This year, in an historic move, the Minister of Health issued letters of expectation to all DHBs which included a directive for action by DHBs to address climate change, together with a priority to reduce health inequities. The new climate change requirement recognises that the health sector is not only a major contributor to the greatest public health issue facing us, but also has the potential to show leadership in addressing climate change in ways that protect and promote health. It can be put in the context of healthcare ethics, particularly that it is unethical to provide healthcare while also harming health through environmental pollution. For this reason, accounting for environmental impacts of healthcare is enshrined in the legislation governing District Health Boards.2

The Minister's directive does not come out of the blue; rather it is the result of a decade of joint advocacy by hundreds of individual health professionals and their professional colleges and organisations, led by OraTaiao: The NZ Climate & Health Council. This advocacy has culminated in the creation of a specific ministerial portfolio on climate change and health. It is built on a growing body of evidence about the impacts of climate change, health and health equity, as well as the potential for multi-solving for health and health equity in climate change mitigation. The directive also responds, belatedly, to the WHO Commission on the Social Determinants of Health’s call “to bring the two agendas of health equity and climate change together”.3

In this issue of the Journal, Bennett and King outline what DHBs can do to respond to this expectation, alongside the Minister’s priority to reduce health inequities. They provide four practical examples, based on experiences from the many DHBs who are already taking action to reduce their greenhouse gas emissions, and to adapt to the climate change impacts which are already locked in through our past inaction. The fact that the authors use ‘blue-skies thinking’ to come up with the four scenarios demonstrates how little research attention has thus far been given to this important topic globally and in New Zealand. It’s clear that bringing together the evidence base about what works to reduce greenhouse gas emissions and what works to reduce health inequities in New Zealand is a much-needed next step.

Together with others (such as OraTaiao, the Sustainable Health Sector National Network and hundreds of health care workers who have signed a letter of petition to the government), Bennett and King call for the Ministry of Health to set up a centre similar to the UK’s Sustainable Development Unit and to require DHBs to measure, report on and reduce their greenhouse gas emissions.

A UK-style Sustainable Development Unit would be flawed in a New Zealand context, partly because the UK’s approach has not yet tackled the intertwined nature of equity and sustainability. What Bennett and King ably demonstrate is that actions to reduce emissions while also addressing health equity are context dependent, and need to
be designed with local communities, particularly in partnership with hapū, iwi and Māori communities. While it has been a challenge to measure the successful reductions in greenhouse gas emissions as a result of the UK SDU work, a complex extension of evaluation will also need to be incorporated to measure impacts on social and health equity.

The Minister’s letter, and Bennett and King’s article, also represent a first step towards a crucial wider conversation about what we mean by ‘health’ and ‘healthcare’ in the context of a full planet—one in which successful human population growth has overwhelmed the ability of most other species to flourish—and a planet on which humans are now affecting the Earth’s systems fundamentally in ways that warrant our own eponymous geological epoch—the Anthropocene.5,6

Climate change is just one of the Earth’s ecosystem limits we have exceeded. Steffen and colleagues describe in detail nine important and interlinked system limits, of which humans have caused the breaching of at least three, (the nitrogen and phosphorous cycles, and biodiversity being the most severe, Figure 1).7 In Aotearoa New Zealand, we have pushed the limits of all three of these, with severe consequences for land use, freshwater quality and native biodiversity.

It is no coincidence that the breaching of these boundaries is the culmination of decades of relentless Western neoliberal free market capitalism, which has assumed that maximising economic growth through de-regulation of economic markets is the only pathway for improving human well-being—through the exploitation of natural and human ‘resources’. Concerningly, the same paradigm of commodification is being used to suggest “tepid market-based solutions”8 to climate change, which fail to adequately reduce greenhouse gas emissions while also often having negative consequences for other health, equity and sustainability outcomes.

Until recently, New Zealand governments across the political spectrum have flown the flag for this flawed economic model, and it has filtered into every aspect of New Zealand life, including health. The results have included increasing social and health inequities, and unacceptable pressures on natural systems, such as fresh water, clean

Figure 1: Planetary boundaries to guide human wellbeing on a changing planet.
air, biodiversity and the climate. A ‘market’
approach to health has led us to value indi-
vidual extensions of life expectancy through
advanced technologies in tertiary care over
safeguarding these fundamental building
blocks of health for future generations.

A serious conversation about equitable and
sustainable health and healthcare therefore
requires significant reorientation. This is
occurring globally in a number of guises. The
UN Sustainable Development Goals set out
17 interlinked health, environmental and
economic targets for countries at all stages
of economic development. New Zealand
has signed up to meeting these goals but
has yet to incorporate them into policy and
action. Meanwhile, in Western public health,
there is a renewed understanding that
health, social and health equity, and global
ecosystem sustainability are intertwined.
Most recently, the Lancet’s deft repackaging
of a range of existing ideas gave rise to the
concept of Planetary Health—a multi-disci-
plinary endeavour to promote sustainable
and equitable consumption, reduce popu-
lation growth and place human health in the
context of well-functioning natural systems.

While these ecological approaches linking
health, healthcare, equity and environ-
mental sustainability feel new to Western
health practice, they approximate and to
some degree echo the unbroken funda-
mental world views of indigenous peoples’
globally, including Māori models of well-
being. These models explicitly which
situate human wellbeing within the health
of local ecosystems. By accepting both the
dominant market-based solutions to climate
change and imported health paradigms, we
continue to silence and devalue voices of
indigenous leadership. By doing so, we are
missing crucial pieces necessary to re-orient
and transform towards health equity and
sustainability.

The root causes of unsustainability and
health inequities in Aotearoa New Zealand
are intimately linked to processes of colo-
nisation and colonialism, which have set
up the social and economic structures of
natural resource exploitation, constrained
indigenous health development and over-
ridden holistic concepts of hauora Māori.

All three of Bennett and King’s scenarios
emphasise strong partnership working with
Māori to ensure action to reduce healthcare
 greenhouse gas emissions are translated into
improvements in hauora Māori, and Māori
health equity. A critical examination is
needed of how our health system reinforces
colonialism, perpetuates inequalities and is
conceptually unsustainable. The re-struc-
turing of our health system that must now
occur (and for which a government review
is currently underway) needs to dismantle
systems and structures that further entrench
the status quo, and centralise Māori knowl-
gedges, governance partnerships and
self-determination.

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Nil.

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