NATIONAL HEALTH AND CLIMATE STRATEGY

WOMEN'S HEALTH GOULBURN NORTH EAST SUBMISSION
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Acknowledgements

Women's Health Goulburn North East acknowledges the wisdom, living culture and connection of the Traditional Custodians of the unceded lands on which we work, and acknowledge the profound disruption of colonisation and the Stolen Generations on Aboriginal and Torres Strait Islander peoples. We also respect the self-determination of First Nations people.

We are intersectional in our approach and are proud to stand beside generations of great women whose work has brought us closer to justice for all. We believe in shared and just cultural transformation that embraces diversity, and these acknowledgements are part of the ethical principles that guide our work and conduct.

About Women's Health Goulburn North East

Women's Health Goulburn North East (WHGNE) is a proudly feminist organisation supporting the creation of regional and rural Victorian communities that centre intersectional equity, care, wellbeing, and safety. We view the world through a prevention lens and work according to a social determinants framework to address the root causes of gender inequality and gendered discrimination, exclusion, oppression, and violence. We believe in shared and just cultural transformation and locate our work within an ecosystem of broad global alliances working across social movements.

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About this submission

As a contributor to and supporter of the Climate and Health Alliance's (CAHA) 2021 Framework for a national strategy on climate, health and wellbeing in Australia, we welcome the Australian Government's development of the first National Health and Climate Strategy. CAHA has been advocating for such a national strategy since 2017 and it is affirming that the federal government recognises the critical nature of such work. Climate justice – that is, climate action that strives for intersectional equity - is one of our core focal points, and we see this national strategy as critical to guiding, inspiring and enabling good, thoughtful and impactful work in this area.

We know that the health impacts of climate change are already being felt in our communities. We have seen these health impacts as result of the smoke inundation that communities across north-east Victoria experienced during the 2019 bushfires; in the flooding that affected communities to the north-west and south of our catchment area; in the uptick in severity and prevalence of family violence before, during and after climate-related disaster, as evidenced by research undertaken by our own organisation following the 2009 Black Saturday bushfires. We've seen it in the risks heatwaves – experienced with increasing frequency and severity – have posed to the people made vulnerable by the gaps, deficiencies, barriers and discriminations embedded in our existing societal and economic systems.

We know that the people who bear the brunt of these health impacts are those who experience different, intersecting and structurally embedded forms of oppression in our society – sexism, racism, colonialism, ableism, ageism, povertyism (the range of harmful and discriminatory attitudes towards low-income people), homophobia and more. Women are often the ones facing compounding risks to their health, when it comes to climate change. They are made financially insecure by gendered pay gaps, gendered unpaid care roles, their disproportionate representation among insecure and low-paid workforces, and historically unbalanced and discriminatory decision-making processes. Indigenous women, women living with disability, older women, regional and rural women, gender-diverse people and intersections of these identities compound the harms these people face and will continue to face if climate action does not contain an equity and social justice focus.

Climate change, thus becomes an issue of gender, and of intersectional equity. And it is with this in mind that we offer our submission to this review.

Our submission is shaped, firstly, by our commitment to gender and climate justice, which is an imperative of our intersectional approach to equity. Gender and climate justice, in this instance, are intimately connected to intersectionality, in that they involve bringing about a culture and a community that "centre the diverse needs, experiences and leadership of people most

impacted by discrimination and oppression." In doing so, we might ensure the policy we create, the action we take and the world we co-design avoids perpetuating the oppressions experienced by those oppressed by the status quo. When it comes to this strategy, we cannot afford to pursue policy and action that "protects the health and wellbeing of people living in Australia from the impacts of climate change" if that policy/action, itself, perpetuates injustice. At the heart of this should be a shift away from solely considering "Australians" as the agents and beneficiaries of this work, and towards considering "people who live in Australia" - including those who may not be citizens, who may have fled war, disaster and conflict in their own lands to our shores.

We also approach this submission with a commitment to "health and wellbeing" beyond the strictly clinical definitions of those concepts. This is a social determinants of health approach, recognising the non-medical/non-health-related conditions and factors that contribute to (or pose barriers to) human wellbeing. These include:

- Income and social protection
- Education
- Unemployment and job insecurity
- Working life conditions
- Food insecurity
- Housing, basic amenities and the environment
- Early childhood development
- Social inclusion and non-discrimination
- Structural conflict
- Access to affordable health services of decent quality

We would also be so bold as to argue that planetary health is a determinant of human health, and that any national strategy designed to not only mitigate the worst health impacts of climate change, but also cultivate a culture and society that enjoys optimal health and wellbeing against the backdrop of climate safety, can only do so by nurturing human respect and wise stewardship of flourishing and valued natural systems.

It is at this point – and as part of a broad alignment across this strategy with its stated objective of valuing Indigenous wisdom and lifeways - that we urge government to expand its understanding of health beyond the clinical and closer towards a more holistic conception of health, to include "the social, emotional and cultural wellbeing of the whole community and the relationships between families, communities, land, sea and spirit." This strategy presents our communities and the nation with an opportunity to recognise that an understanding of "planetary health" is right here already, embedded in the thousands of years of wisdom of

Indigenous communities. This strategy is an opportunity for us all to better understand and share in this wisdom and culture.

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

We are concerned that this strategy contains no clearly articulated vision to underpin the objectives and principles of the document. Without a clear vision, we believe it will be difficult for the strategy to clearly shepherd action towards a set of measurable outcomes.

We note the strategy's purpose to "protect the health and wellbeing of Australians from the impacts of climate change," however, we recommend this purpose be rewritten to better reflect the "health in all policies" (HiAP) approach. HiAP is consistent with a social determinants of health approach, recognising that health and health equity are not merely the domain of the health system, but are largely affected by policies beyond the health sector, including policies influencing transport, housing, urban planning, the environment, education, agriculture, finance, taxation and economic policy.

As such, it's imperative this strategy offers an ambitious, bold, yet achievable vision statement that describes how our communities can be different – healthier, safer, more equitable – as a result of this strategy, and a purpose that encapsulates the health in all policies approach.

We would therefore like to recommend the following:

- **Strategy vision:** A climate safe community and net zero health system in which inter-generational health equity and planetary health are prioritised.
- **Strategy purpose:** To support the development and coordination of cross-department and – sector initiatives that ambitiously mitigate the health and health equity impacts of climate change and guide efforts to reduce the health sector's contribution to climate change.

It then follows that the strategy's objectives require an overhaul to support this vision. These objectives should be described as detailed actions, plotted against a timeline and allocated measurable indicators, to ensure a process of reflection, learning, "tweaking" and ongoing implentation of climate mitigation and adaptation work, and to ensure agents can be held to account for this implementation.

Objective 1: Promote and protect health and wellbeing, and health equity – This strategy will guide the design and implementation of policy across all levels and departments of government, to protect and champion health equity in the context of climate change mitigation and adaptation.

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Objective 2: A climate-safe community – This strategy will guide initiatives to build the resilience of the community, the health system and other government sectors to respond to the health impacts of climate change.

Objective 3: A net zero health and aged care system – This strategy will support the development of a comprehensive national net zero plan for health and aged care, which reflects best scientific evidence and is informed by a detailed assessment of the health system's carbon footprint (including scope 1, scope 2 and scope 3 emissions).

As part of this, it's imperative that this strategy includes specific emissions reductions targets that are consistent with best scientific evidence, that is 75% below 2005 levels by 2030 and net zero emissions for all sectors by 2035. To advocate for anything less would be to undermine the strategy's own commitment to protect the health and wellbeing of people living in Australia from climate change.

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

While we broadly support the strategy's principles, we would like to see a commitment to the right to health, health equity and a safe planet centred in these principles. We see this strategy as an opportunity for the nation to embed an understanding of the intimate links between planetary and human health across our economy, our health system, our culture and the day-to-day functioning of our communities.

1. **Health as a universal human right** – Recognises the government's legal obligations to guarantee the "appropriate conditions for the enjoyment of health for all people without discrimination" and the "indivisibility" of health from other human rights such as food, housing, work, education, information and participation. This is particularly important to this strategy, requiring that it look beyond government obligations to "Australians" and instead commit to the right to health for all people living in Australia, regardless of their visa status.

2. **Planetary health** – Rather than "One Health," we believe the strategy should take a broader view of health and instead embrace the principle of "planetary health." This principle is "based on the understanding that human health and human civilisation depend on flourishing natural systems and the wise stewardship of those natural systems." While similar to broader conceptualisations of One Health (which take "One Health" beyond its preoccupation with zoonotic disease), the principle of Planetary

Health puts stronger emphasis on "adherence to planetary boundaries and...the management of the consequences for everyone on the planet of exceeding such boundaries." We believe this more global view, and a recognition of planetary boundaries, is consistent with what should be a striving for intergenerational health equity throughout this strategy.

3. **First Nations rights, recognition and reconciliation** – a commitment to Voice, Truth, Treaty, self-determination must be central to the co-design of all levels of climate and health policy. Likewise, Indigenous wisdom and knowledge systems

4. **Intergenerational equity in health** – requires that the strategy acts with urgency and equal concern for the health equity of present and future generations, requiring us to focus not only on present "costs" of climate change, but also future "benefits" of swift, ambitious and rights-based action.

5. **Primary prevention –** reflects a commitment to preventing the occurrence of a condition (health or otherwise) in the first place. This principle is as relevant to health and health equity as it is to climate mitigation, and emphasises ploughing effort, time, wisdom and resources into challenging the root causes of wicked problems like climate-change and inequity.

6. **Whole-of-community inclusion and participation in the co-design** of holistic, nationally consistent, equitable and accessible human and planetary health-centred responses to climate change.

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

We believe this strategy's emissions reduction efforts should include all three types of greenhouse gas emissions – direct emissions (scope 1) produced within the boundary of the health system/health services, energy-related indirect emissions (scope 2), such as via offsite energy production (scope 3) such as emissions generated in the broader economy, mostly via the upper supply chain.

The inclusion of scope 3 emissions is particularly important, with data suggesting that these emissions comprise 65–95% of most companies' carbon impact, with 80% of an organisation's supply chain emissions related to as few as one-fifth of its purchases.

Including all three types of emissions is consistent with what we think should be this strategy's commitment to planetary health, health in all policies and intergenerational health equity objectives. In line with this, we believe this strategy should commit to efforts to:

- Drive the implementation of stronger and more ambitious national emissions reduction targets across all sectors of the Australian economy (inclusive of scope 2 and 3 emissions) – that is, 75% below 2005 levels by 2030 and net zero emissions for all sectors by 2035;
- Advocate for the rapid transition of Australia's energy generation facilities away from fossil fuel (including the cessation of taxpayer subsidies to fossil fuel industries, the closure of fossil fuel generated power facilities, the just transition of associated workers away from the sector) and towards 100% renewable by 2030;
- Transition the health sector to net zero scope 1 emissions by 2035
- Mandate a sustainable procurement process within the health system in order to effect reductions in scope 3 emissions, including emissions created through the overseas manufacture of health products.

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?

WHGNE strongly supports a commitment to a strengths-based approach to engagement with First Nations people as part of its work towards mitigating and adapting to climate change and achieving planetary health and health equity for all people in Australia.

We recommend the government directly engages with First Nations communities, Elders, organisations and services in order to craft the strategy and ensure all potential impacts and benefits to First Nations people are considered. It is critical that this section of strategy clearly outlines how and over what period of time government and all sector stakeholders will respectfully engage with First Nations communities, how those communities might maintain sovereignty over their input and be able to hold government accountable to its strategic commitments.

To do justice to its commitment to the centring of Indigenous knowledge, it is also critical that this strategy is genuinely open to an understanding of "health" and "wellbeing" that extends beyond clinical definitions of physical health, but also encompasses "the social, emotional and cultural wellbeing of the whole community, in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of the community. [This is a] whole-of-life view and includes the cyclical concept of life-death-life."

Other policies and resources that may help to underpin the strategy, in its commitment to First Naitons country, culture and wellbeing, include:

- Lowitja Climate Change and Aboriginal and Torres Strait Islander Health discussion paper -
- Heal Country, Heal Climate Priorities for climate and environment -
- National Agreement on Closing the Gap
- United Nations Declaration on the Rights of Indigenous Peoples
- First Nations Disability Network

When it comes to accountability processes, the Victorian Government's plan for an Aboriginal-led Evaluation and Review Mechanism may provide an example of how this could be accomplished.

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?

We urge government to work directly with First Nations communities and individuals to determine what governance forums would enable best access, support, participation and self-determination in strategy decision-making.

QUESTION 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?

Our organisation is not involved in any existing/planned initiatives to measure or report on health system emissions. However, we would like to express support for an evidence-based approach to setting priorities for decarbonising the health system – including scope 1, 2 and 3 emissions across aged care, healthcare suppliers and manufacturers.

Given that scope 3 emissions account for such a huge proportion of an organisation's/sector's emissions, we believe more precise data around these emissions, in relation to the Australian health system, in particular, would support the sector and its organisations/operators, to pinpoint those areas of its supply chain that might yield the "quickest wins" when it comes to emissions reductions. The existing Global Green and Healthy Hospitals Climate Impact Checkup Tool, which some member health facilities already use to measure their scope 1, 2 and 3 emissions, may be informative for this purpose.

Initiatives to measure/report on health system emissions/energy use should, as stated earlier, align with scientifically backed emissions reductions targets, as stated in our response to Question 3.

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

As stated above, we strongly support the inclusion of scope 3 emissions reductions in this strategy. We would also like to stress emissions reductions efforts – and other climate action – pursued as part of this strategy must observe our proposed "objective 1" - the protection and promotion of health, wellbeing and health equity. These interconnecting objectives would be well supported by "data" gleaned by drawing upon and valuing the lived experience of intersectional communities across Australia – that is, communities already demonstrated to be most impacted by the intersections between health inequity and climate change.

<u>QUESTION 8.</u> What do you think of these proposed focus areas for emissions reduction? Should anything else be included?

WHGNE has considered this question in the context of our recommendation for a revised "Objective 3" for this strategy, that is, ***Objective 3: A net zero health and aged care system*** – *This strategy will support the development of a comprehensive national net zero plan for health and aged care, which reflects best scientific evidence and is informed by a detailed assessment of the health system's carbon footprint (including scope 1, scope 2 and scope 3 emissions).*

It is critical this strategy emphasises the urgency with which scope 1, 2 and 3 emissions be reduced, and the fact that health equity, in the context of climate change, also depends upon emissions reductions beyond the health sector, across all sectors and areas that contribute to health and health equity – in short, the social determinants of health.

This section must include science-backed decarbonisation targets for the health sector and detail the process by which these targets will be communicated, prioritised, and the action towards them resourced, both financially and in terms of workforce.

The six proposed focus areas are a good launch pad for emissions reductions initiatives, and we are particularly supportive of the "prevention" focus point, as this has emphasises the need to exert effort, wisdom and resources tackling problems at their cause. We would also urge the government to rename the "waste" focus point to "resource use."

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We would like to also propose the inclusion of "land use, biodiversity and ecosystem services" and "food" as additional focus points. Importantly, these focus points offer opportunities to achieve health and environmental co-benefits beyond the reduction of emissions.

Land use, biodiversity and ecosystem services – it is critical that this strategy registers the links between health equity, unsustainable land use, land degradation, the loss of biodiversity and ecosystem services and climate change. Land degradation "contributes to one quarter of the world's greenhouse gas emissions," as well as putting enormous pressure on ecosystems, while contributing to the poor health of some of our society's most vulnerable people. Climate change will only compound this. This strategy must include actions that protect ecosystems and advocate for an end to land degradation and the pollution of air and water, via forestry, mining, urban sprawl and unsustainable forms of agriculture. This aligns well with the strategic principle of "health in all policies" and articulates the need for health advocates to have a role in decision-making around land use, ecosystem and biodiversity protection beyond the health system itself.

Food – this strategy must include food as a focus area, as not only does food production, transportation, procurement and preparation contribute to the carbon footprint of the health system, but it has knock-on effects on health equity and wellbeing. Reducing the diversity of impacts that food production and transportation has on the environment will likewise have co-benefits for human health and wellbeing.

QUESTION 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?

We're strongly supportive of this action area's focus upon reducing emissions generated via the construction of buildings (including the creation of materials used) and during the life of buildings themselves, via the transition to renewable energy and the use of energy efficient devices. It is critical the strategy requires that all new health facilities be gas-free and renewably powered (either via on-site renewable energy generation or purchased power), as well as setting a scientifically backed target date for the transition of existing facilities to renewable energy. It is critical that this strategy offers an outline as to how this transition will be supported and resourced by government.

We also recommend that this section of the strategy include guidelines around health facility construction on greenfield sites and the remediation potential and climate and health equity benefits of brownfield sites. Research around the emissions related to brownfield land

development for housing in San Francisco demonstrated that brownfield land "offers large tertiary impact reductions due to higher [building] density, less utility and road construction needs, shorter commute distances."

This highlights the opportunity for this strategy to align policy around built environment-related emissions reductions with climate mitigation.

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

We are supportive of the broad aim of this action area to increase the adoption of zero emissions fleet vehicles used by health services and to improve fuel quality, and would urge government to adopt targets and deadlines for these two bodies of work.

We recommend this section include plans for how governments at all levels can collaborate towards the resourcing of better, more efficient, universally accessible public transport links in order to provide equitable and emissions-free (or reduced emissions) health access for all people, particularly in regional and rural communities where public transport services are severely lacking. The existing lack of adequate public transport connections, and this strategy's focus on personal vehicles (even if they are electric) discriminates against those people without access to personal vehicles – even *forcing* car ownership for some people who have no public transport alternatives - and compounds other existing health inequities.

This strategy must outline a process for governments at all levels to plan for and resource comprehensive and reliable public transport links to all health services across the country. Such action would also have the potential to positively impact emissions reductions via land use, in that health facilities could reduce the paved surfaces currently dedicated to onsite car parking.

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

We are broadly supportive of the actions outlined to reduce supply chain-related emissions, and recognise the federated structured of Australia's government to require a more complicated process for achieving this than the English NSH roadmap, cited as an example. However, this highlights the need for this section of the strategy to include very specific targets for the reduction of emissions from health sector supply chains, and to commit to equity, broader planetary health and social justice standards as part of the procurement process.

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

N/A

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

According to the World Health Organisation, 85% of waste generated by healthcare activities is non-hazardous waste, while the remaining 15% is considered hazardous in that it is toxic, infectitious or radioactive.

This section of the strategy presents an opportunity for a strong commitment to the implementation of a circular economy, that is, the "designing out" of waste by keeping products and materials in use. This principle of circularity is broadly included in the strategy, however it is imperative that specific actions and targets are included for designing out the above-mentioned 85% of non-hazardous waste, at the very least.

These actions must include education, resourcing, oversight and regulatory strategies around waste segregation and disposal, and safe and environmentally sound methods for treating healthcare waste that would otherwise be incinerated.

QUESTION 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?

As a primary prevention organisation, we're strongly supportive of the inclusion of preventative care as an emissions reduction action area. Climate change mitigation is, in itself, a preventative health strategy in its tackling of climate change at the cause, and so urgent and ambitious mitigation action across all levels of government and all policy areas is critical in this regard.

An important element of this is the ongoing allocation of adequate amounts of government funding to existing preventative healthcare, and expansion and consolidation of this type of healthcare across our communities to ensure equity of access to it. Linked to this is a need for government to divest from activities and policies that are "unhealthy" for people and planet – whether that is mining, military expenditure, unhealthy food, taxation subsidies that increase existing inequities, etc. Money divested from "unhealthy" economic activity not only enables

the prevention of the forms of ill health related to these activities, but also frees up funding for economic activity that aligns the social determinants of health.

This strategy must include specific target and actions for pursuing preventative health measures, across all policies, in accordance with a social determinants of health approach. This approach promotes the idea that individual and collective health are determined by non-medical factors that sit outside the "health system." These include:

- climate safe, accessible, affordable and connected housing
- access to and support in education
- meaningful employment with good conditions for the holistic support of employees
- equitable access to secure supplies of nutritious and culturally appropriate food
- social inclusion, non-discrimination and participation in democratic decision-making.

As such, prevention becomes a matter of recognising and taking collective responsibility for universal access to safe housing, education, dignified and just employment conditions, nutritious food and the resources and opportunities necessary to participate in our democracy. These should be the bedrocks of any action towards preventative health and care.

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

We believe it is important that this strategy explores not only how to involve private providers in emissions reductions efforts, but also in health equity efforts in the face of climate change.

With regards to climate change mitigation and emissions reductions, the strategy should outline goals and targets for including these requirements into accreditation standards across both the private and public spheres. This would also entail extensive education and awareness-raising within the private sector regarding service responsibilities for including climate change risks in strategic and operational plans.

This strategy must go further than this, however, involving private health providers in work to embed health equity and broader conceptualisations of planetary health in their work. This is particularly important considering the increasing out-of-pocket costs that Australians are incurring for healthcare and the fact that this "willingness to pay" is often constrained by "ability to pay", with "people at socio-economic disadvantage — who generally have poorer health — having a lower ability to pay the higher prices often paid by those at socio-economic advantage." This is effectively pricing many people out of accessing the healthcare they need and undermining commitments to universal health access. As climate change continues to

impact the health and wellbeing of people in Australia, particularly those at "socio-economic disadvantage," the barriers to health posed by market-based health services are only going to increase.

QUESTION 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 15 to 20) are the highest priorities for action?

We believe this strategy must take a more nuanced approach to prioritising climate mitigation efforts than what is suggested by this section of the draft strategy, and this question.

As this strategy is taking a "health in all policies" approach, we believe it must prioritise climate mitigation efforts (including *both* emissions reductions and ecological protection and remediation) in those areas where emissions are highest and ecological degradation (including the loss of biodiversity and carbon sinks) causes the greatest harm to both human and planetary health. There is considerable overlap between these areas.

These priorities must be informed by the best available scientific evidence, and must not be limited by political will or cost.

The CSIRO notes that the sectors that were the greatest contributors to Australia's greenhouse gas emissions in 2020 were:

- Energy (specifically the burning of fossil fuels for electricity generation) - 33.6%
- Stationary energy (fuel use in manufacturing, mining, residential and commercial sectors) - 20.4%
- Transport – 17.6%
- Agriculture – 14.6%
- Fugitive emissions (losses, leaks and releases of gases such as methan and C02, associated with industries producing natural gas, oil and coal) - 10%
- Industrial processes – 6.2%
- Waste – 2.7%

Much of Australia's biodiversity loss and ecosystem degradation is the result of land-clearing around cities, for agricultural purposes (particularly livestock), logging and mining.

As an example, priority could be given to transitioning at scale and pace away from fossil fuel extraction, and the use of fossil fuel-generated energy, and towards renewable forms of energy across the entire economy. This would reduce energy-related emissions as well as protecting ecosystem services - including national carbon sinks - and biodiversity, as well as having considerable co-benefits to health related to reduced air and water pollution.

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

N/A

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?

We are concerned that this section of the strategy does not make explicit the reason for increased susceptibility to climate-related negative health effects for some people and communities in Australia. In fact, it almost implies that this increased susceptibility is an innate part of belonging to these communities, rather than the result of cultural, social, economic systems that actively discriminate against and oppress some people, based on their intersecting social and cultural identities.

The omission of this detail may have adverse consequences for the resulting priorities for adaptation action identified by the strategy, and may lead to adaptation actions that fail to address the root causes of vulnerability and health risks, or, worse still, exacerbate this vulnerability.

We also believe this section of the strategy is taking the wrong focus, and that it should better reflect the (revised) objectives we have offered, above:

Objective 1: Promote and protect health and wellbeing, and health equity – This strategy will guide the design and implementation of policy across all levels and departments of government, to protect and champion health equity in the context of climate change mitigation and adaptation.

Objective 2: A climate-safe community – This strategy will guide initiatives to build the resilience of the community, the health system and other government sectors to respond to the health impacts of climate change.

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Objective 3: A net zero health and aged care system – This strategy will support the development of a comprehensive national net zero plan for health and aged care, which reflects best scientific evidence and is informed by a detailed assessment of the health system's carbon footprint (including scope 1, scope 2 and scope 3 emissions).

That is, it must focus on adaptation not only in the event of climate crisis and disaster, but in the face of incremental climate change, with "health equity for all" the principle aim, not only across the health sector, but "in all policies."

This section of the strategy should provide an opportunity to explore how adaptation action can present government at all levels, and in all policy areas, with an opportunity to build more equitable and resilient communities in the face of climate change as an integral part of all climate adaptation work.

As such, we recommend this section of the strategy takes a deeper dive into intersectionality, interrogating the ways in which certain people *are made* more vulnerable to climate change – whether this is manifested incrementally or suddenly, in times of disaster - because of the ways our systems structurally discriminate against their identities. This interrogation will then provide opportunities to bring these people, and their lived experience, into the planning and prioritisation of adaptation actions. It will show up the places where "vulnerability" is actually the interplay of sexism, racism, colonialism, ableism, ageism, geographic discrimination, homophobia, visa discrimination, "povertyism" (to name but a few) and demonstrate that climate adaption requires "health in all policies" action that prioritises:

- Climate-safe, accessible, affordable and connected housing as a universal right
- Universal access to culturally safe health and wellbeing in all communities (including visa-holders and non-citizens)
- The establishment of regulatory and taxation regimes that enable government to provide dignified and just social safety nets for all, and support the transition to a low-carbon economy
- Public transport systems that adequately facilitate equitable participation in public life
- Universal access to nutritious food
- A universal basic income that offers a minimum degree of financial security and access to basic needs to all people, without condition, in order to enable people time for the care-giving and social connection activities that are foundational to human life and health
- Equitable pay and good employment conditions to ensure all workers receive holistic support to facilitate their basic needs

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<u>QUESTION 19.</u> 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?

We strongly support the development of a National Health Vulnerability and Adaptation Assessment and National Health Adaptation Plan, as long as these plans are consistent with the health in all policies approach, and are whole-of-government processes, rather than being isolated within the Department of Health.

These plans must also take a holistic and social determinants approach to considering "health," and account for the lived experience of all people in Australia, including non-citizens. It should also be co-designed with all levels of government and community – particularly those likely to be most impacted by climate change and its amplifying effect on existing health inequities - to ensure health equity sits at the centre of this plan. This is in recognition of the fact that adaptation is "means-based" - those with the capacity to adapt, adapt. Those without – that is, those who are already experiencing inequity and oppression in other parts of our systems – get left behind.