SARRAH

Services for Australian Rural and Remote Allied Health

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

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Services for Australian Rural and Remote Allied Health (SARRAH) submission: National Climate and Health Strategy

Thank you for the opportunity to provide a submission on the Draft National Climate and Health Strategy.

Services for Australian Rural and Remote Allied Health (SARRAH) is the peak body representing rural and remote allied health professionals (AHPs) working in the public, private and community sectors, across primary and other health settings, disability, aged care, and other service systems. SARRAH was established in 1995 as a network of rurally based allied health professionals and continues to advocate on behalf of rural and remote communities to improve access to allied health services and support equitable and sustainable health and well-being. SARRAH maintains that every Australian should have access to health services wherever they live and that allied health services are fundamental to the well-being of all Australians.

SARRAH is also a member of the Climate and Health Alliance and strongly supports the leadership and advocacy CAHA has taken in this critical area of national, public policy.

SARRAH commends the Australian Government for following through on the commitment to prioritise development of a National Climate and Health Strategy. Action must be urgent, ongoing, iterative and responsive and encompass development, implementation, review and resourcing of coordinated efforts to mitigate the extent and impacts of climate change. Protecting human health and wellbeing now and into the future must remain a national priority.

We also thank the Department for facilitating opportunities for stakeholder engagement in the development phase of the draft Strategy and hope to have further opportunities to engage in the process. In our experience, the quality and substance of material presented and the approach to discussions by officials and participants was constructive frank, informed and open.

Our overarching comments on the draft Strategy follow.

a) SARRAH supports CAHAs position on the Strategy and stress their position that ***the importance of this Strategy can not be understated.***

b) As many stakeholders have stressed, Australia's National Climate and Health Strategy needs to adopt a **scope and scale commensurate with the challenges we face** (nationally and globally) to address an unsurpassed threat to human health. The consequences of inaction or ineffective action are profound and as great or greater than any matter requiring government and community responses, including those related to global pandemics and major military conflicts.

- The Strategy needs to be bold, purposeful and sustained to contribute to addressing the impacts of climate change.
- For this reason, SARRAH strongly supports the *Health in All Policies* approach described in the draft Strategy (page 32).
- Further, we consider the matter should be a standing agenda on First Ministers' meetings and other national ministerial meetings reporting to National Cabinet.

c) **The Strategy needs to be agreed, resourced, and implemented as a matter of urgency.** This is underscored by the extent and rapidity of global environmental shifts (e.g. escalating record-breaking global temperature increases – at faster rates and with more widespread and catastrophic effects than the most sophisticated models have predicted)[1]. The extreme weather and related events being felt across the northern hemisphere at present must raise extreme concerns about the potential severity and impact of events we will face in Australia in the lead up to the 2023-24 summer period and beyond.

- The prevailing shift in climatic conditions is more rapid than has been factored into international agreements and commitments to date which means governments need to act with more urgency and be prepared to escalate our planning and responses far more rapidly and extensively. Standard policy development and implementation timeframes are too slow, in the face of dramatic increases that must be ameliorated to slow global impacts. The focus and effort should more closely reflect the urgency that accompanied initial responses to the COVID pandemic.
- Globally, more political leaders are openly crediting climatic and related events/disasters to and (human influenced) climate change. The reality of having to address more frequent, severe, dislocating and costly events and trends, appears to be strengthening resolve to act and accept the science and modelling. The costs and implications of mitigation activity, while costly, must be weighed against the inordinate costs and impacts attributable to inaction.
- While public opinion on climate change continues to vary, the clear and growing majority view in Australia is toward greater action to address climate change[2], which should embolden policy makers.
- SARRAH encourages Australian Governments to take action on climate change commensurate with the risk it poses.

[1] The scientific evidence is overwhelming and it is appropriate that this inform leaders' decision- making and preparedness to act, regardless of whether the veracity of objective information is questioned by elements of the community: e.g. the International Panel on Climate Change (IPCC); the CSIRO; NASA; etc

[2] For example – as reported by the ABC – here.

d) **SARRAH strongly supports the proposed Health in All Policies approach.** The draft Strategy outlines the rationale for taking a coherent and integrated approach to national policy as it relates to health, well-being and climate change:

> *The Australian Government also recognises climate change has impacts on the wider determinants of health and some populations (such as the elderly and people with disabilities and pre-existing health conditions) are more vulnerable to these impacts. For First Nations communities, climate change will exacerbate pre-existing high levels of ill-health; compound existing challenges in accessing safe water and appropriate housing, infrastructure and health services; and affect cultural and spiritual connections to Country. Many decisions influencing the social, economic, cultural, environmental, and commercial determinants of health are made outside the health system. Many of these decisions not only negatively impact on health and wellbeing, including equity, but also drive climate change, highlighting the importance of developing a holistic response to the health impacts of climate change*. (From pages 3 and 4 of the draft Strategy.)

By recognising the impacts of climate change on health, the Australian Government acknowledges a responsibility to adopt policy, regulatory and funding approaches to better address the complexities and interactions involved. This would represent a major step in policy setting, which SARRAH believes, would set the necessary foundation for better quality, more equitable and sustainable policy and service provision (in health and other areas), and prove more cost effective and efficient in the medium and longer term. Further, as CAHA argues in their submission on the draft Strategy:

> *All dimensions of climate change are interlinked with human health. Health should be understood in the holistic sense, as "... a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Therefore action to reduce the health risks from climate change requires working across all sectors and all levels of government.* (CAHA Submission, page 4)

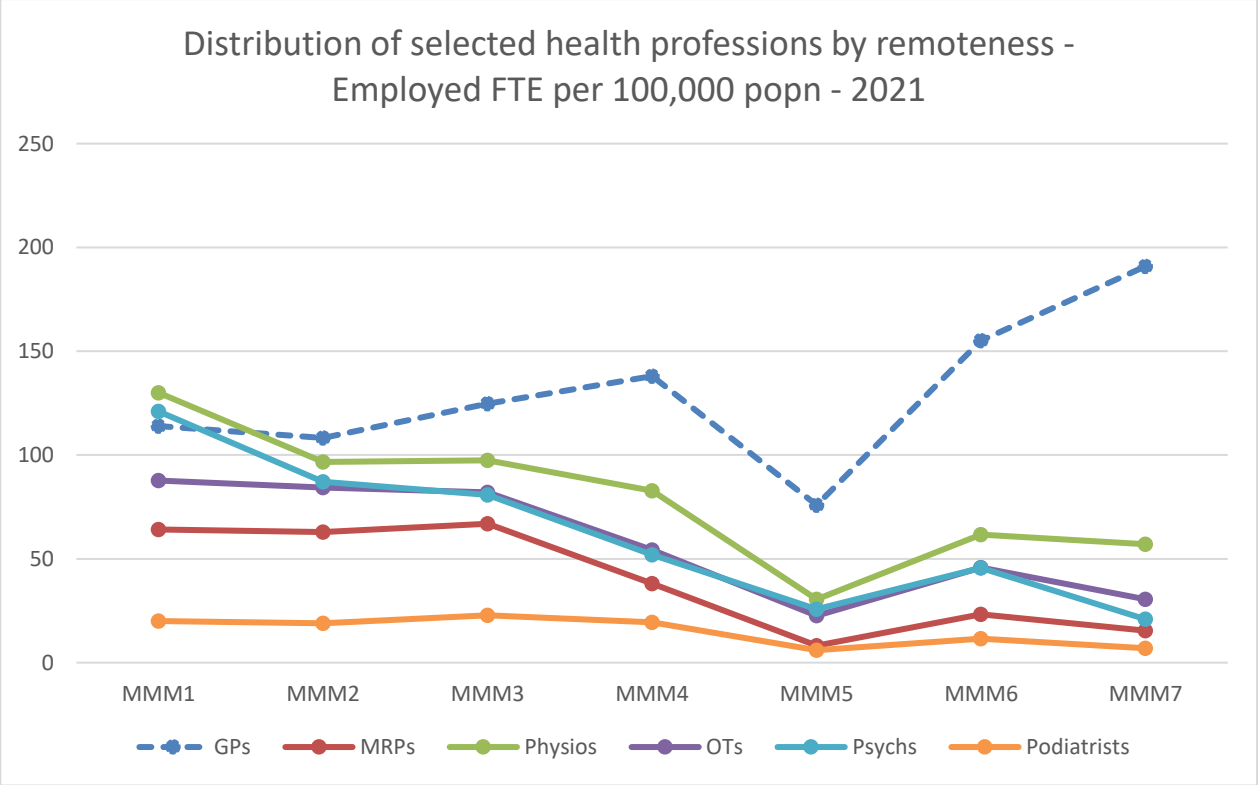
e) SARRAHs considers the National Climate and Health **Strategy also provides an opportunity to contribute to improved equity of access and outcomes across the population.** The objectives of the Strategy are fully compatible with delivering more sustainable and effective health and social services to populations identified as being at most at risk: including people living in rural and remote Australia. The long-standing situation has been, in short:

- Australians living in rural and remote Australia experience substantially worse health and wellbeing outcomes at the population level than do other Australians.
- These differentials are generally magnified in rural and remote areas where people face other risks of inequality (such as Aboriginal and Torres Strait Islander Peoples, people with disability etc – as identified in the draft Strategy).
- The level of disadvantage is substantial, multi-faceted, extensively documented and long-standing[3], illustrating the limited effectiveness of previous and existing policy and program approaches to address those inequities.
- The impacts of climate change and the risks they pose for people appear to be most extreme in environments we might typically consider harsh (e.g. remote inland

[3] For example: as demonstrated by data and reports produced by the Australian institute of Health and Welfare (AIHW); https://www.flyingdoctor.org.au/nswact/news/RFDS-Best-for-the-Bush-report/; The Australian Atlas of HealthCare Variation series, produced by the Australian Commission on Safety and Quality in HealthCare; the 2022 report of the Senate Standing Committee on Community Affairs report of their inquiry into the Provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians and the very many submissions to that inquiry, including SARRAHs; the Evidence base for more investment in rural and remote health (2023, commissioned by the National Rural Health Alliance); etc.

communities) and/or at the forefront of rapid change (e.g. northern coastal and island communities) – communities that already experience higher need for but lesser access to services.

- There is a close correlation between health workforce mal-distribution, access to services and population health outcomes. The maldistribution is stark when presented on a comparable per head of population distribution graph (below). However, the access and service challenges (and frequently the associated operating resource demands) are magnified greatly by factors inherently determined by location. It is a vastly more challenging situation to deliver health and related care to similarly sized populations that occupy the space of a few inner-city suburbs compared with an area larger than Victoria, with substantial variation in terrain, climate and limited infrastructure. Typically, even this situation is complicated by higher rates of disease (often co-morbidities) and lower levels of personal income.



Notes – For other allied health (not included), generally a similar pattern exists to those identified; also noting Australia does not collect or hold workforce data on many allied health professions, including speech pathologists, exercise physiologists, dietitians, social workers and more. While GPs appear to be relatively well distributed, this can be somewhat misleading given too few medical professionals are practicing as or becoming GPs (an overall shortage), the distribution of other medical specialists is far more metro-centric. The relative absence of allied health and medical specialists exacerbates demand pressures (while also constraining treatment options) on GPs. As a result, the nursing workforce (which is more evenly distributed than other professions) is critical to maintaining health services and access in rural and remote health areas but are under increasing pressure. Aboriginal and Torres Strait Islander health practitioners and health workers provide vital services and are comparatively well represented in rural and remote areas but are too few in number to meet service need. Across the board, challenges of servicing large and diverse geographic areas mean the ratio of health workforce to population should be higher.

- Many of the current programs used to provide health services to rural and remote residents and communities exist because of and designed around the absence of local health service and workforce availability. These can be very resource (and carbon) intensive; for example, high use of Fly-In Fly-Out workforce (even for basic health care or

avoidable conditions/events); emergency retrievals – e.g. RFDS (including avoidable events); hospitalisations due to lack of access to timely preventive and primary care; patient assistance transport schemes (again, where timely local care could have prevented the need for travel etc) and so on.

- Given Australia's geography, environment, size and population distribution we will always need mechanisms to enable people from lower population centres to access more specialised services that are can only feasibly be delivered in larger population centres. While that is accepted, too little is being done to assess the relative health outcome and cost benefits of increasing local service and workforce provision.
- Emergency and stop-gap services are too often the default policy response, arguably perpetuated by insufficient efforts to establish and maintain tailored local primary and preventive health care capacity.
- In this regard, a key action for a National Climate and Health Strategy may be to reduce the need for high resource use interventions (such as emergency air retrieval and/or avoidable hospitalisations) by ensuring timely access to local, preventive and primary care and related services. As the Draft Strategy states (page 22):

  > *Health care costs, and associated emissions, are increasing because of an ageing population and in particular, changes in the way care is being delivered. One clear pathway for reducing emissions is by keeping people healthy and out of the health system through prevention.*

- **Development and implementation of better rural and remote service and workforce capacity** (enabled by complementary digital health initiatives etc) **represents a significant and tangible national action to progress not only the National Climate and Health Strategy**, but many other imperatives - including the Strengthening Medicare and preventative health agenda , supporting further progress of a sustainable and effective NDIS, the Aged Care reform process, the national Closing the Gap commitment, the Jobs and Skills agenda, productivity improvements and more.

The potential for all of these agendas (and more) to be advanced together while making a tangible contribution to constraining the climate impact of the health and related service systems demonstrates how and why an approach such as *Health in all Policies* can be pursued while aligning with the particular objectives of any of these contributing agendas. High level political leadership, coordination and will is the essential keystone.

Our more <u>specific comments</u> on elements of the draft Strategy follow.

Re: *Q 1. How could these objectives be improved to better support the vision of the Strategy?* (Page 5)

- SARRAH fully supports the statement that *"The outcome of the Strategy must be to prevent illness, injury and death associated with climate change; minimise the healthcare systems' contribution to Australian emissions; and, ensure health systems resilience."*
- The Objectives listed on page 5 are vitally important. They focus on the extent to which the health system itself contributes to the issue. However, the overarching issue is that human health and the systems that have been developed to support and maintain human health will be overwhelmed or redundant unless we are able to contain global warming and its impacts in the face of presently uncontrolled and rapid warming. Consequently, it would be appropriate for the

National Climate and Health Strategy to place the objectives currently expressed on page 5 within an overarching objective about the critical importance of limiting the extent and impact of global warming so that as much of Australia (and the planet) remain viable for human habitation as possible.

Re: *Q2. How could these principles be improved to better inform the objectives of the Strategy?* (Page 6)

- As mentioned above, SARRAH welcomes the draft Strategy and the objectives. These could be further strengthened as indicated in the response above and possibly by citing links explicitly connected to other national strategies and priorities (e.g., Closing the Gap), especially those where National Cabinet has indicated an intention to provide continuing oversight and commitment.
- As a critical enabler, SARRAH would argue that addressing chronic health workforce shortages and service access issues experienced by people living in rural and remote Australia should also be recognised as an important action to be promoted and monitored as part of the Strategy.
- The CAHA Submission also identifies the issue: *The prevention of disease and injury is the most certain way of reducing the health sectors environmental footprint. By preventing disease and injury, particularly chronic conditions, fewer people need to access health services and the carbon load is reduced. It is recommended that prevention of disease is embedded within mitigation approaches and that the Commonwealth budget reflects the commitment of 5% of health budget spending towards preventive health.* (CAHA submission, page 8)

Re: *Q8. What do you think of these proposed focus areas for emissions reduction? Should anything else be included?* (Pages 15-16)

- Each of the identified focus areas should be considered in reducing emissions. In addition to these - and as a cross-cutting consideration – each focus area should include and be informed by a rural and remote lens. The reality of this will often vary greatly from what exists, is available or viable in major population centres. Explicit consideration of rural and remote circumstances, including tailored investments to enable the balance of emissions controls and service reach and impact, is needed. In addition, to be effective, investments must be secure and applied on scale, rather than be limited to short term trials and pilots.

Re: *Q10. Which specific action areas should be considered relating to travel and transport, over and above any existing policies or initiatives in this area?* (Page 18)

- Please refer to our overarching comments on the Strategy as well as our response to the previous question.

Re: *Q14. 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? (*page 22)

- Please refer to our overarching comments on the Strategy, especially in relation to established levels of health service access, workforce and the differential access and outcomes that characterise Australia's health system.

Re: *Q21. What immediate high-priority health system adaptation actions are required in the next 12 to 24 months?* (Also referencing questions 19 and 20 – Page 29).

- Citing CAHAs submission (page 10) *Principle 2, 'tackling health inequalities', should include inter- and intragenerational health inequality in climate impacts. For example, young people are more impacted by the climate crisis and therefore need specific focus in policy development and implementation. Principle 2, 'tackling health inequalities', should be strengths based, going beyond 'supporting action' to 'taking action'*
- There is no more urgent need than to enable local health service and workforce capacity, which rural and remote Australians need now and have done for many years.

Re: *Q14. 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?*

- SARRAH strongly supports the response provided in the CAHA submission (pages 18-19). CAHAs response identifies:
  - the breadth of action needed;
  - the numerous areas of policy activity that could be productively leveraged in contributing meaningfully to the National Climate and Health Strategy; and
  - the urgent need for concerted and coordinated effort across these areas.
- An area of immediate priority should be to develop and implement a comprehensive national rural and remote health workforce strategy. The strategy should be prioritised through National Cabinet and recognise the cross-service sector implications (public, private, community-controlled, health, disability, aged care etc) and address:
  - The absence of a national Allied Health workforce strategy of any kind – despite decades long the projected further demand growth, maldistribution and chronic shortages (in rural and remote areas especially) of this workforce; and
  - Inadequate coherence, integration, accessibility and pathway facilitation of education and training for this workforce – and integration with clinical service systems/supports.

Under **Enablers** (page 35), the draft Strategy highlights the importance of working with and supporting the **entire health and aged care workforce** to contribute to the goals of the Strategy.

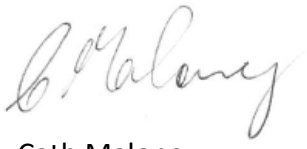
- SARRAH strongly supports this position goal and suggests that to achieve the required breadth and commitment to engagement, concerted effort is needed that respects, engages with and facilitates contributions from all elements of that workforce.
- The current wording of *E1.1. (Encourage medical colleges and other education and training institutions to ensure the impacts of climate change on health form part of the training curriculum for all health care professionals)* risks perpetuating an imbalance in health and related system engagement and empowerment by distinguishing between the medical profession (i.e. medical colleges) and "other".
- "Other" in this case refers to more than 90 per cent of health professionals, carers, administrators and others working across this diverse sector.
- Many of these people have substantial independent control/influence on systems' clinical and other resource usage. In many cases, profession-specific education and training

bodies will have little influence or expertise in the day-to-day decisions and actions that will contribute to achievement of the Strategy.

- It is not clear why medical colleges would be singled out (at the risk of narrowing the audience) when the Strategy would be better aimed at encouraging and enabling major system-wide change and more efficient resource use.

SARRAH would be happy to contribute further to development of the Draft National Climate and Health Strategy. If you would like to discuss issues raised in SARRAHs response or require further information, please contact me at catherine@sarrah.org.au or Allan Groth at allan@sarrah.org.au.

Yours Sincerely



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