability assessment and adaptation planning in the health system is standardised, effective, and aligned with best practices.

National 'liveability' ratings across the country could be used for public infrastructure planning, private investment decision making, remuneration and tax incentives (eg similar to the remote area allowances currently available) and working conditions (eg not working more than six hours outside when temperatures and/or humidity exceed certain thresholds). The 'liveability' rating could be applied in a similar way to current remoteness factors, but for climate exposure.

Carbon farming is a potentially high value-add initiative (especially where re-forestation can be applied and on Indigenous lands) for health, economic and environmental benefits.

Examples of existing guidance that can be drawn from include:

- **Climate Change and Health Adaptation Planning Guide - Victoria**, Australia: This guide provides a framework and step-by-step process for undertaking health vulnerability assessments and developing adaptation plans. It covers topics such as climate impacts, vulnerability assessment, adaptation options, and implementation strategies.
- **National Health Service (NHS) Sustainable Development Unit (SDU)** - United Kingdom: The NHS SDU has developed guidance on assessing climate change risks to health and adapting health systems. It provides practical tools, case studies, and resources for conducting risk assessments, identifying adaptation options, and integrating climate change considerations into health service planning.
- **Intergovernmental Panel on Climate Change (IPCC) Guidelines**: The IPCC provides comprehensive guidelines on vulnerability assessment and adaptation planning in the context of climate change. These guidelines cover a broad range of sectors, including health, and can serve as a valuable resource for developing national guidance.

21. What immediate high-priority health system adaptation actions are required in the next 12 to 24 months?

Investment in a national heat related illness surveillance system and development of early warning indicators to reduce the impact of heat on climate-sensitive health conditions. This would also support a necessary cultural shift in Australia away from "it's always hot" to an understanding of health impacts of extreme heat and behaviours which can minimise health impacts.

Elevate the role, functions and visibility of Public Health Physicians and the public health profession within the Health system in relation to leadership in adaptation and resilience.

For Approval

The dual benefit of this is to build awareness of the interdependency of human health on planetary health, as well as attract people to this vital field.

Prioritise the assessment and retrofitting of health infrastructure for increase resilience to climate-related risks.

Develop targeted interventions and support systems for vulnerable populations, including the elderly, children, low-income communities, and indigenous populations.

Proposed Objective 4: Health in All Policies

22. What are the key areas in which a Health in All Policies approach might assist in addressing the health and wellbeing impacts of climate change and reducing emissions?

The key areas which should be targeted in a Health in All Policies approach are:

- apply a greater economic value to the environment and associated health of the population
- reform public housing
- support and expand two-way and bi-lingual learning in education (in remote communities in the NT) as an effective way of building awareness and respect for First Nations' knowledges

23. What are the most effective ways to facilitate collaboration and partnerships between stakeholders to maximise the synergies between climate policy and public health policy? What are some successful examples of collaboration in this area?

A mission oriented approach, such that all government initiatives align with/reach for this overarching mission, has been used to great effect by the OECD to align efforts across national borders and CSIRO are applying this to their research portfolio to enable inter-sectoral engagement and collaboration.

Whilst it is important to be clear about the scope and deliverables (to ensure actual progress), the launch of this Strategy is also a critical opportunity to establish a unifying mission to enable aligned national efforts. This is more than a target, but includes a framework which encourages and facilitates transformative, boundary spanning collaborative effort towards the unifying mission.

In practical terms, the Strategy could include mechanisms for better **coordination** of effort.

Question:

- Does Health in All Policies include broader actions/initiatives (beyond 'policy') such as opportunities to align the design/trial of new models of care and health funding models which incentivise action on climate action targets because this effectively represents an investment in reduced (or at least stable) future demand of health services)?

To be approved

Enablers

24. How could these enablers be improved to better inform the objectives of the Strategy? Should any enablers be added or removed?
Reforming (or redesigning some key elements of) the **public sector budget mechanisms** could enable more aligned, interagency collaborative effort, as well as longer investment horizons (eg ability to quarantine/allocate investment for generational change) would be valuable. Surveillance, both clinical and climate related, should be added as a key action to **Research**. To support these areas it would be valuable for national standards/benchmarks to be developed so there is consistency regarding what is measured.
25. For each of these enablers: a. What is currently working well? b. What actions should the Strategy consider to support delivery?
a. There are currently multiple initiatives and efforts occurring across all of these enablers. The Climate and Health Alliance, and Global Green and Healthy Hospitals are both active and effective in facilitating connected/coordinated effort. The CSIRO mission orientated approach is also a step in the right direction in terms of inviting and facilitating research collaborations. b. Harmonising these efforts under identified/nominated umbrella areas could help gain traction and accelerate change nationally, ie it is more effective as a nation to identify existing leaders in certain portfolio areas to define and set up frameworks, standards, processes or priorities, rather than have multiple, uncoordinated parallel initiatives duplicating effort.

Other comments

Suggestions which are not directly in the scope of the Commonwealth DHAC, but ultimately influence population health outcomes were:

- use policy levers in the agriculture sector to incentivise/support plant based food production, regenerative farming practices and promote vegetable based culinary cultures directly and indirectly
- rebalance Australia's economic system through restorative actions such as:
  - incentivising regenerative practices, investment and business models
  - embedding/supporting a circular economy approach across all industries
  - applying a greater value to the environment (whereby it makes more financial sense to invest in biodiversity and carbon capture than land clearing)

Thank you for taking the time to complete this survey – your feedback is greatly appreciated!

Please submit this form in Word format to Health.Climate.Consultation@health.gov.au.

To be approved

COLLEGE OF INTENSIVE CARE MEDICINE
OF AUSTRALIA AND NEW ZEALAND

31 July 2023

Department of Health and Aged Care
Via email: Health.Climate.Consultation@health .gov.au

To whom it may concern,

Re: Consultation - National Health and Climate Strategy

The College of Intensive Care Medicine, Australian and New Zealand (CICM) thanks the Department of Health and Aged Care for the opportunity to review and provide feedback on the draft National Health and Climate Strategy.

The CICM is responsible for intensive care medicine specialist training and education in Australia and Aotearoa New Zealand. The College provides continuing medical education and professional development, maintains standards, and advocates to government in support of policies to improve the healthcare of all Australians and Aotearoa New Zealanders.

As a medical specialist training college, CICM has a role in leading Fellows, Trainees and College staff to recognise the impact of climate change, and place preventive strategies at the centre of work practices. In 2019, CICM published its Statement on Sustainability and in 2021, collaborated on a multi-college report, Climate Change and Australia's Healthcare Systems. Last year the College launched its Environmental Sustainability Special Interest Group (ESSIG) to provide support and guidance in relation to environmental sustainability, and develop and deliver education to CICM members on sustainability, climate change and health.

I also wish to draw your attention to the Australian and New Zealand Intensive Care Society's (ANZICS) *A beginners guide to sustainability in the ICU* which includes a range of ideas and actions ICUs can implement to help reduce the sector's carbon footprint and improve the health of the population.

Please find our feedback on the National Health and Climate Strategy attached (Appendix 1). We hope that the information contained in our submission is helpful. Should you have any queries or comments regarding our feedback, please feel free to contact [redacted]

Yours sincerely,

[redacted]

[redacted]
President

The College of Intensive Care Medicine acknowledges and pays respects to the traditional Custodians of the lands across Australia on which our members live and work, and to their Elders, past, present and future. We pay respect to the Wurundjeri Peoples as the Traditional Custodians of the land on which CICM's office stands. CICM acknowledges Māori as tangata whenua and Treaty of Waitangi partners in Aotearoa New Zealand.

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Australian Government
Department of Health and Aged Care

NATIONAL HEALTH AND CLIMATE STRATEGY

Detailed submission form

This form allows you to provide responses to the full set of questions in the Consultation Paper available here.

Alternatively, you may wish to complete the briefer online survey available here.

Please submit this form in Word format to Health.Climate.Consultation@health.gov.au.

Respondent details

What is your name?
[redacted]
What is your email address?
[redacted]
What is your organisation?
The College of Intensive Care Medicine (CICM)
Have you read and agreed to the Privacy Statement? (NB we will not be able to use your submission unless you tick this box)
☒ I have read and agreed to the Privacy Statement
Do you identify as Aboriginal and/or Torres Strait Islander? (Yes/No/Prefer not to say)
[redacted]
Please select which applies to you: ☐ Individual citizen ☐ Health Service Provider ☐ Industry and Life Sciences Organisation or Representative ☐ Academic or Researcher ☐ Primary and/or Allied Health Peak or Advocacy Organisation or Representative ☐ Aged Care Service Provider ☐ First Nations Health Service Provider ☐ First Nations Community Group ☐ First Nations Peak or Advocacy ☒ Medical College or Peak professional body

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Questions for feedback from the Consultation Paper

Introduction

1. How could these objectives be improved to better support the vision of the Strategy?

Introduction

To provide context to readers, the CICM suggests that that the introductory text include content on the fundamental causes of climate change (e.g. excessive use of consumables and population growth etc.) as prevention and management of these causes is essential to ensuring a healthy population.

Measurement

The CICM suggests that:

- the Government clarifies its **methods** of measure for this objective—particularly measurement of direct healthcare energy (electricity and fossil gas) use, water and waste, and healthcare anaesthetic gases (e.g. nitrous oxide) in addition to greenhouse gas (GHG) emissions.
- Measurement should not be restricted to health system GHG emissions, but other environmental impacts such as water use, waste outputs, air pollutants etc.
- It would be helpful to include measurement estimates and models of the beneficial effects of different types of interventions on healthcare emissions, e.g. reducing obesity rates by 10% and the effect this would have on emissions.

Mitigation

- The CICM suggests including carbon emission targets to track improvements to mitigation strategy. We would like to emphasise the importance of aiming for Carbon emission targets that keep Australians below a temperature rise of 2°C.

Health in all policies

- The CICM recommends explicitly including the role of First Nations people here.

The CICM also suggests adding an Objective about what decarbonisation aims and targets are **necessary** to avoid the dire health consequences of more than 2°C warming.

2. How could these principles be improved to better inform the objectives of the Strategy?

The inclusion of a strong **governance** framework is needed.

For example:

- What are the roles and responsibilities of the National Climate Change, Sustainability and Health Unit, alongside the various state based similar sustainable healthcare units (NSW and WA currently)?
- How can these bodies collaborate to move Australian healthcare towards a low carbon, high value system?
- What role will each team have in encouraging other health focussed groups (e.g. private healthcare providers, hospitals in general, medical research organisations) to achieve net zero?

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The CICM suggests explicitly highlighting the importance of data-sharing in these principles. Environmental sustainability data will need to be tracked at a national level with considered models for collaboration and governance in place. This could be part of the "Evidence-informed policymaking" principle.

3. Which of the various types of greenhouse gas emissions discussed above should be in scope of the Strategy's emission reduction efforts?

All greenhouse gas (GHG) emissions should be in scope of the Strategy's emission's reduction efforts, as all GHGs cause climate change. Scope 3 (indirect) GHGs are particularly relevant to healthcare, as repeated environmentally extended input-output (EEIO) whole of healthcare studies have shown that GHG emissions from health procurement form the majority of GHGs in healthcare.

There should be a mechanism to measure the complex interplay between different types of GHG in healthcare. For example, adopting reusable medical equipment instead of single use equipment lowers associated GHGs, particularly when the electricity source of hospitals transitions to renewables. If only Scope 1 GHG emissions were measured, however, it would show an increase in emissions, as electrical reusable equipment would be more frequently used. Therefore, the reduction in Scope 3 GHG emissions would not be captured.

Moreover, measurement of Scope 1 and 2 emissions already exists in most Australian jurisdictions. Standardising measurement of Scope 3 emissions carefully via process-based life cycle assessment (LCA) is vital and should be considered in the strategy.

4. What existing First Nations policies, initiatives, expertise, knowledge, and practices should the Strategy align with or draw upon to address climate change and protect First Nations country, culture, and wellbeing?

It is that further development of the Strategy is guided by the knowledge and learnings of First Nations individuals, communities, and organisations across the country.

The Australian Indigenous Doctor's Association's (AIDA) policy statement on Climate change and Aboriginal and Torres Strait Islander people's health highlights the importance of engaging Aboriginal and Torres Strait Islander organisations in the development of climate change and health policies and strategies.

5. What types of governance forums should be utilised to facilitate co-design of the Strategy with First Nations people to ensure First Nations voices, decision-making and leadership are embedded in the Strategy?

As described above.

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Proposed Objective 1: Measurement

6. Beyond the schemes already noted above, is your organisation involved in any existing or planned initiatives to measure and report on health system emissions and/or energy use in Australia?
Caution against over reliance on Environmentally Extended (Economic) Input Output (EEIO) studies to guide local decision making (including by individual and groups of clinicians) is critical. EEIO studies are useful for setting the scene and providing a broad overview of the healthcare sector's GHG emissions. EEIO studies are not nuanced enough to guide individual clinician's and groups of clinicians' choices towards processes and procedures that result in fewer GHG emissions.
7. What additional data and information is required to support targeted emissions reduction efforts within health and aged care?
The CICM would suggest including the following additional data and information: 1. Inclusion of the methods used to measure GHG emissions, including: • direct healthcare energy use • water and waste • anaesthetic gases • pharmaceuticals • medical equipment We note that measurement of the carbon footprint of pharmaceuticals and medical equipment is currently uncertain and rudimentary and would encourage further work in this area. 2. Inclusion of process-based Life Cycle Assessments (LCAs) As opposed to environmentally extended input output (EEIO) studies, process based LCAs are more specific in scope. Process based LCAs require careful analyses of the components, their masses, place of manufacture, and energy sources used to deliver the final product. They are a reliable method to make comparisons between different clinical pathways; information which is becoming increasingly important for clinicians. The CICM notes that EEIO studies can be overly simplistic— it assumes a linear relationship between financial and environmental costs (see discussion in McGain et al's article on the treatment of patients with septic shock: https://pubmed.ncbi.nlm.nih.gov/30482138/) 3. Measurement of other environmental impacts 4. Measurement estimates and models of different type measurement estimates and models of the beneficial effects of different types of interventions on healthcare emissions, e.g., reducing obesity rates by 10% and the effect this would have on emissions.

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Proposed Objective 2: Mitigation

8. What do you think of these proposed focus areas for emissions reduction? Should anything else be included?

The CICM believe the proposed focus areas are reasonable, but suggests that the order be rearranged, placing “Prevention and Optimising Models of Care” first. Avoiding building more hospitals than necessary through optimising alternative models of care will be vital.

The greatest effort should be placed upon changing clinician behaviour and the healthcare system in Australia to be high value, low carbon care. This could look like prioritising health promotion and disease prevention, reducing low value care, and keeping people at home and away from hospitals. Reducing GHGs stemming from the “Built environment” and “Medicines and Gases” is still important, but we believe that the order and emphasis should be upon models of care.

Moreover, engagement of clinicians to reduce low value care is likely to flow into interest in other clinician efforts to prioritise low carbon healthcare.

9. Which specific action areas should be considered relating to the **built environment and facilities (including energy and water)**, over and above any existing policies or initiatives in this area?

The CICM would like to congratulate existing policies such as the move to 100% renewable electricity in Tasmania, the ACT, South Australia, and public hospitals in Victoria. We note the importance of reducing energy use through energy efficiency measures such as hospital zoning, operating theatre setbacks out-of-hours, etc.

Continuing fully electrified builds of hospitals as shown in the ACT (Canberra Hospital), South Australia (New Women and Children’s Hospital) and Victoria (Melton Hospital) is essential—there should be no new gas builds.

The CICM also suggests prioritising improving existing facilities over building new hospitals.

10. Which specific action areas should be considered relating to **travel and transport**, over and above any existing policies or initiatives in this area?

All new and existing hospitals should have excellent public transport services, with the option of free transport for patients’ families and friends.

The reach of telehealth meetings for staff, patients, and their families/friends should be increased and improved. It may be valuable to consider the role of artificial intelligence to augment this reach e.g., automated check ins with patients/families/friends.

Senior medical and other hospital staff should not be remunerated for business class (high carbon) plane flight to conferences etc.

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11. Which specific action areas should be considered relating to **supply chain**, over and above any existing policies or initiatives in this area?
The CICM suggests the following action areas: 1. Emulating the efforts of the Greener NHS program (https://www.england.nhs.uk/greenernhs/). In particular, we should be incorporating purchasing preferences or robust, reusable medical devices wherever possible. 2. Mandate all medical device suppliers to explain why their devices are not reusable, and what efforts they have taken and will take to make their devices reusable in the future. This could be achieved by collaborating with the Medical Services Advisory Committee (MSAC) and the Therapeutic Goods Administration (TGA) to initially encourage, then mandate that all device manufacturers incorporate life cycle assessments into their products. 3. Work with the Pharmaceutical Benefits Scheme (PBS) to ensure that all new listed drugs undertake life cycle assessments.
12. Which specific action areas should be considered relating to **medicines and gases**, over and above any existing policies or initiatives in this area?
The CICM suggests the following: 1. Expand the section on medicines and gases on page 19 to include all Medicines. Currently it only covers anaesthetic drugs and inhalers. As stated earlier, more work needs to be done investigating the carbon footprint of pharmaceuticals. 2. Encourage all new hospital to avoid installing piped nitrous oxide as recommended by the Australasian Health Facility Guidelines (https://aushfg-prod-com-au.s3.amazonaws.com/download/RDS_ORGN_5_0.pdf) 3. Encourage midwives, obstetricians, anaesthetists, and patients to consider ways to reduce nitrous oxide use during birthing. Nitrous oxide is not a particularly effective labour analgesic—please see the Australian and New Zealand College of Anaesthetists (ANZCA) media release on the carbon footprint of nitrous oxide (https://www.anzca.edu.au/resources/media-releases/2022-media-releases/nitrous-oxide-australian-anaesthesia-2022.pdf) 4. Acknowledgment of the environmental footprint of the production of oxygen and adopting a more scientifically sound approach to the use of oxygen.
13. Which specific action areas should be considered relating to **waste**, over and above any existing policies or initiatives in this area?
The CICM suggests the following: 1. Mandatory targets relating to waste. While it is important to initially encourage opportunities to reduce waste, there should be a transition to more enforceable, mandated targets. 2. Removing item 2.5.2 “sustainable single-use items”—only reusable equipment should be considered sustainable.

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14. Which specific action areas should be considered relating to **prevention and optimising models of care**, over and above any existing policies or initiatives in this area?

The CICM suggests the following:

1. Rearrange the order so item 2.6.4. “Supporting Public Health Initiatives” is in first place (2.6.1)—this should be prioritised.
2. Low value care should be specifically and explicitly mentioned. See https://pubmed.ncbi.nlm.nih.gov/34699070.

15. What can be done to involve private providers within the health system in the Strategy's emissions reduction efforts?

The CICM suggests the following:

1. Provide financial incentives to avoid low value (and thus high carbon) healthcare and encourage high value health care via MBS billing.
2. Initially encourage and eventually mandate GHG emission targets linked to funding, particularly in private hospitals

16. Where should the Strategy prioritise its emissions reduction efforts?

a. How should the Strategy strike a balance between prioritising emissions reduction areas over which the health system has the most direct control and prioritising the areas where emissions are highest, even if it is harder to reduce emissions in these areas?

b. Which of the six sources of emissions discussed above (on pages 13 to 18 of the Consultation Paper) are the highest priorities for action?

16.a

1. Efforts to reduce healthcare’s GHG emissions should be undertaken by everyone associated with healthcare, everywhere, and across everything related to healthcare. The CICM emphasises the urgency tied to getting to net zero GHG emissions.
2. The strategy should first prioritise quick wins in areas which the health system has most control. For example, cessation of the use of desflurane everywhere and nitrous oxide where practical and dramatic reductions in the use of propellant based metered dose inhalers.
3. Prioritising electrifying everything and ‘getting off gas’ is crucial. This should look like no new gas builds and gradual removal of gas fired boiler heaters in hospitals.

16.b

The CICM believes that the following three sources of emissions should be prioritised:

1. Models of care (including avoiding new hospital builds)
2. Building energy and water use
3. Procurement of medical devices and instruments

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17. What 'quick wins' in relation to emissions reduction should be prioritised for delivery in the twelve months following publication of the Strategy?
The CICM suggests the following: 1. Ban desflurane anaesthetic use as soon as is practical—Scotland has already banned it, and NHS England has committed to phasing it out by 2024 https://www.bbc.com/news/health-64347191 2. No new nitrous oxide piping in hospitals 3. Aim to reduce propellant-based inhalers to <10% of total inhaler sales, replacing them with dry powder inhalers. 4. Cease all taxpayer funded business class trips. 5. Provide research funding for a comprehensive process-based life cycle inventory of commonly used reusable and single use medical equipment and emulate this process for pharmaceuticals.

Proposed Objective 3: Adaptation

18. What health impacts, risks and vulnerabilities should be prioritised for adaptation action through the Strategy? What process or methodology should be adopted to prioritise impacts, risks, and vulnerabilities for adaptation action?
The following actions should be prioritised for adaptation action: 1. Collaboration with external experts such as Defence and Emergency Services, First Nations people, and National Parks and Wildlife to prioritise the best methods to adapt healthcare to the new and changing realities of climate change. 2. Work with First Nations people to avoid building new hospitals on land precarious to climate change. 3. Work with people at risk (First Nations, low socioeconomic status etc) to reduce the risk of morbidity and mortality from extreme weather. It should always be stressed that Mitigation is far more important than Adaptation—if we reach 3°C warming, adaptation would no longer be feasible.
19. Should the Australian government develop a National Health Vulnerability and Adaptation Assessment and National Health Adaptation Plan? If yes: a. What are the key considerations in developing a methodology? b. How should their development draw on work already undertaken, for example at the state and territory level, or internationally? c. What are the key areas where a national approach will support local/jurisdictional vulnerability assessment and adaptation planning?
The CICM believes that the Australian Government should develop a National Health Vulnerability and Adaptation Assessment and National Health Adaptation Plan, however, efforts should still primarily be focussed on Mitigation.

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20. Would there be value in the Australian government promoting a nationally consistent approach to vulnerability assessment and adaptation planning for the health system specifically, for instance by issuing guidance and associated implementation support tools for states, territories, and local health systems? If yes, what topics should be covered to promote a nationally consistent approach? What examples of existing guidance (either from states/territories or internationally) should be drawn from?
21. What immediate high-priority health system adaptation actions are required in the next 12 to 24 months?
The CICM recommends avoiding building all new healthcare establishments upon land deemed likely to be damaged by the effects of climate change. For example, building on flood prone areas should be avoided.

Proposed Objective 4: Health in All Policies

22. What are the key areas in which a Health in All Policies approach might assist in addressing the health and wellbeing impacts of climate change and reducing emissions?
1. A Health in All Policies (HIAPs) approach will emphasise the importance of upstream influences of GHG emissions in healthcare. 2. A HIAP framework should be grounded in the severity of climate change and the existential threat it poses to our health and society
23. What are the most effective ways to facilitate collaboration and partnerships between stakeholders to maximise the synergies between climate policy and public health policy? What are some successful examples of collaboration in this area?
The CICM suggests procuring publicly signed support from other Federal agencies—this would encourage the concept of Health in All Policies across multiple departments.

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Enablers

24. How could these enablers be improved to better inform the objectives of the Strategy? Should any enablers be added or removed?
1. GHG emissions in healthcare should be measured and tracked. 2. Clinician engagement is vital—this could be modelled on the roles of the clinical leads of the NSW Health Climate and Risk Unit. 3. Work with the Doctors for the Environment (DEA) and Climate and Health Alliance (CAHA) – engaging with frontline clinicians already working in this field is crucial.
25. For each of these enablers: a. What is currently working well? b. What actions should the Strategy consider to support delivery?
a. Clinician engagement through DEA and medical colleges (e.g., RACP, ANZCA, RACGP, CICM, RACS, ANMF, AMA etc) has been in place for years and should be utilised by the strategy. b. The Strategy should systematise clinician engagement to make low carbon Australian healthcare a nationwide objective.

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Thank you for taking the time to complete this survey – your feedback is greatly appreciated!

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NATIONAL HEALTH AND CLIMATE STRATEGY

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Respondent details

What is your name?
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What is your role?
Chief Executive Officer
What is your organisation?
Australian Society of Anaesthetists (ASA)
Have you read and agreed to the Privacy Statement? (NB we will not be able to use your submission unless you tick this box)
☒ I have read and agreed to the Privacy Statement
Do you identify as Aboriginal and/or Torres Strait Islander?
☒ No
Please select which applies to you: ☒ Medical College or Peak professional body

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Questions for feedback from the Consultation Paper

Introduction

1. How could these objectives be improved to better support the vision of the Strategy?
The ASA feels that the objectives provide a well-structured and clear support for the vision of the Strategy. As a peak industry body representing Specialist Anaesthetists in both public and private hospitals, the ASA is positioned to offer advice particularly on measurement and mitigation. As an organisation dedicated to healthcare the ASA sees Health in all Policies (and the principle of "One Health") as a fundamental.
2. How could these principles be improved to better inform the objectives of the Strategy?
The ASA fully supports the principles as outlined.
3. Which of the various types of greenhouse gas emissions discussed above should be in scope of the Strategy's emission reduction efforts?
The ASA advocates very strongly that the entirety of scope 1, 2 and 3 emissions should be within the Strategy's emission reduction efforts. Within the Australian healthcare sector, hospitals are the largest single source of emissions (totalling 44% of all emissions if public and private hospitals are combined – Malik). Data from the NHS shows that most of the health–related CO2 equivalent emissions (60%) are scope 3. The Australian healthcare system is likely to be very similar. Therefore, accurate estimates of all emission scopes should be a priority for both public and private hospitals. As a first step, there should be dis-aggregation of scope 2 (electricity consumption) figures for the hospital system at least. The conversion of hospital energy use to 100% renewable (see question 9 below) can then be targeted and emissions reductions measured. The ASA supports a target of 100% electricity consumption from renewable sources for all hospitals as soon as practicable. A longer-term target should be quantification of all scope 3 emissions by hospitals. As many hospitals are very large business concerns, this would be in keeping with the Governments' climate-related financial disclosure strategy. The ASA advocates for a goal of net zero emissions by all hospitals by 2040. This could become part of hospital accreditation. Measurement, reporting (and reduction) of emissions could form the basis for a 9th National Safety and Quality in Healthcare standard (NSQHS).

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The ASA supports the ACSQHC Draft Sustainable Healthcare Module, which outlines a framework that can be incorporated into any health care organisation's existing clinical governance structure.

References:

Malik A, Lenzen M, McAlister S, McGain F. The carbon footprint of Australian health care. The Lancet Planetary Health. 2018;2(1):e27-e35.

National Health Service. Delivering a 'net zero' National Health Service webpage NHS; 2020. Available from: https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf

4. What existing First Nations policies, initiatives, expertise, knowledge and practices should the Strategy align with or draw upon to address climate change and protect First Nations country, culture and wellbeing?

Nil comment.

5. What types of governance forums should be utilised to facilitate co-design of the Strategy with First Nations people to ensure First Nations voices, decision-making and leadership are embedded in the Strategy?

The ASA is fully supportive of the Australian Indigenous Doctors Association (AIDA). It should be noted that AIDA has sustainability as one of its 6 key strategic priorities.

The ASA is also supportive of the AMA Taskforce on Indigenous Health.

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Proposed Objective 1: Measurement

6. Beyond the schemes already noted above, is your organisation involved in any existing or planned initiatives to measure and report on health system emissions and/or energy use in Australia?

The Australian Society of Anaesthetists is a member organisation with a diverse membership base representing anaesthetists in metropolitan and regional areas as well as in public, private and blended public/private practice. While it is not directly linked to frontline healthcare provision, it is indirectly linked through its support and advocacy on behalf of members whose primary profession is healthcare provision.

The ASA is not currently involved in any existing or planned initiatives to measure and report on health system emissions and/or energy use in Australia.

7. What additional data and information is required to support targeted emissions reduction efforts within health and aged care?

It is the ASA's position that the healthcare sector (in particular the hospital sector) should be working towards reporting in a dis-aggregated manner on scope 1, 2 and 3 emissions, justified by the fact that hospitals are significant emitters. The Australian healthcare sector is responsible for approximately 7% of total emissions in this country and just under half of that comes from the hospital sector (Malik et al).

For scope 2 emissions, this would require reporting of electricity/energy consumption (at a facility level) and for scope 3, all purchasing of pharmaceuticals, equipment and disposables (more likely to be done at a health service or organisational level). Consideration must be given to the administrative burden for individual facilities or organisations - such reporting goes beyond that currently legislated under the National Greenhouse and Energy Reporting Scheme (NGER) but could be facilitated by a national Australian Sustainable Healthcare Unit (SHU) as proposed by Doctors for the Environment Australia (DEA) (see our response to question 17 below).

References:

Malik A, Lenzen M, McAlister S, McGain F. The carbon footprint of Australian health care. The Lancet Planetary Health. 2018;2(1):e27-e35.

Doctors for the Environment Australia: Net zero carbon emissions: responsibilities, pathways and opportunities for Australia's healthcare sector. Accessed 7/10/2023. Available at: https://dea.org.au/wp-content/uploads/2020/12/DEA-Net-Zero-report_v11.pdf

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Proposed Objective 2: Mitigation

8. What do you think of these proposed focus areas for emissions reduction? Should anything else be included?

The ASA agrees with the scope of the proposed areas.

9. Which specific action areas should be considered relating to the built environment and facilities (including energy and water), over and above any existing policies or initiatives in this area?

The ASA supports the proposed objectives concerning building design, construction and operation.

With regards to building operation, the ASA joins other medical organisations in advocating for hospitals to target 100% of their electricity and energy use from renewable sources. As stated in the paper (and in many of the references) there is a moral and ethical imperative for the healthcare sector to reduce their carbon dioxide emissions and not contribute to what is the major public health issue of the 21st century – "First do no harm". In addition to this moral and ethical duty, it sends a strong and valuable message to the public and the market.

To re-iterate, this could be incentivised nationally by linking such activity to hospital accreditation (since it clearly has major health benefits).

For hospital rebuilds or new builds, additional factors not mentioned in the paper are those that reduce reliance on private motor vehicle transport such as public transport access (which also benefits vulnerable groups unable to drive) and provision of adequate bicycle storage areas. Note this also encourages increased activity levels amongst providers and patients.

10. Which specific action areas should be considered relating to travel and transport, over and above any existing policies or initiatives in this area?

As stated in the paper, even low rates of electric vehicle uptake provide emission reductions and important health benefits. It is thus critical for all state governments to start moving immediately towards electrification of their vehicle fleets. In the consultation paper, it is proposed at 2.2.1 that policy levers are utilised to facilitate this. We would again recommend that a key way to remove barriers to this change within the state hospital system is to make such action a part of hospital accreditation. In addition, as suggested in The Australian Government's National Electric Vehicle Strategy, collaboration in procurement between all states and New Zealand should be very actively pursued. Importantly, patient and staff travel must be included in the measurement and mitigation of travel and transport emissions.

Telehealth consultations are discussed within the paper ant the use of telehealth is an easy way to reduce transport-related emissions. In an attempt to safely and efficiently manage pre-anaesthetic consultations, Specialist Anaesthetists may be frequent users of telehealth, but mostly via phone only. To encourage and augment this activity, appropriate

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telehealth item numbers (including for phone consultations) should be permanently embedded in the Medicare Benefits Schedule.

References:

The Australian Government: Australia's National Electric Vehicle Strategy. Available at:

https://www.dcceew.gov.au/sites/default/files/documents/national-electric-vehicle-strategy.pdf, accessed 7/10/2023.

11. Which specific action areas should be considered relating to supply chain, over and above any existing policies or initiatives in this area?

The ASA strongly supports the NHS procurement initiatives outlined in the paper. We believe the Australian healthcare system can follow suit. In terms of achieving similar initiatives in the Australian federated state structure this can be done by making such activity part of hospital accreditation.

We also note that purchasing oversight of individual hospitals if often provided by state and territory bodies. Therefore, to review the capacity for reducing emissions from scope 3 sources, it would be useful to first review the climate impacts of hospital purchases at a state aggregated level, before burdening individual hospitals with complex measurement and mitigation tasks.

Circular procurement policies are also linked to management of waste and are partly addressed below (see question 13). Hospitals may be linked into long-term (years) contracts for purchase of disposable plastic items that utilise no recycling in their manufacture. National legislation to mandate a minimum of 50% recycled plastic content in manufacture of medical disposables can help address this.

12. Which specific action areas should be considered relating to medicines and gases, over and above any existing policies or initiatives in this area?

The ASA acknowledges that anaesthesia providers have an absolute duty to consider both individual and population health harms and benefits in their choice of anaesthetic agents. As discussed in the paper, desflurane is especially harmful in terms of CO2 equivalent emissions. The ASA fully supports legislation and action to reduce or eliminate the use of desflurane wherever possible.

The NHS is decommissioning the use of desflurane by early 2024 with use only allowed in exceptional circumstances. This has the full support of the Royal College of Anaesthetists and the Association of Anaesthetists in the UK.

The European Union has proposed legislation for a ban on desflurane commencing January 2026.

In addition, policy and legislation could be directed towards:

1. Promoting anaesthetic gas capture and recycling. Technology now exists to capture and recycle both sevoflurane and desflurane. **This requires TGA approval** for pharmaceutical companies to market and utilise the technology. Once approved it

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could be mandated for theatre usage and co-managed and funded by the producers of anaesthetic gases.

2. Reduction in nitrous oxide leakage and venting to atmosphere.
    a. Bulk nitrous oxide for hospital use is supplied in large cylinders – these are returned to suppliers with significant residual nitrous oxide as they cannot be fully emptied on the hospital manifolds due to pressure reduction in the cylinder. Major suppliers of bulk nitrous oxide have been unable to verify that they do not just vent this nitrous oxide to atmosphere. The ASA suggests that legislation mandates this residual cylinder gas is captured and re-cycled.
    b. Hospitals must urgently assess and upgrade their nitrous oxide infrastructure to reduce leakage.
3. Routine audit of individual facility nitrous oxide and anaesthetic gas consumption. Funding should be directed towards this as part of hospital sustainability and accreditation, both as part of scope 1 emissions measurement and to track progress in reductions.

References:

Association of Anaesthetists: Joint statement on NHSE's plan to decommission desflurane by early 2024. Available at: https://anaesthetists.org/Home/News-opinion/News/Joint-statement-on-NHSEs-plan-to-decommission-desflurane-by-early-2024

13. Which specific action areas should be considered relating to waste, over and above any existing policies or initiatives in this area?

As discussed within the consultation paper, there are multiple opportunities within the hospital system for more responsible management and minimisation of waste. Pursuing these opportunities requires a cultural shift amongst hospital administration and frontline healthcare workers (to which there are barriers).

The ASA already supports anaesthetic trainees through their organisation: **Trainee-led Research and Audit in Anaesthesia for Sustainable Healthcare – "TRA2SH".** www.tra2sh.org. Such organisations have enormous potential for significant long-term improvements through a true bottom-up change in practice. The ASA believes they (and any similar trainee organisations) should be prioritised for government funding and support.

Additional specific policy levers that could be pursued are:

Reduction in single use plastics (aiming for a "circular" plastics economy)

- Engage with national accreditation standards to support reusable equipment in place of disposable, where possible.
- Look at legislating for Australian manufacturers to use minimum 50% recycled plastic content in manufacture of medical items.
- Promote policy change at both state procurement level and individual hospital policy level to only allow purchase of "single use" plastic items that have a minimum 50% recycled content (through accreditation mechanism).

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- Development of regulation to enable businesses to provide safe “re-processing” of single use items within the Australian healthcare system – such processes are in use in the USA and have FDA approval.

Fund local incineration and recycling facilities to reduce transport related emissions. (eg: currently Tasmania transports all of its contaminated waste and pharmaceutical waste to South Australia for incineration. Likewise, there are no incineration services in the Northern Territory).

References:

Davies JF, Seglenieks R, Cameron R, Kuruvilla NA, Grove EM, Shrivathsa A, Grobler S Operation clean up: A model for eco-leadership and sustainability implementation. Anaesthesia and Intensive Care 2023; 51(2): 88-95

14. Which specific action areas should be considered relating to prevention and optimising models of care, over and above any existing policies or initiatives in this area?

The ASA believes the best way to reduce emissions associate with acute and hospital-based care is to markedly increase investment in and strengthen both health prevention and our primary healthcare system.

We see primary healthcare and general practice as being at a crisis point in Australia. Junior doctor numbers entering general practice training are at an all-time low. This must be reversed. Corporatisation of general practice and task substitution will not solve the problem.

We feel that it is essential to urgently overhaul the Medicare Benefits Schedule in relation to general practice, over and above the small increment recently provided.

It is critical for the system as a whole, that GPs receive remuneration that is adequate to attract and retain medical graduates into general practice. Without this, the crowding in public hospitals will only increase, resulting in expensive and wasteful interventions and increases in CO2 emissions.

15. What can be done to involve private providers within the health system in the Strategy’s emissions reduction efforts?

As discussed in the paper, private providers are already showing signs of committing to emission reduction efforts (Ramsay Healthcare). The ASA believes that consumer expectation will drive change for many providers and the rest will follow as system regulation discussed above incentivises sustainable practice, including the instigation of the necessary accreditation standards.

16. Where should the Strategy prioritise its emissions reduction efforts?

a. How should the Strategy strike a balance between prioritising emissions reduction areas over which the health system has the most direct control

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and prioritising the areas where emissions are highest, even if it is harder to reduce emissions in these areas?

b. Which of the six sources of emissions discussed above (on pages 13 to 18 of the Consultation Paper) are the highest priorities for action?

The ASA advocates that action should be commenced now on the areas where emissions are highest as these may also take longer to effectively address. We see the 2 priorities as:

- Addressing supply chains to mimic the NHS move towards significant reductions in scope 3 emissions – this will require legislation and hospital accreditation changes to affect a nationwide change.
- Addressing preventive and primary healthcare to reduce hospital activity.

We would also advocate that while action is commenced on the above there could be simultaneous efforts towards the "quicker wins" listed below.

17. What 'quick wins' in relation to emissions reduction should be prioritised for delivery in the twelve months following publication of the Strategy?

Reduction in scope 1 emissions

- Hospitals urgently examine and repair nitrous delivery infrastructure.
- Bulk nitrous manufacturers are prevented from venting residual cylinder gas to atmosphere.
- Regulation on desflurane usage.
- Move forward with TGA approval of anaesthetic gas capture and recycling.

Reduction in scope 2 emissions

- All hospitals to target 100% electricity consumption from renewable sources.

Reduction in scope 3 emissions

- Appropriate telehealth consultation items are embedded in the MBS.

Monitoring and measurement of these by making sustainable practice a hospital standard and creation of a national Sustainable Health Unit to oversee governance of the standard and provide assistance and funding for audit and monitoring.

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Proposed Objective 3: Adaptation

18. What health impacts, risks and vulnerabilities should be prioritised for adaptation action through the Strategy? What process or methodology should be adopted to prioritise impacts, risks and vulnerabilities for adaptation action?
Nil comment.
19. Should the Australian government develop a National Health Vulnerability and Adaptation Assessment and National Health Adaptation Plan? If yes: **a. What are the key considerations in developing a methodology?** **b. How should their development draw on work already undertaken, for example at the state and territory level, or internationally?** **c. What are the key areas where a national approach will support local/jurisdictional vulnerability assessment and adaptation planning?**
Nil comment.
20. Would there be value in the Australian government promoting a nationally consistent approach to vulnerability assessment and adaptation planning for the health system specifically, for instance by issuing guidance and associated implementation support tools for states, territories and local health systems? If yes, what topics should be covered to promote a nationally consistent approach? What examples of existing guidance (either from states/territories or internationally) should be drawn from?
The ASA supports completely the principle of a nationally consistent approach, as this is likely to be most efficient and will aid in disaster response when a region unaffected by a disaster may be called on to assist an affected region.
21. What immediate high-priority health system adaptation actions are required in the next 12 to 24 months?
Nil comment.

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Proposed Objective 4: Health in All Policies

22. What are the key areas in which a Health in All Policies approach might assist in addressing the health and wellbeing impacts of climate change and reducing emissions?
Nil comment.
23. What are the most effective ways to facilitate collaboration and partnerships between stakeholders to maximise the synergies between climate policy and public health policy? What are some successful examples of collaboration in this area?
Nil comment.

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Enablers

24. How could these enablers be improved to better inform the objectives of the Strategy? Should any enablers be added or removed?
The ASA believes that the existing enablers should be extended to include the development of sharp, focused, practicable and nationally uniform frameworks and guidelines for: • How environmental impacts should be incorporated into economic evaluation of health programs? • How service/product level emissions should be consistently monitored?
25. For each of these enablers: **a. What is currently working well?** **b. What actions should the Strategy consider to support delivery?**
The ASA has addressed a number of factors relevant to the enablers in responses above. To summarise: **Enabler 1 (Workforce, leadership and training):** The ASA supports that climate change and health (interactions and management) should be part of the curriculum for all medical colleges. **Enabler 2 (Research):** Targeting trainee-led bodies for funding and support such as "TRA2SH" will assist in sustained bottom-up change. **Enablers 4 and 5 (Collaboration and Monitoring and evaluation):** Creation of a national Sustainable Health Unit, explicitly involving First Nations representatives and a hospital standard will allow for establishment of governance structures and ongoing reporting on progress.

Thank you for taking the time to complete this survey – your feedback is greatly appreciated!

Please submit this form to Health.Climate.Consultation@health.gov.au.

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Feedback on the National Health and Climate Strategy Consultation Paper

AIDA Submission to the Department of Health and Aged Care

July 2023

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About AIDA

The Australian Indigenous Doctors' Association (AIDA) is the national peak body representing Aboriginal and Torres Strait Islander doctors and medical students. Our vision is for self-determination and equitable health outcomes for Aboriginal and Torres Strait Islander people in a culturally safe healthcare system.

AIDA supports its membership of Indigenous medical students, doctors in training and the medical workforce through advocating for culturally safe healthcare and medical education systems. Without this, our systems will continue to fail Aboriginal and Torres Strait Islander students, doctors and patients.

AIDA acknowledges and pays respect to the Traditional Owners of the lands across Australia on which our members live and work, and to their Elders and ancestors, past and present. We respect Aboriginal and Torres Strait Islander peoples continuing connection to land, waters and community, and thank ancestors for their role as the caretakers of the land we enjoy today.

Contact

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Recommendations

AIDA recommends:

1. the Strategy include a clearly articulated vision for which all other components can align to.
2. the Strategy include clear targets and measures to support effective implementation and accountability.
3. a glossary of definitions be included in the Strategy.
4. alignment with the National Agreement on Closing the Gap. Specifically, the four Priority Reforms of the National Agreement, which address structural change and genuine co-design.
5. dedicated engagement with Torres Strait Island communities and leaders.
6. the scope of the Strategy be reframed beyond carbon emission reduction of the healthcare system, to address health impacts of climate change on the population.
7. the Strategy take a strong preventive health approach in recognition that addressing the impacts of climate change will lead to greater improvements to population health.
8. the Government increase investment in preventive health and climate change mitigation initiatives.
9. the Strategy commit to not exacerbating the health inequities currently impacting Aboriginal and Torres Strait Islander people, with a goal to overturning these inequities.
10. the Strategy integrate Aboriginal and Torres Strait Islander expertise in all efforts to address the impacts of climate change on health.
11. the Strategy test assumptions and address unintended consequences.

Introduction

AIDA welcomes the development of the National Health and Climate Strategy, and the opportunity to provide feedback to what extent the current Consultation Paper meets the needs of people in Australia.

The need to address the impacts of climate change on health has been well defined and longstanding[1,2,3,4]. Globally, it is known that climate change disproportionately impacts Indigenous peoples, due to their close connection with the environment, and the exacerbation of inequalities already experienced[5].

This Strategy must be brave and ambitious to not only address the inequitable impacts experienced by Aboriginal and Torres Strait Islander peoples but must go so far as to protect the future of Australia, its lands, and its people.

The narrow scope of the Strategy outlined in the Consultation Paper does not sufficiently address the health impacts of climate change; the focus and proposed solutions cannot rest on 'greening' the healthcare system alone. There is a great opportunity for this first-of-its-kind strategy to break down the silos of our government and systems to truly address the impacts of climate change on health in a culturally appropriate way. Health in all policies requires all policy areas to be in scope – including those beyond the confines of the Department of Health and Aged Care.

The Consultation Paper and the questions posed in it hinder real engagement on the scope of the emerging strategy, and AIDA provides this submission with the intent of improving the eventual Strategy, actions and implementation plan.

Specific responses to the Consultation Paper questions appear later in this paper.

AIDA welcomes the opportunity to engage further with the Department of Health and Aged Care in the development of the National Health and Climate Strategy.

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Feedback on the National Health and Climate Strategy Consultation Paper

Define essential components of the Strategy and overhaul language

There are glaring omissions from the Strategy that are necessary in defining its success. A well-articulated vision statement, as well as measures of success and associated targets are standard and necessary inclusions in a strategy. It'd also be helpful to understand the audience for the strategy to understand where accountability for implementation and progress monitoring should align. Further, the timeframe for implementation needs to be clear in order to drive timely change.

AIDA recommend the Strategy include a clearly articulated vision for which all other components can align to.

AIDA recommend the Strategy include clear targets and measures to support effective implementation and accountability.

The language of the Consultation Paper assumes that the reader is familiar with climate-related terminology and the mechanisms to address climate change. There also appears to be an inconsistent understanding of the definition of health, especially with regard for the holistic concept of Aboriginal and Torres Strait Islander health. The Aboriginal and Torres Strait Islander understanding of health is holistic and refers to social, emotional and cultural wellbeing of the whole community[6]. This holistic concept of wellbeing explicitly refers to the 'connection to Country and land' as a critical domain in providing wellbeing for Aboriginal and Torres Strait Islander peoples.

AIDA recommend a glossary of definitions be included in the Strategy.

The glossary should be plain English, easy to understand and terms that are assumed to be consistently understood.

Align with the National Agreement on Closing the Gap

The National Agreement on Closing the Gap (National Agreement), agreed to by all Australian Governments, represents a new approach where policy making that impacts Aboriginal and Torres Strait Islander people occurs in full and genuine partnership with Aboriginal and Torres Strait Islander people[7].

The National Agreement on Closing the Gap is a commitment from Australian governments to four Priority Reforms target which will fundamentally change the way governments work with Aboriginal and Torres Strait Islander people and communities.

In seeking to protect the health and wellbeing of Aboriginal and Torres Strait Islander peoples from the impacts of climate change, it is essential that the Strategy align with the National Agreement and the following four priority reforms:

- Strengthen and establish formal partnerships and shared decision-making
- Build the Aboriginal and Torres Strait Islander community-controlled sector
- Transform government organisations so they work better for Aboriginal and Torres Strait Islander people
- Improve and share access to data and information to enable Aboriginal and Torres Strait Islander communities make informed decisions.

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In developing the National Health and Climate Strategy, Government must meet its obligations to the National Agreement and these priority reforms. Through this, the Strategy will have a greater opportunity to reflect the needs of Aboriginal and Torres Strait Islander peoples, ensure culturally appropriate mitigation, adaptation and prevention activities are established and ultimately improve the chance of successfully addressing the impacts of climate change in Australia.

AIDA recommend alignment with the National Agreement on Closing the Gap. Specifically, the four Priority Reforms of the National Agreement, which address structural change and genuine co-design.

The need to genuinely partner and co-design on the development National Health and Climate Strategy is especially critical for Torres Strait Islander populations. Rising sea levels as a result of the climate crisis are threatening the Torres Strait Islands – with detrimental effects to the health and wellbeing of its people[8].

Evidence of the Governments failed engagement and action is no greater than the landmark case that was won by the Torres Strait 8[9]. In September 2022, the United Nations Human Rights Committee found that the Australian Government had breached its human rights obligations through inaction on climate change[10]. The consequences of continued inaction in addressing climate change will be irreversible for the Torres Strait Islands; coastal erosion, destruction of sacred sites and, ultimately, low-lying island communities becoming uninhabitable[11].

The Strategy must right these wrongs. The Department must engage with these impacted regions respectfully, and with urgency, in the Development of the Strategy.

AIDA recommend dedicated engagement with Torres Strait Island communities and leaders.

Protect the health of the population

The current scope of the strategy appears to be focused on the impacts of the healthcare system on climate change and inadequately acknowledges or addresses the impact of climate change on population health. This is especially critical when the determinants of health sit largely outside the healthcare system.

AIDA agrees that the sustainability of the healthcare system is a necessary component of the Strategy, and there is a great opportunity for the sector to lead in this space. However, the Strategy cannot sell itself short by avoiding consideration of the upstream influencers and enablers to counter the impacts of climate change on health outcomes.

AIDA recommend the scope of the Strategy be reframed beyond carbon emission reduction of the healthcare system, to address health impacts of climate change on the population.

The purpose of the strategy (hidden in a sentence) is to protect the health and wellbeing of Australians from the impact of climate change, through reform of the health care system. This narrow-minded approach fails to consider climate change mitigation and management as a preventive health measure.

The World Health Organization (WHO) defines preventative health as actions aimed at avoiding the manifestation of disease"[12]. Preventative health is largely underinvested in Australia; in 2020-21, public health expenditure was less than 5% of total health expenditure across all governments, almost a tenth of what was spent on hospitals in the same period[13]. In 2021, the Department of Health and Aged Care (formerly the Department of Health) released the National Preventive Health

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Strategy 2021-2030[14] with a bold tagline of 'valuing health before illness'. Yet our funding continues to be misaligned.

If we continue to focus effort, investment and reform 'downstream' to the issue, we will continue to see the impacts of climate change increase. This Strategy could be a catalyst to instigate adequate preventive health investment as a priority for Government.

AIDA recommend the Government increase investment in preventive health and climate change mitigation initiatives.

The National Preventive Health Strategy acknowledges the effects of a variety of determinants on health, including the negative impact of climate change (p15), and the protective effects of culture on health (p17). However, and disappointingly, the Preventive Health Strategy fails to articulate the intersection between addressing climate change in the achievement of its lofty policy goals, such as improving access to a healthy diet, increasing physical activity and protecting mental health[15].

AIDA recommend the Strategy take a strong preventive health approach in recognition that addressing the impacts of climate change will lead to greater improvements to population health.

Prioritise protection of Indigenous health and wellbeing

Aboriginal and Torres Strait Islander people's health and wellbeing is intrinsically intertwined with other social determinants of health – historical, political, cultural and social. The disproportionate rates of preventable illness, chronic disease and intergenerational trauma experienced by Aboriginal and Torres Strait Islander people must be understood through the ongoing impacts of colonialisation, past and emerging government policies and practices, and those that still negatively impact Aboriginal and Torres Strait Islander people today. The scope of the strategy as presented in the Consultation Paper fails to adequately acknowledge, address and overturn these inequities experienced by Aboriginal and Torres Strait Islander peoples. IAs is evidenced throughout the Torres Strait 8 case[16], Aboriginal and Torres Strait Islander people are disproportionately impacted by climate change yet are less likely to contribute to it[17,18]. The case also highlights the inextricable link of Indigenous culture to the natural environment[19]. The Government has previously acknowledged that *Indigenous communities are more vulnerable to climate change because of the social and economic disadvantages already faced*[20]. Yet, current and emerging policies and practices fail to protect the health of Indigenous peoples.

AIDA recommend the Strategy commit to not exacerbating the health inequities currently impacting Aboriginal and Torres Strait Islander people, with a goal to overturning these inequities.

There is little reassurance in the Consultation Paper that there is an understanding of the holistic definition of health, and consequently an incomprehensive consideration of the strategies required to protect and promote the health of Aboriginal and Torres Strait Islander peoples.

Recognise, value and embed Indigenous knowledges, experiences and expertise

Aboriginal and Torres Strait Islander peoples have been nurturing and caring for Country for tens of thousands of years, with expertise in managing their traditional lands. It is appreciated that the Strategy calls out the importance of Indigenous knowledge in informing how Australia can address the problem of climate change, however, the commitment appears tokenistic at best.

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As noted earlier, Aboriginal and Torres Strait Islander health centres around a holistic concept of connectedness [21]. This holistic concept of wellbeing explicitly identifies 'connection to Country and land' as a critical domain in providing wellbeing for Aboriginal and Torres Strait Islander peoples. As Traditional Custodians of Australian lands, Aboriginal and Torres Strait Islander peoples have a breadth of knowledge, experience and expertise that must be embedded to inform an adequate strategy. References to data, research and expertise largely excludes Aboriginal and Torres Strait Islander perspectives, despite the overwhelming evidence that exists around the disproportionate impact of climate change on Indigenous peoples worldwide[22,23].

How is the Department committed to the principle of 'First Nations Leadership' throughout the development of the Strategy? AIDA note a single roundtable was held 5 days before consultation closed. What further mechanisms are being pursued to embed First Nations Leadership in the evolution of the draft Strategy?

It is unclear whether Aboriginal and Torres Strait Islander peoples or Communities were engaged in the development of the Consultation Paper. In its current form, it is evident that the perspectives of Aboriginal and Torres Strait Islander peoples have not been considered or represented. Seed Mob – a network of the youngest generations of the oldest continuing cultures[24] - are leading the conversation on delivering climate action. They clearly state, "an attack on Country is an attack on [Aboriginal and Torres Strait Islander peoples]. Climate inaction is a silent and persisting attack."

The continued power imbalance experienced by Aboriginal and Torres Strait Islander peoples means they are continually marginalised regarding involvement in climate-related health policies and initiatives, due to lack of inclusion and respect in discussions and decision-making[25]. This is despite Aboriginal and Torres Strait Islander peoples expertise in caring for Country, that has been practiced over tens of thousands of years. This cannot be dismissed. Governments must ensure these knowledges and expertise are supported through good policy and practices. The scope of the strategy as it stands fails to deliver for Aboriginal and Torres Strait Islander peoples, and the broader Australian community.

AIDA recommend the Strategy integrate Aboriginal and Torres Strait Islander expertise in all efforts to address the impacts of climate change on health.

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Refine assumptions and address unintended consequences

There are significant and undefined assumptions made throughout the Consultation Paper, which have resulted in unintended and detrimental consequences.

As a starting point, the Consultation Paper fails to outline the communities, population groups and representatives that have contributed to its development. Knowledge of this would reassure invested stakeholders and the general public of the commitment made by the Department to date. Assumptions could be made that this Consultation Paper adequately reflects the needs of society with regard to redressing climate change impacts on health; though that is not the reality.

Incorrect assumptions include:

- **Language is universally understood**: As outlined earlier in this submission, a glossary of terms would enable a universally understood Strategy. At present, there are assumptions made about the level of understanding of climate-related terminology and health related terminology. Stakeholders engaging in this Strategy are likely to represent sectors beyond climate change and health, and it is imperative that language is universally understood.

- **Access is equal**: Throughout the Consultation Paper there are sweeping statements that indicate a lack of awareness of the inequity experienced across Australia when it comes to climate change, the impacts on health, infrastructure, and more.
  The Strategy is ill informed about the vast diversity of our nation and the inequity to accessing infrastructure, initiatives and support for climate change action. There are many Aboriginal and Torres Strait Islander peoples who are living in conditions that result in ill health[26], in which the suggested actions cannot resolve.
- **Infrastructure is adequate**: It has been well discussed that the carbon emissions reduction efforts across the healthcare system goes only part of the way to delivering on the needs of society. We know that chronic disease and heat stress combine to exacerbate morbidity[27], and we are acutely aware of the significantly increasing temperatures being experienced in many parts of remote Australia[28]. Carbon emissions reduction efforts cannot solve the reality that is being experienced. The current housing and healthcare infrastructure is inadequate in many remote regions, and this Strategy glances past this issue. Place-based community-led solutions are essential.

There are many more incorrect assumptions, and may detrimental unintended consequences that will eventuate if the Strategy commits to siloing its response.

- **Decarbonising the healthcare system will address health inequities**.
- **'Traditional' sustainability measures are the solution.** Solar farms lead to displacement. Electricity connection is unstable in remote areas of Australia.
- **All areas of Australia are at an equal state of readiness.** There is a chronic shortage of available housing in many Aboriginal and Torres Strait communities, having a critical impact on health[29].

AIDA recommend the Strategy test assumptions and address unintended consequences.

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Responses to Consultation Questions

Q1. How could these objectives be improved to better support the vision of the Strategy?

The vision and purpose of the Strategy are not clearly articulated or defined within the Consultation Paper. This should be addressed as a priority in order to successfully align the objectives and other Strategy fundamentals to this.

It is difficult to be constructive about how to improve the objectives when the vision of the strategy is unclear. However, despite a lacking vision statement, the following suggestions are offered:

- **Measurement is an enabler**. AIDA supports the inclusion of measurement within the Strategy, as an enabling mechanism – not an objective.
- **Health in all Policies should be prioritised**. There is a great opportunity for this first-of-its-kind strategy to break down the silos of our government and systems to truly address the impacts of climate change on health. Health in all policies requires all policy areas to be in scope – including those beyond the confines of the Department of Health and Aged Care. The narrow scope of the Strategy outlined in the Consultation Paper does not sufficiently address the health impacts of climate change; the focus and proposed solutions cannot rest on 'greening' the healthcare system alone.
- **Mitigate more than just greenhouse gas (GHG) emissions**. This again aligns with broader feedback that the scope of the Strategy must be more than reducing greenhouse gas emissions from the healthcare system.
- **Adapt our approach in all settings**. The responsibility of creating a resilient environment needs to work beyond the healthcare system setting.

Q2. How could these principles be improved to better inform the objectives of the Strategy?

In general, AIDA supports the sentiment of the principles proposed in the Consultation Paper. It is suggested that the definitions and language of each could be reframed to be strengths-based with clearer, plain language.

There is strong support for First Nations Leadership to be embedded in all elements of Strategy design, development and implementation. To date, it has been unclear how the Department has committed to this principle in practice.

'Tackling health inequities' should be more ambitious than 'take account' of disparities. It should seek to overturn, reverse and adequately address the health inequities experienced for Aboriginal and Torres Strait Islander people.

AIDA strongly supports 'Population Health and Prevention' as a principle, with an emphasis on enacting preventive health measures that address climate change. Preventing disease = decrease climate change; addressing climate change = preventing disease.

The concept of 'One Health' is akin to the concept of planetary determinants of health. No longer is this about social, cultural, economical determinants (etc) in isolation. The planet is telling us that there is a problem that needs to be addressed, and the consequences are planetary.

'Evidence informed policymaking' must include evidence beyond the colonially accepted peer reviewed journals and publications. There is abundant qualitative evidence available that speaks to the knowledges, experience, and expertise of Aboriginal and Torres Strait Islander peoples – if you choose to seek it out.

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Further on this principle, actions prioritised on cost-effectiveness will create a wealth of unintended consequences. The cost of doing nothing will far exceed the immediate investment for innovative and novel approaches to address the problems of climate change. This strategy could pave the way for adequate investment in preventive health initiatives. Cost-effectiveness must be balanced with equity principles that ensure further exacerbation of the inequities experienced by Aboriginal and Torres Strait Islander peoples is avoided.

The concept of 'partnership-based working' is supported, however, a nationally consistent response to climate change cannot be the definition of the principle. It is evidenced that the impacts from climate change varying significantly across Australia[30]. Holistic responses to climate change that acknowledge the vast impact is appropriate, and place-based responses are essential. The experience and impact of climate change in remote areas will be different to that in urban areas. Access to services, infrastructure, etc will impact 'national consistency'. For example, travel-related emissions may not be an appropriate target area for rural and remote communities where alternative solutions are not readily available.

Q3. Which of the various types of greenhouse gas emissions discussed should be in the scope of the Strategy's emission reduction efforts?

AIDA supports the inclusion of scope 1, 2 and 3 emissions, and the leadership that the health and aged care sector can display in mitigating emissions without compromising quality and safe care. However, as outlined in this submission, the scope of the Strategy must be more ambitious than reduction of emissions from the sector.

Q4. What existing First Nations policies, initiatives, expertise, knowledge and practices should the Strategy align with or draw upon to address climate change and protect First Nations country, culture and wellbeing?

As clearly outlined in the submission, the Strategy must meet its obligations under the National Agreement on Closing the Gap. Despite the Consultation Papers reference to the National Agreement, there has been no evidenced demonstration of implementing the priority reforms. Further to this, there are ample First Nations policies and initiatives that must be considered, aligned with and learnt from, including (but not limited to):

- The United Nations Declaration on the Rights of Indigenous Peoples
- The National Aboriginal and Torres Strait Islander Health Plan 2021-2031
- The National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031
- The Lowitja Institutes' Climate Change and Aboriginal and Torres Strait Islander Health Discussion Paper 2021
- The outcomes of the Torres Strait 8 United Nations Human Rights Committee case
- The success of the Aboriginal and Torres Strait Islander response to COVID-19
- Seed Mob leadership

Government must persevere in its requirement to incorporate Indigenous perspectives in the development of the Strategy. Failure to adequately consult, engage and integrate Aboriginal and Torres Strait Islander knowledges, experiences and expertise will reduce the opportunity for the Strategy to succeed.

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Q5. What types of governance forums should be utilised to facilitate co-design of the Strategy with First Nations people to ensure First Nations voices, decision-making and leadership are embedded in the Strategy?

Governance is essential in ensuring equitable oversight between mainstream and Aboriginal and Torres Strait Islander representation.

First Nations perspectives must be included in all governance structures associated with the design, development and implementation of the Strategy. The Strategy and the governance of it will only be effective if it is underpinned by genuine co-design principles, as outlined in the National Agreement on Closing the Gap.

As outlined in this submission, Aboriginal and Torres Strait Islander knowledge, experience and expertise must be valued. There must be an ongoing and reciprocal process to embed Aboriginal and Torres Strait Islander perspectives and leadership in the goals, targets and actions of the Strategy. This can not be a once only, set and forget approach. By embedding Aboriginal and Torres Strait Islander leadership in all levels of governance, we can ensure any proposed solutions are continually tested and refined.

Q6. Beyond the schemes already noted, is your organization involved in any existing or planned initiatives to measure and report on health system emission and/or energy use in Australia?

AIDA is not involved in existing or planned activities in this space. However, we believe the Strategy would benefit from a dedicated team to collate and report on carbon emissions of the health system, with public reporting on progress.

Q7. What additional data and information is required to support targeted emissions reduction efforts within health and aged care?

Comprehensive data is needed on current emissions across the health and aged care system to better inform and focus emissions reduction efforts. Further, this data should align with the focus areas outlined in the Consultation Paper across scope 1, 2 and 3 emissions.

It is clear that data is collated and reported across multiple areas of Government, and only reinforces the need for the National Health and Climate Strategy to be a whole-of-Government strategy. There should be clear links to environmental health policies and strategies including workforce and education initiatives, and the integration of consumer and lived experience perspectives.

Assumptions are made that the infrastructure across the health sector is in a state of readiness to transition to greener infrastructure, processes and initiatives. The health services infrastructure in remote and rural areas is barely adequate to support essential healthcare practices, let alone further emissions reduction efforts. Travel to attain necessary health care in these areas is also extensive when compared to more metro locations and limits immediate opportunities for some services. And workforce shortages will also pose a barrier to success of emissions reduction efforts, regardless of location.

Q8. What do you think of these proposed focus areas for emissions reduction? Should anything else be included?

A better understanding of how these focus areas came to be selected will be useful in demonstrating that a considered approach has been taken. Further details about proposed priorities, actions, timelines and targets are essential. This should also take into account the place-based differences that will significantly impact the approach taken for each focus area.

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AIDA supports the proposed focus areas with the continuing acknowledgement that assumptions need to be addressed to ensure Aboriginal and Torres Strait Islander peoples do not continue to be marginalised when it comes to accessing the benefits of climate change and health initiatives.

Q9. Which specific action areas should be considered relating to the built environment and facilities (including energy and water), over and above any existing policies or initiatives in this area?

AIDA supports the efforts in reducing carbon emissions related to built environment and facilities. When considering appropriate actions, the focus cannot be solely on policy levers; there must be translation to action. We have seen to date that policy alone does not result in change in practices.

The Strategy should equip the health sector with relevant support mechanisms to implement the suggested actions; transitioning to these new ways cannot be done without guidance, incentives and management. Any specificities should be underpinned by the principles defined in the Strategy.

Further, it is unclear who has proposed to the Department the actions already outlined in the Consultation Paper. Again, the lack of clarity around the development of this Consultation Paper fails to adequately reassure us that appropriate people have been involved in its initial developments.

Q10. Which specific action areas should be considered relating to travel and transport, over and above any existing policies or initiative in this area?

AIDA supports the efforts in reducing carbon emissions related to travel and transport. Regarding travel and transport, the limited scope of only considering emissions reduction strategies for health system owned vehicles fails to acknowledge the multi-sectored commitment required.

Again, who has proposed these actions to the Department?

Again, actions beyond 'policy levers' must be considered.

Again, these actions should be underpinned by the principles of the Strategy.

The NHS data is not an adequate reference point when considering actions needed for Australia's system with regard to travel and transport.

Q11. Which specific action areas should be considered relating to supply chain, over and above any existing policies or initiatives in this area?

AIDA supports the efforts in reducing carbon emissions related to the supply chain, as it presents a fundamental opportunity to reduce the environmental footprint of the healthcare system.

Again, who has proposed these actions to the Department?

Again, actions beyond 'policy levers' must be considered. Consideration of appropriate legislation in this area is needed to ensure that accountability is applied.

Again, these actions should be underpinned by the principles of the Strategy.

The NHS data is not an adequate reference point when considering actions needed for Australia's system.

Q12. Which specific actions areas should be considered relating to medicines and gas, over and above any existing policies and initiatives in this area?

AIDA supports the efforts in reducing carbon emissions related to medicines and gas, without compromise to patient care and safety. The Department must engage with the Therapeutic Goods Administration and the Pharmaceutical Benefits Advisory Committee, so the Strategy is appropriately informed and supported.

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Again, who has proposed these actions to the Department?

Again, actions beyond 'policy levers' must be considered.

Again, these actions should be underpinned by the principles of the Strategy.

Q13. What specific action areas should be considered relating to waste, over and above any existing policies or initiatives in this area?

AIDA supports the efforts in reducing carbon emissions related to waste, with further detail around emissions footprints related to the various types of waste identified across the healthcare system. Food waste will require different management approaches to medical waste, and this must be explicitly explored and defined.

Again, who has proposed these actions to the Department?

Again, these actions should be underpinned by the principles of the Strategy.

Q14. Which specific action areas should be considered relating to prevention and optimising models of care, over and above any policies or initiatives in this area?

AIDA strongly supports prevention and optimising models of care as a key focus area of the Strategy. Eliminating diagnostic overshadowing should also be acknowledged as a values-based model of care that can support reduced emissions and improved patient care and safety.

The Strategy can succeed in this area by embedding preventative health as a climate change mitigation mechanism, that also serves to address the determinants of health inequity. Optimising models of care should acknowledge planetary determinants of health and develop strategies to address them in the context of climate change action.

Again, who has proposed these actions to the Department?

Again, these actions should be underpinned by the principles of the Strategy.

Q15. What can be done to involve private providers within the health system in the Strategy's emissions reduction efforts?

AIDA supports the inclusion of all healthcare service providers in the scope of the Strategy, including private providers. The Department must understand any similarities and differences between the variety of healthcare service settings and providers, and ensure goals are appropriately aligned.

Q16. Where should the Strategy prioritise its emissions reduction efforts?

a. How should the Strategy strike a balance between prioritising emissions reduction areas over which the health system has the most direct control and prioritizing the areas where emissions are highest, even if it is harder to reduce emissions in these areas?
b. Which of the six sources of emissions discussed (pages 13 to 18 of the Consultation Papers) are the highest priorities for action?

Priorities should be articulated through a comprehensive implementation plan, once the Strategy is finalised. Priorities should be informed by robust consultation, feasibility and the impact as determined by experts in these areas. Cost should not be the priority.

Q17. What 'quick wins' in relation to emissions reduction should be prioritized for delivery in twelve months following publication of the Strategy?

Whole-of-Government commitment to addressing the impacts of climate change on health. Many examples of 'quick wins' have been suggested earlier in this submission.

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Q18. What health impacts, risks and vulnerabilities should be prioritised for adaptation action through the Strategy? What process or methodology should be adopted to priotise impacts, risks and vulnerabilities for adaptation action?

The health vulnerabilities experienced by Aboriginal and Torres Strait Islander peoples are exacerbated by the impacts of climate change. The Strategy must prioritise mitigation and adaptation that:

- Supports place-based, Community-led solutions.
- Recognises, values and integrates Aboriginal and Torres Strait Islander knowledges, experience and expertise.
- Supports education and awareness of the impacts, risks and vulnerabilities of continued inaction.

Q19. Should the Australian Government develop a National Health Vulnerability and Adaptation Assessment and National Health Adaptation Plan? If yes:

a. What are the key considerations in developing a methodology?
b. How should their development draw on work already undertake, for example at the state and territory level, or internationally?
c. What are the key areas where a national approach will support local/jurisdictional vulnerability assessment and adaptation planning?

AIDA supports the development of a National Health Vulnerability and Adaptation Assessment and National Health Adaptation Plan. In developing the methodology, it is essential that it be a whole-of-Government initiative that is underpinned by the principles agreed in the Strategy.

Q20. Would there be value in the Australian Government promoting a nationally consistent approach to vulnerability assessment and adaptation planning for the health system specifically, for instance by issuing guidance and associated implementation support tools for states, territories and local health systems? If yes, what topics should be covered to promote a nationally consistent approach? What examples of existing guidance (either from states/territories or internationally) should be drawn from?

A nationally consistent approach to vulnerability assessment and adaptation planning could be valuable if it was based on accurate assumptions, informed by comprehensive consultation, and resulting plans genuinely addressed place-based risks. There must be a recognition of the diversity of vulnerabilities across Australia, the priorities across the vast ecosystems and the impact of climate change on communities.

Q21. What immediate high-priority health system adaptation actions are required in the next 12-24 months?

AIDA acknowledges that climate change-related impacts to the environment and population health are occurring more frequently and with greater force than ever before. Strong national leadership is required immediately to coordinate across all jurisdictions in taking action.

- Education for the health workforce on climate change impacts.
- Integration of climate change mitigation as part of preventive and primary health care.
- Define and understand the cost of doing nothing.

Q22. What are the key areas in which a Health in All Policies approach might assist in addressing the health and wellbeing impacts of climate change and reducing emissions?

AIDA supports a *Health in all Policies* approach, and as outlined earlier, health in all policies requires all governmental policies to be in scope for the Strategy; this is especially true for environmental policies. There needs to be recognition that health equity and the determinants of health are

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influenced by more than the healthcare system itself. Health in all policies needs to deliver on a commitment to not exacerbate the existing health inequity experienced by Aboriginal and Torres Strait Islander peoples.

Q23. What are the most effective ways to facilitate collaboration and partnership between stakeholders to maximise the synergies between climate policy and public health policy? What are some successful examples of collaboration in this area?

AIDA supports genuine collaboration and partnership in addressing the impacts of climate change on health. This approach needs to identify, consider and map the intersections of climate and public health policies, and establish overarching working group (or other governance structure) that consists of relevant expert representatives. This must include Aboriginal and Torres Strait Islander expertise.

Q24. How could these enablers be improved to better inform the objectives of the Strategy? Should any enablers be added or removed?

Q25. For each of these enablers, what is currently working well? What actions should the Strategy consider to support delivery?

AIDA supports the inclusion of enabling elements of the Strategy to enable delivery and implementation of actions and initiatives. Suggestions to strengthen these are outlined below.

- **Measurement is an enabler**. AIDA supports the inclusion of measurement within the Strategy, as an enabling mechanism – not an objective. It could be consolidated with 'monitoring, evaluation and reporting'. This enabler should define specific targets, goals, actions and timelines, with clear accountability and responsibility frameworks.
- **Workforce, leadership and training**. Support for workforce is essential for the success of any national health and climate strategy, and must be more than just mandatory training modules. Leaders need to be equipped to effect change.
- **Research is essential**. Better data is essential for enabling effective climate change efforts. More importantly, research needs to extend beyond the westernised peer-reviewed journal article approach, focused on quantitative evidence. This is a significant limitation of the Strategy. The richness of qualitative data and experiential evidence must inform climate-related health wellbeing measures. Aboriginal and Torres Strait Islander leadership must underpin research efforts in this way, recognising their knowledges, experience and expertise.
- **Collaboration needs to underpin the Strategy implementation**. The Department must commit to removing the silos and barriers that limit the impact of this Strategy. Collaboration is needed with those affected by climate change, with policy makers beyond the Department of Health and Aged Care, and with experts from cross cutting fields.
- **Governance and planning.** AIDA supports the inclusion of governance as an enabler of the Strategy, with Aboriginal and Torres Strait Islander leadership represented at all levels. Governance should be appropriately structured to support implementation planning, decision-making and funding prioritization.

The strategy must also consider the behavioural change required by individuals to ultimately deliver on any actions and targets that are eventually defined. This will require education and support across the healthcare system and beyond.

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AUSTRALIAN SUSTAINABLE BUILT ENVIRONMENT COUNCIL

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31 July 2023

National Health, Sustainability and Climate Unit
Australian Government, Department of Health and Aged Care

Submitted via: Health.Climate.Consultation@health.gov.au

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To Whom It May Concern

NATIONAL HEALTH AND CLIMATE CHANGE STRATEGY

The Australian Sustainable Built Environment Council (ASBEC) is a collaborative forum of peak bodies in the Australian built environment, focused on sustainable, productive and resilient buildings, communities and cities. Our membership[i] consists of industry associations, professional bodies, academia, non-government organisations and government observers who are involved in the planning, design, delivery and operation of our built environment.

ASBEC has a longstanding focus on cities, infrastructure and urban-scale policy to support a sustainable, liveable and resilient built environment. We have an interest in ensuring both private and publicly funded health infrastructure is responsive, integrated, sustainable and climate resilient. We also strongly believe that the built environment is key to ensuring communities are supported to take action against the health and wellbeing impacts of climate change.

ASBEC welcomes the opportunity to provide feedback on the National Health and Climate Change Strategy Consultation Paper (the Paper). Our feedback will focus on ASBEC's collective expertise on the ways in which a sustainable, productive, and resilient built environment in Australia can influence positive health outcomes and help Australia achieve its emission reduction objectives.

We recommend the following priorities be considered as part of the National Health and Climate Strategy:

1. Commit to achieving applying trusted, robust and credible building rating systems such as Green Star and NABERS in all new healthcare facilities and existing assets (Section 2.1, Question 9)
2. Leverage the government's strong market presence to deliver better-performing, resilient buildings, achieve emissions reduction targets and encourage a decarbonised supply chain (Section 2.3, Question 11)
3. Recognise and educate the community that efficient, electrified homes are healthier, comfortable, and more resilient to the impacts of heat stress (Section 2.6, Question 14)

▾ Commit to achieving applying trusted, robust and credible building rating systems such as NABERS and Green Star in all new healthcare facilities and existing assets (Question 9)

ASBEC recommends that all healthcare facilities commit to applying trusted, robust and credible building rating systems, such as Green Star and NABERS, to drive sustainable outcomes in public projects. These rating systems provide benchmarks – and an independent, auditable verification of their achievement – for effective measurement of emissions reduction, as well as a range of other sustainability metrics. Government should also support industry adoption of these rating systems and make their use a requirement where federal funding is provided to states and territories for social infrastructure projects.

NABERS provides simple, reliable, comparable and trusted sustainability measurements across a number of building sectors. Over the last 20 years, they have proven that "What gets measured gets managed." A NABERS rating helps to accurately measure, understand, and communicate the environmental performance of a building while identifying areas for cost savings and future improvements.

NABERS has a public hospitals tool for energy and water[ii], helping healthcare facilities lead the way by measuring, disclosing and setting energy efficiency targets for these assets. It is being used by all Public Hospitals in QLD, VIC and SA and is being piloted in NSW and WA. NABERS also has a tool for waste, and many healthcare facilities have already taken advantage of this program.

Green Star[iii] is an internationally recognised rating system that delivers independent verification of sustainable outcomes throughout the life cycle of the built environment. It sets the standard for healthy, resilient, positive buildings and places. Thousands of sustainable fitouts, buildings, homes and communities have been certified with Green Star, including a number of health and aged care facilities.

NABERS and Green Star are designed to complement each other and drive and support sustainable outcomes in buildings using these rating tools together. Data and knowledge are shared to encourage performance improvements across the health industry. Where ratings information, knowledge and data are shared, we see marked improvements across industry.

▾ Leverage the government's strong market presence to deliver better-performing, resilient buildings, achieve emissions reduction targets and encourage a decarbonised supply chain

By setting clear targets on efficiency, electrification and embodied carbon through procurement processes, governments can integrate requirements that will help lower emissions in public projects, create a market for sustainable building products and improve community facilities.

Buildings account for over 50% of electricity use in Australia and almost a quarter of its emissions[iv]. As Australia's electricity grid decarbonises and more buildings are powered by 100% renewable electricity, the proportion of emissions generated upfront is expected to rise drastically. Emissions from materials used in construction, such as steel and cement, are expected to become the largest source of carbon emissions in the building sector in the coming decades.

Stronger standards for energy performance in healthcare facilities present a significant opportunity for the Australian Government to deliver major budget savings, deliver against our environmental targets, and demonstrate leadership in energy productivity and managing climate-related risk and opportunities. Assertive action is needed to raise the energy performance of new healthcare infrastructure and incentivise investment in existing building upgrades.

ASBEC commends the proposal in 2.1.2.1 regarding the transitioning towards renewable energy sources for electricity and electrification. ASBEC's Unlocking the Pathway[v] report notes that electrifying the built environment could deliver $49 billion in energy saving between 2024 and 2050 compared to business as usual and 199MT of avoided CO^2-e emissions. However, we know that electrification needs to be partnered with clear requirements around energy performance – considering the performance of a building as an integrated whole.

As described in Every Building Counts[vi], the Australian Government could use its significant market presence to drive improvements in building energy performance. This would not only deliver significant financial savings for the public sector and taxpayers, but also contribute to emissions reduction and build skills and capability in the market. The Australian Government already has a commitment for a net zero public service by 2030; a similar goal for the healthcare system would a have a significant impact on reducing energy consumption and mitigating the effects of climate change.

▾ Recognise and educate the community that efficient, electrified homes are healthier, comfortable, and more resilient to the impacts of heat stress

Housing is integral to the health, wellbeing and economic outcomes for all Australians. Many people are living in homes which are cold in winter and hot in summer, putting them at risk of increased health problems. It increases their susceptibility to extreme weather events and heat waves.

Better performing houses offer more resilience to extreme weather, improve occupant comfort and health[vii], and reduce stress on the electricity grid. By prioritising energy performance retrofits and electrification as a health response strategy (i.e. "primordial prevention" as described in the paper), the

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Australian Government can make significant progress on creating environments that promote health and wellbeing.

The National Health and Climate Strategy consultation provides an enormous opportunity to ensure that healthcare facilities and the health system more broadly support more sustainable, productive, liveable and resilient communities across Australia. We would be pleased to engage further with the Department of Health and Aged Care, and facilitate further consultation with our members, should you require more information on any of the above.

Should you have any further queries, do not hesitate to contact me via alison.scotland@asbec.asn.au or on 0409 157 112.

Yours sincerely



Alison Scotland
Executive Director

[i] https://www.asbec.asn.au/membership/current_members/
[ii] https://www.nabers.gov.au/ratings/spaces-we-rate/public-hospitals
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CLIMATE CHANGE AUTHORITY

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National Health and Climate Strategy consultation

Health and climate change are intrinsically linked. In the aftermath of climate-related events, such as floods, fires and heatwaves, first responders, hospitals and other health services are crucial for mitigating and managing physical health impacts. The sector also provides critical services to address the growing mental health impacts of climate change. As climate change is increasing the frequency and intensity of hazard events, the health sector needs to adapt to become more resilient to today's climate and a range of possible future climates. This involves undertaking locally relevant actions that will help organisations reduce and manage their local climate risks.

The health sector also contributes to greenhouse gas emissions, for example from vehicles used to transport patients, energy used in its buildings, and the waste it produces. It is important that the sector decarbonises to contribute to Australia's and the world's efforts to reduce emissions.

The Climate Change Authority (the Authority) has noted the links between climate change and health services in prior publications. In its report *entitled* *Prospering in a low-emissions world: An updated climate policy toolkit for Australia* (2020), the Authority recognised that 'actions for preparing and responding to climate change include… reducing health risks and considering climate in health service planning' and that adaptation responses are likely to be most effective if integrated with other policies including health (in line with the IPCC 2018).

The Authority also notes that actions taken to reduce emissions can have very positive health outcomes, for example by:

- reducing the negative impacts of air pollution by replacing coal-fired electricity generation and petrol-fueled cars with renewable energy and electric vehicles;
- enhancing energy efficiency and lowering the costs of heating and cooling for low income households and those living in public housing;
- reducing risks associated with hazardous materials reaching landfill by promoting a circular economy that minimises waste, including solar panels and batteries;
- supporting mental health in regional/farming communities through the availability of climate programs such as the Emissions Reduction Fund which help farmers diversify their income streams and enhance economic security.

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Under the *Climate Change Act 2022* (Cth) the Authority has an expanded remit to consider the risks and impacts of climate change, including on health. Section 12(f) of the Act requires the Authority to provide advice on the 'risks to Australia from climate change impacts, such as those relating to Australia's environment, biodiversity, health, infrastructure, agriculture, investment, economy or national security' to inform the Minister's Annual Climate Statement. Recently, the Authority published an Issues Paper which includes a 'wellbeing' framework setting out how the Authority plans to assess progress towards a just transition towards a lower emissions economy and climate-resilient nation. This framework explicitly includes health as a determinant of overall wellbeing. The framework also highlights that different groups such as rural and regional Australians, First Nations people, and low-income earners should receive particular attention due to their greater vulnerability to climate change impacts, including on their health.

The Authority would like to draw your attention to advice provided in several recent publications and submissions to other consultation processes which have addressed several questions in your consultation paper. We hope this may be helpful to inform the Strategy.

A. Prospering in a low emissions world

In addition to broadly discussing the links between climate change hazards and health as discussed above, the Authority's *Prospering in a Low-Emissions World* report provides advice relevant to the National Health and Climate Strategy, specifically on emissions reduction from waste minimisation and building energy efficiency.

- There is a significant opportunity to increase the energy efficiency of existing buildings owned or leased by governments including hospitals (COAG Energy Council 2019c). As a major presence in the building sector, governments can leverage their market power to drive energy efficiency and normalise best practice. This would reduce emissions, deliver significant financial savings for the public sector and build skills and capability in the market (Property Council of Australia and GBCA 2019) (***question 9***).
- Organic material (including food, garden and timber waste) creates particular problems in landfill because it releases methane, produces liquid leachate that can pollute groundwater, creates odour and attracts vermin (Blue Environment 2018). Some studies have demonstrated that the healthcare sector in Australia generates large amounts of food waste (Collins and Porter 2023). Addressing food waste within the health care sector could be an additional area to consider relating to waste and help achieve the Government's goal of halving food waste and the amount of organic waste sent to landfill by 2030 (***question 13***).

B. Climate-related financial disclosure submission

The Authority recently published its submission (2023) to the Department of Treasury climate-related financial disclosure consultation. The following points draw on the recommendations of this submission and are adjusted to the context of the National Health and Climate Strategy.

- Scope 1, 2, and 3 emissions should be considered in the Strategy's emission reduction efforts (***question 3***). In its Trade and Investment report, the Authority found that emissions associated with goods and services in companies' supply chains (Scope 3 upstream and downstream emissions) often outstrip the direct emissions from companies' own operations (Scope 1) and from their electricity use (Scope 2). The National Health and Climate Strategy consultation paper also highlights supply chains as an area of focus for emissions reduction. Therefore Scope 3 emissions should be considered for all organisations in the health system.

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- Data and methods to support the calculation of Scope 3 greenhouse gas emissions and improved scenario analysis to understand transition risks would enable targeted emissions reduction efforts within health and aged care (***question 7***).
- Practical plans with targets for the whole health sector and across all focus areas (built environment and facilities, travel and transport, supply chain, medicine and gases, waste, prevention and optimising models of care) for emissions reductions are needed. These should be complemented by monitoring and evaluation and public reporting of progress (***question 9, 10, 11, 12, 13, 14***).
- An assessment of climate risk exposure and associated risk mitigation plans and strategies for the health sector should be undertaken. This could be through the proposed National Health Vulnerability and Adaptation Assessment that identifies priority impacts, risks and vulnerabilities, and National Health Adaptation Plan. The National Health Vulnerability and Adaptation Assessment should be complemented by monitoring and evaluation and public reporting of progress. The National Health Vulnerability and Adaptation Assessment and National Health Adaptation Plan should draw on and complement existing work such as the National Climate Risk Assessment, National Adaptation Plan and states and territories work where appropriate to avoid duplication and inconsistency (***question 18, 19***).

C. Fuel efficiency standard consultation

The Authority has published its submission to the Fuel Efficiency Standard consultation. These points draw on the recommendations of this submission and are adjusted to the context of the National Health and Climate Strategy.

- There is a need for greater deployment of electric vehicle charging and hydrogen refueling infrastructure. This is applicable within the healthcare context (***question 10***).
- The health sector will need to define a decarbonisation pathway for transportation, particularly if emergency services vehicles are excluded from a fuel efficiency standard. It is important to consider that the global transition from internal combustion engines could leave emergency services vehicles exposed to price and supply chain challenges in the near- to mid-term. (***question 10***).

We look forward to engaging closely with the Department of Health and Aged Care in the future and contributing to the National Health and Climate Strategy.



Yours sincerely
Brad Archer

31 July 2023

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31 July 2023
National Health, Climate and Sustainability Unit
Department Health and Aged Care
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RE: Draft National Health and Climate Strategy Submission

UnitingCare Queensland (UCQ) welcomes the opportunity to contribute to the development of Australia's first National Health and Climate Strategy.

As the health and community services provider of the Uniting Church, UCQ supports over 430,000 individuals, families and communities in Queensland through aged care, hospital, disability, child and family services. And we recognise that our mission to improve the wellbeing of individuals, families and communities must extend beyond frontline services—we must also promote and preserve a healthy environment, by reducing our carbon footprint, improving resource efficiency, enabling climate resilience, and greening our built environments.

For over a decade, UnitingCare has been implementing changes that align with the National Health and Climate Strategy objectives. These initiatives include:

- measuring and reporting emissions;
- decarbonising our vehicle fleet;
- partnering on heatwave resilience research projects;
- installing rooftop solar and energy efficiency upgrades;
- industry-leading recycling programs; and
- undertaking an enterprise climate change risk assessment.

UCQ broadly supports the introduction of a National Health and Climate Strategy. We believe this is an important step in preparing to meet the health needs of all people in Australia—for present and future generations—in the face of the climate crisis. You will find UCQ's responses to the Detailed Submission Form attached.

Thank you for considering UCQ's submission. Should you have any questions, please contact [redacted], UCQ's Senior Manager Environmental Sustainability, on [redacted]

Sincerely,

UnitingCare Queensland

Australian Government
Department of Health and Aged Care

NATIONAL HEALTH AND CLIMATE STRATEGY

Detailed submission form

This form allows you to provide responses to the full set of questions in the Consultation Paper available here.

Please submit this form in Word format to Health.Climate.Consultation@health.gov.au.

Respondent details

What is your name?
[redacted] Senior Manager Environmental Sustainability
What is your email address?
[redacted]
What is your organisation?
UnitingCare Queensland
Have you read and agreed to the Privacy Statement? (NB we will not be able to use your submission unless you tick this box)
☒ I have read and agreed to the Privacy Statement
Do you identify as Aboriginal and/or Torres Strait Islander? (Yes/No/Prefer not to say)
[redacted]
Please select which applies to you: ☐ Individual citizen ☒ **Health Service Provider** ☐ Industry and Life Sciences Organisation or Representative ☐ Academic or Researcher ☐ Primary and/or Allied Health Peak or Advocacy Organisation or Representative ☒ **Aged Care Service Provider** ☒ **First Nations Health Service Provider** ☐ First Nations Community Group ☐ First Nations Peak or Advocacy ☐ Medical College or Peak professional body

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Questions for feedback from the Consultation Paper

Introduction

1. How could these objectives be improved to better support the vision of the Strategy?
UnitingCare Queensland broadly supports the proposed objectives. However, it is difficult to assess their alignment to the Strategy vision as this is not clearly articulated in the document. Although vision-like statements are included in the About the Strategy section, it would be helpful to have the vision articulated under a clear heading. UnitingCare Queensland strongly supports emissions measurement as a priority of the Strategy; our organisation has been committed to emission measurement for over a decade. However, Measurement may be better placed within the Strategy as an enabler, rather than a standalone objective.
2. How could these principles be improved to better inform the objectives of the Strategy?
We don't believe that it's possible at this stage (pre-implementation) to determine whether the objectives are informed by the principles. We conceive of the objectives as the WHAT, while the principles are the HOW – the role of the principles is to inform how the Australian Government and industry pursues the Strategy objectives. Time will tell whether this occurs; however, UnitingCare Queensland supports the proposed principles and agrees that they SHOULD inform our collective response to climate change and achieving the Strategy objectives. In particular, UnitingCare Queensland strongly supports the foregrounding of equity, First Nations leadership, and One Health interconnectedness (commonly known as 'planetary health') in the proposed principles; these align well with UnitingCare Queensland's own mission and values.
3. Which of the various types of greenhouse gas emissions discussed above should be in scope of the Strategy's emission reduction efforts?
UnitingCare Queensland supports the inclusion of Scope 1, Scope 2 and Scope 3 emissions in the Strategy's targeted emission reduction efforts. While UnitingCare is still on the journey of incorporating Scope 3 emissions into our measurement and reporting, we recognise that this will be essential to the health sector playing its part in Australia's net zero transition.
4. What existing First Nations policies, initiatives, expertise, knowledge and practices should the Strategy align with or draw upon to address climate change and protect First Nations country, culture and wellbeing?
UnitingCare Queensland strongly supports the Strategy's strengths-based approach of valuing First Nations cultural knowledge, and articulation of climate change impacts on First Nations peoples' wellbeing. In particular, UnitingCare Queensland supports the Strategy's intention to align closely with the Closing the Gap Framework, and uphold First Nations self-determination. Additionally, UnitingCare's Aboriginal and Torres Strait Islander Strategy and Partnerships Team have shared the following cultural practices and priorities that should be central to the Strategy design:

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- Respect for the connection First Nations peoples have with Country, and the fact that Country is a provider of physical, spiritual and mental wellbeing. For example, this could mean prioritising adaptation options that support First Nations people to stay on Country.
- A community-led care model will be critical to addressing climate change impacts on First Nations peoples. This approach will also help the Strategy address the diversity and heterogeneity among Aboriginal and Torres Strait Islander communities.

5. What types of governance forums should be utilised to facilitate co-design of the Strategy with First Nations people to ensure First Nations voices, decision-making and leadership are embedded in the Strategy?

UnitingCare Queensland strongly supports the Strategy's commitment to co-design with First Nations peoples. Through the advice of UnitingCare's Aboriginal and Torres Strait Islander Strategy and Partnerships Team, we recommend that the following governance forums be utilised to facilitate Strategy co-design:

- The Voice to Parliament (pending Referendum outcome);
- Aboriginal and Torres Strait Islander Land and Sea Councils, which provide community-specific forums;
- The Uniting Aboriginal and Islander Christian Congress (UAICC), which UnitingCare Queensland is in relationship with through the Uniting Church; and
- Aboriginal and Torres Strait Islander Youth Advisory Groups through University Networks.

The 2023-2026 Strategic Plan of Pinangba may also serve as a valuable reference in the Strategy design. Pinangba is an Aboriginal and Torres Strait Islander led service delivery arm of UnitingCare Queensland, delivering a range of services across Queensland including aged care, respite, family therapy and drug and alcohol rehabilitation services.

While there are many forums available, the importance of HOW to engage with First Nations peoples cannot be overstated. UnitingCare Queensland's Aboriginal and Torres Strait Islander Strategy and Partnerships Team recommends Strategy co-design and implementation be underpinned by:

- Understanding that First Nations people and communities operate through a different way of being than non-Indigenous people.
- Equipping yourself to be in a yarning/learning (not corporate) environment.
- Respecting the need to form relationship before delving into 'business'. This will take time, and is critical to enabling effective and long-term collaboration.
- Being specific, starting small, and sinking deep roots in a specific community.

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Proposed Objective 1: Measurement

6. Beyond the schemes already noted above, is your organisation involved in any existing or planned initiatives to measure and report on health system emissions and/or energy use in Australia?
UnitingCare Queensland measures and reports energy and emissions performance through: • National Greenhouse and Energy Reporting Scheme (mandatory; reporting under the corporate entity *Uniting Church in Australia Property Trust Queensland*) • ABS Energy and Water Survey (mandatory) • Our Annual Sustainability Report (voluntary) • Global Green and Healthy Hospitals (voluntary) UnitingCare Queensland has voluntarily published carbon footprint and waste/recycling performance since 2018-19; first, through its Annual Report, and more recently (2020-21) through a standalone annual Sustainability Report. This reporting includes Scope 1, Scope 2 and limited Scope 3 emissions.
7. What additional data and information is required to support targeted emissions reduction efforts within health and aged care?
UnitingCare Queensland supports the inclusion of Scope 3 emissions in the Strategy. However, the cost of meaningfully measuring Scope 3 emissions—particularly in the supply chain—may present a barrier to some health and aged care providers; particularly not-for-profit providers. For context, UnitingCare hospitals and aged care services deal with over 6,800 suppliers. The Strategy should consider what central support (e.g. resources, training, funding) can be provided to help overcome this barrier. Furthermore, with differing Scope 3 measurement methodologies in use, our sector is missing an opportunity for benchmarking. There is an opportunity for the Strategy to support the development of a universal methodology for healthcare providers to measure and report on Scope 3 emissions consistently.

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Proposed Objective 2: Mitigation

8. What do you think of these proposed focus areas for emissions reduction? Should anything else be included?
UnitingCare broadly supports the proposed emission reduction focus areas, which roughly align to the seven priority areas of the Global Roadmap for Health Care Decarbonization (2021). However, this alignment could be strengthened by directly referencing the Roadmap, to emphasise consistency with global health system decarbonisation efforts and plans.
9. Which specific action areas should be considered relating to the **built environment and facilities (including energy and water)**, over and above any existing policies or initiatives in this area?
No feedback at this time.
10. Which specific action areas should be considered relating to **travel and transport**, over and above any existing policies or initiatives in this area?
No feedback at this time.
11. Which specific action areas should be considered relating to **supply chain**, over and above any existing policies or initiatives in this area?
No feedback at this time.
12. Which specific action areas should be considered relating to **medicines and gases**, over and above any existing policies or initiatives in this area?
No feedback at this time.
13. Which specific action areas should be considered relating to **waste**, over and above any existing policies or initiatives in this area?
No feedback at this time.
14. Which specific action areas should be considered relating to **prevention and optimising models of care**, over and above any existing policies or initiatives in this area?
No feedback at this time.

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15. What can be done to involve private providers within the health system in the Strategy's emissions reduction efforts?

UnitingCare Queensland—along with many other private providers in Australia—has a long history of emissions reduction leadership. We employed our first Environmental Sustainability Manager in 2012, and have been scaling up renewable energy, energy efficiency, waste and recycling, and fleet decarbonisation programs ever since. In the five years since 2016-17, UnitingCare Queensland has achieved an 11.4% reduction in our measured emissions (Scope 1, Scope 2 + limited Scope 3).

The Strategy is an opportunity to leverage this private sector leadership, by providing a clear, ambitious decarbonisation plan (including timebound targets) that sets out responsibilities and opportunities for the private sector, provides certainty and helps inform decisions and investment.

To accelerate involvement in the Strategy's emission reduction efforts, the Strategy should also consider how early leadership in this work can be rewarded, and how tangible reductions by health and aged care organisations can be incentivised.

Building capability and resourcing across not-for-profit health and human service organisations is a critical factor to growing the impact of emissions reduction efforts. As a large service provider, UnitingCare has the purchasing power and scale needed to take a coordinated approach to emissions reduction and see success. However, this is not true of all providers who may not have the same negotiating power and investment capability to take on more ambitious reduction targets. There is an opportunity for government to engage with industry bodies and key stakeholders to support group buying schemes or provide subsidies to high emission service types, for example community-based aged care which typically involve a high level of vehicle usage.

16. Where should the Strategy prioritise its emissions reduction efforts?

a. How should the Strategy strike a balance between prioritising emissions reduction areas over which the health system has the most direct control and prioritising the areas where emissions are highest, even if it is harder to reduce emissions in these areas?

b. Which of the six sources of emissions discussed above (on pages 13 to 18 of the Consultation Paper) are the highest priorities for action?

a. No feedback at this time.

b. UnitingCare Queensland suggests the following priority ranking for the six proposed emission reduction areas:

1. Built environment and facilities (inc. energy and water)
2. Waste
3. Supply chain
4. Prevention and optimising models of care
5. Travel and transport
6. Medicine and gases

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17. What 'quick wins' in relation to emissions reduction should be prioritised for delivery in the twelve months following publication of the Strategy?
• Net zero facility master planning guidelines • Publishing of fuel efficiency standards (recognising this is already in train through The Department of Infrastructure, Transport, Regional Development, Communications and the Arts) • Support in responding to infrastructure challenges – many providers are ready to invest in EVs and chargers, but hidden costs of infrastructure upgrades in older facilities heighten the investment risk / are a cost barrier • Nationally consistent procurement standards that include criteria for greenhouse gas emissions, waste, resource depletion, and chemical impacts

Proposed Objective 3: Adaptation

18. What health impacts, risks and vulnerabilities should be prioritised for adaptation action through the Strategy?
In April 2023, UnitingCare Queensland commenced work on its first Climate Change Risk Assessment and adaptation planning. While this work is not yet complete, our assessment of present-day risk has highlighted the following areas as priority risks/vulnerabilities requiring adaptation action: • Heat-related morbidity and mortality is of high priority to UnitingCare Queensland, as we serve some of the most vulnerable groups (older people with complex health needs living in their home, people experiencing homelessness, people with underlying chronic illnesses). • Increasing mental health impacts of climate change (e.g. climate anxiety, limited access to services during acute weather events, trauma/anxiety during and after extreme weather events). • Safety risks for health and aged care workers; in particular, heat-related illness for staff delivering community-based services. • Supply chain disruption from climate-related events that impact both facilities (e.g. access to goods and services) and delivery of health services. • Overall increase in burden of disease because of climate change. • Health and aged care service disruption due to facility evacuations, major asset impacts (e.g. mould outbreak), and access challenges for clients and staff during extreme weather events (e.g. being cut off during floods).
19. Should the Australian government develop a National Health Vulnerability and Adaptation Assessment and National Health Adaptation Plan? If yes: **a. What are the key considerations in developing a methodology?** **b. How should their development draw on work already undertaken, for example at the state and territory level, or internationally?** **c. What are the key areas where a national approach will support local/jurisdictional vulnerability assessment and adaptation planning?**
Yes, a focused plan with targeted actions to address direct health impacts is needed. The methodology should consider using the existing fact base and approaches used by other states and territories in their adaptation planning. This will encourage greater alignment of identified actions. A cross-portfolio approach should also be taken so critical touch points

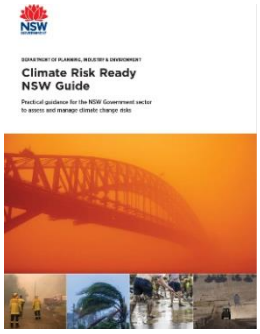
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in the areas of health, aged care, disability, housing, public infrastructure etc. are identified and actions can be coordinated under the plan.

The fact base, scenarios, tools and process used to support the planning should be made publicly available to support other organisations to do their own planning. This would provide a consistent toolkit to organisations that can be used and adapted across a range of areas. This could be facilitated by engagement with key industry stakeholders.

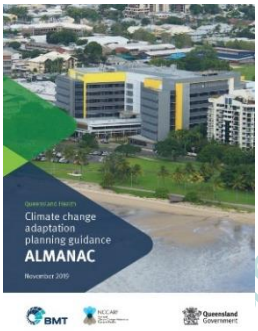
20. Would there be value in the Australian government promoting a nationally consistent approach to vulnerability assessment and adaptation planning for the health system specifically, for instance by issuing guidance and associated implementation support tools for states, territories and local health systems? If yes, what topics should be covered to promote a nationally consistent approach? What examples of existing guidance (either from states/territories or internationally) should be drawn from?

After reviewing available climate risk and adaptation guidelines, UnitingCare Queensland has selected the following resources to inform our climate change risk planning:



<u>NSW Government **Climate Risk Ready** (2020):</u>

- User friendly
- Addresses enterprise-level assessment and transition risks
- Comprehensive toolkit, including Excel templates for Climate Risk Maturity Health Check and Risk Assessment Tool
- Aligned to the general process and considerations contained in ISO 31000:2108 – *Risk management guidelines and ISO 14091 – Adaptation to climate change – Guidelines on vulnerability, impacts and risk assessment*.



<u>QLD Health **Climate Change Adaptation Planning Almanac** (2019):</u>

- Examples of risks and opportunities relevant to health services / sector
- Provides layman summaries of climate change projections for 15 Qld regions

21. What immediate high-priority health system adaptation actions are required in the next 12 to 24 months?

UnitingCare Queensland suggests that the following system-level adaptation actions should be prioritised by the Strategy in the next 12 to 24 months:

- Promote and support climate risk assessments to be undertaken by health and aged care providers.
- Facilitate climate risk management capacity building for organisations (e.g. similar to the NSW Government Climate Risk Ready training program).
- Sectoral adaptation will only be effective if the wider community understands the risks to health from climate change, and are empowered to take health protective actions. As such, the Strategy should include a public education campaign that highlights the risks to health and the health benefits of adaptation as critical to the success of any adaptation action.

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Proposed Objective 4: Health in All Policies

22. What are the key areas in which a Health in All Policies approach might assist in addressing the health and wellbeing impacts of climate change and reducing emissions?

UnitingCare Queensland supports a 'Health in All Policies' approach.

We suggest the following action areas as priorities outside the health system:

- Embedding meaningful human health and planetary health indicators into Treasury's upcoming Measuring What Matters Framework;
- Urban planning for heat resilience, e.g. through 'green infrastructure';
- Energy and climate policy that provides confidence in renewables investment;
- Performance standards for buildings, vehicle fuel economy, appliance energy efficiency; and
- Establishing centres for First Nations cultural knowledge, to facilitate agency, knowledge sharing, and practicing of culture that supports greater First Nations health and wellbeing.

Additionally, the full societal costs of climate inaction should be fully and systematically considered to prevent the hidden transfer of costs to the health sector.

23. What are the most effective ways to facilitate collaboration and partnerships between stakeholders to maximise the synergies between climate policy and public health policy? What are some successful examples of collaboration in this area?

We recommend engaging with key industry and peak groups and organisations who are early or emerging leaders in climate adaptation and sustainability. In aged care, our industry peak is Aged & Community Care Providers Association (ACCPA), and Council of the Ageing (COTA) is a critical consumer peak group. UnitingCare Hospitals are member to Catholic Health Australia (CHA), which represents the nation's largest non-government grouping of hospitals, aged and community care services. And finally, UnitingCare Australia is the national body for the Uniting Church's community services network, representing one of the largest community services networks in Australia.

Representatives from UnitingCare Queensland are available to engage with government to provide advice and real-world examples to inform and support climate and public health policy, and to look for opportunities to work together. A successful example of collaboration is UnitingCare's recent work on heat health under the Queensland Human Health and Wellbeing Climate Change Adaption Plan (H-CAP). Enabled by state government funding, UnitingCare worked with the Queensland Government and university partners on two key aged care sector climate change resilience projects:

- Heatwave community outreach project to reduce health impacts of heatwaves for elderly community members. This project delivered new industry resources including: Expanded Environment and Emergency Response Checklist; Heat Preparedness & Response Plan; Heat health e-learning module; Heat health resource and communications package.
- Developed a model aged care facility Heat Mitigation Adaptation Plan and supporting toolkit on 'green infrastructure' — like trees, water features and shade sails — and its impact on residents' health and wellbeing during extreme heat events.

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Enablers

24. How could these enablers be improved to better inform the objectives of the Strategy? Should any enablers be added or removed?
UnitingCare Queensland broadly supports the enablers identified by the Strategy. However, we recommend that Finance be added as an enabler. As a private not-for-profit service provider, dependency on internal funding can be a major barrier to implementing climate adaptation and mitigation measures. This cost impact of climate would also need to be built into future costing models for aged care services. As highlighted in Question 6, UnitingCare Queensland suggests that measurement may be better placed within the Strategy as an enabler, rather than a standalone objective.
25. For each of these enablers: **a. What is currently working well?** **b. What actions should the Strategy consider to support delivery?**
No feedback at this time.

Thank you for taking the time to complete this survey – your feedback is greatly appreciated!

Please submit this form in Word format to Health.Climate.Consultation@health.gov.au.

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