



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 in Word format to Health.Climate.Consultation@health.gov.au.

Respondent details

What is your name?
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What is your email address?
Email: mfisher@asa.org.au
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)
<input checked="" type="checkbox"/> I have read and agreed to the Privacy Statement
Do you identify as Aboriginal and/or Torres Strait Islander?
<input checked="" type="checkbox"/> No
Please select which applies to you:
<input checked="" type="checkbox"/> 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?

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).

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.

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

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 and 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 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 is 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 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).
- 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 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.

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.

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.

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!

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