



# **Climate Change Action in Community Health**

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## **Acknowledgements**

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## **Executive Summary**

### **Introduction**

Climate change is arguably one of the greatest environmental challenges in recent history and is likely to have significant impacts on lifestyles, economy and health in the future. An adequate response to this important issue requires timely and robust actions at an international, national, state and local level.

The impact of climate change on human health is predicted to be substantial and of a predominantly negative nature. Climate change is clearly an issue of considerable relevance for the health sector. The Community Health (CH) sector as a major provider of primary health care in Victoria has an important role to play, particularly at a local level. Community Health Services (CHSs), like all in the community, also have a social responsibility to decrease their own environmental impact.

The aim of the Climate Change Action in Community Health project is to determine the capacity of metropolitan community managed CHS\* in Victoria to respond to climate change.

The objectives of the project are to:

- determine the current understanding of climate change within metropolitan community managed CHSs;
- document the extent to which CHSs currently implement policy & practices that respond to climate change; and
- identify the barriers affecting the capacity of CHSs to respond to climate change.

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\* The term “community managed” CHSs has been used by the author to describe CHSs which are independently governed by a Board of Management representing their local communities. In the development of this project these were initially described as “stand alone” CHSs and this is the terminology used in the documents in the appendix of this report.

## **Background**

The major drivers of climate change are significantly increased atmospheric concentrations of carbon dioxide, methane and nitrous oxide. Carbon dioxide is by far the most significant of these due to its much higher levels and much greater rate of growth in the atmosphere. These increases have been caused predominantly by human activity; in particular the use of fossil fuels, such as coal, oil and natural gas, and to the clearing of land and to a lesser degree agricultural activity.

The most recent report of the Intergovernmental Panel on Climate Change (IPCC) outlines a number of effects of climate change that are already known to be occurring. These include:

- increased temperatures - eleven of the twelve years between 1995 – 2006 were among the warmest in terms of global surface temperature since record keeping began in 1850,
- sea levels have risen by an average of 3.1 millimetres per year from 1993 – 2003,
- changes in precipitation – floods and droughts,
- wind changes – contributing to droughts,
- extremes of temperature, including heat waves, and
- increased extreme weather events such as cyclones.

The IPCC predicts that current patterns of change are likely to worsen in the future with further increased global surface temperature, rising sea levels, more frequent extreme weather events, significant adverse impacts on plant and animal communities and agriculture, decreased water quality and decreased water and food security.

Health effects of climate change predicated for the future include:

- altered rates and distributions of some infectious diseases – food, vector and water borne;
- food and water insecurity;
- increased malnutrition and diarrhoeal disease;
- decreased air quality leading to increased incidence of respiratory and cardiovascular illnesses;
- increased death, disease, stress related disorders, injury due to heat waves, floods, storms, fires and droughts; and
- vast numbers of people living in low lying areas around the world will be displaced.

Climate change is likely to increase health inequalities across the world and within Australia.

## **Results and Discussion**

Twelve metropolitan community managed CHSs participated in the project. This equates to fifty two percent of possible CHSs. All metropolitan regions were represented. Participation was voluntary and results have been de-identified. Representatives of the participating CHSs were asked a series of questions relating to the aim and objectives of the project. See appendix one for interview questions. Interviews occurred by telephone in June and July 2007.

### *Understanding of Climate Change*

Most CHSs were able to provide reasonable definitions of climate change. Eleven of the twelve CHSs correctly referred to increased fossil fuel use and/ or its bi-products as a major causative factor. No respondents referred to agricultural activities or deforestation as a cause of green house gas emissions, possibly due to the metropolitan base of those interviewed.

When asked about the effects of climate change, the most commonly noted impact was that of rising sea levels, followed by direct health impacts and extreme weather events. Increased temperatures, effects on fauna and flora, economic downturn, lifestyle change and effects on farming were less frequently mentioned. In total seven different direct health impacts were named by the nine CHSs. The combined responses from the CHSs covered most of the major health impacts of climate change, however generally those interviewed only named one or two specific health impacts.

The understanding of climate change by those in the metropolitan CH sector is therefore probably at a similar level to that of the general population. Many people interviewed openly expressed that they were not confident in their level of knowledge. This is not surprising given the complexity of the issue and the fact that climate change has not as yet registered as an area of focus for CH, as will become evident later in this report.

### *Current Policy and Practices*

In order to ascertain if climate change action was embedded at a strategic level within CHSs, participants were asked whether or not they had:

- a governance level policy relating to climate change;
- an organisational plan which refers to the issue;
- a person or committee who is assigned responsibility for action;

- any systems of monitoring, measuring, reporting or reviewing climate change action areas; and
- any resources assigned to climate change within their organisation.

Responses indicated a low strategic take up of climate change as an issue in CH (see Figure 3 on page 20 for results). Many responded that action within their organisation was being driven strongly “from the ground up” and as such a systematic and strategic response had not as yet occurred.

It became clear, however, when asked about climate change policies and practices, that CHSs were taking action in a number of areas. Action areas mentioned in order of frequency included waste management, transport, energy use, actions targeting the community, staff awareness, building design, water use and purchasing.

All CHSs were taking action in some areas, although the magnitude and scope of the actions varied considerably. On average CHSs reported four areas with policies and/or practices that addressed climate change. A strong relationship was evident between agencies with environmental working groups and those undertaking systematic climate change action. All CHS with such a group were taking action in a greater number of areas than the average (between five to seven areas).

Many agencies also reported that some environmental practices were being led by staff and were not necessarily formalised nor embedded into the organisation. This was particularly in the areas of staff awareness raising, composting and household recycling.

#### *Scope of Possible Action*

There were four major areas that were commonly reported as areas for climate change action in CH. The number of CHSs nominating this is written in brackets after each area listed. These were to:

- decrease their organisation’s impact on the environment (12 );
- take a multifaceted health promotion approach to the issue which incorporates a robust lobbying and advocacy strategy (11);
- provide a direct service response to members of the community affected by climate change (5); and
- be involved in collective action (5).

It was felt that this collective action should occur in conjunction with peak organisations such as Victorian Healthcare Association (VHA) and Victorian Council of Social Service (VCOSS).

### *Barriers to Action*

CHSs identified a large number of barriers affecting their capacity to respond to climate change. Funding was described as the “major hurdle” for the sector. Most CHS felt that in order to move forward in a significant way, specific funding needed to be made available. Many complained of an inability to afford capital improvements and purchases that would improve their energy efficiencies.

Government leadership was the next most commonly mentioned barrier. The focus of most responses was on the Victorian government, which is not surprising as it provides the majority of funding to CH. These responses centred on the lack of policy regarding climate change that is applied to CH, and the resultant lack of profile which climate change has attracted within the sector. They felt that although the State government has a strong environmental record, they were not driving the issue of climate change in CH. Examples cited included that of the absence of energy reduction targets and environmental building regulations in CH and the lack of identification of climate change as a Victorian health promotion priority.

Some comments were also made in relation to the Federal government. Respondents expressed concern regarding the lack of public policy responses to climate change and the government’s perceived scepticism about the issue. They were frustrated by the inability of CHSs to access LPG gas conversion rebates and by tax legislation which results in lower fringe benefits tax rates for fleet vehicles that have driven further.

CHSs also recognised that greater internal leadership and support is required in order for organisations to improve their responses to climate change. Another significant barrier identified was that of lack of skills, information and knowledge about climate change. CHSs reported a need for clear and concise evidence based information about effective strategies to enable decision making. Lack of time was reported by many CHSs. Most of those who spoke of the lack of time qualified their responses by references to competing interests and demands.

Other less commonly reported barriers noted included:

- a sense of powerlessness in relation to climate change - expressed in language such as “It feels bigger than Texas” and we “need to be able to feel that we are going to make a difference” ;
- a lack of commitment – although an equal number of CHSs also specifically commented that this was not an issue;
- negative attitudes to climate change action; and
- ageing buildings and infrastructure.

### **Conclusion**

CHSs are an integral part of the Victorian health system. The CH sector with its strong focus on health promotion, its record of working in partnership with others and its close connection with vulnerable sections of the community has an important role to play in responding to climate change.

The capacity of CH to respond to climate change is currently limited by a number of significant factors. Insufficient availability of specific funds for climate change action was identified as the greatest barrier. An inadequate level of government leadership was also perceived as a major impediment. This includes a lack of a broad Federal strategy around climate change which potentially can decrease the effectiveness of action taken at a local level. There also is a need for greater policy direction and support from the State government, which is the major provider of funds to CH. This lack of government leadership and direction has resulted in climate change not yet registering as a priority for strategic action by many CHSs.

The provision of clear information about climate change and related evidence based practice would also greatly assist the sector to increase its knowledge base and its ability to undertake effective action.

The metropolitan community managed CHSs in Victoria have however displayed an interest, a willingness and an ability to respond to climate change. All CHSs involved in this study agreed that climate change is an important issue for the sector and expressed a desire to strengthen their responses in the future. CHSs have identified a range of action areas in which the sector should be involved. These are to decrease the environmental impact of individual CHSs, to be involved in multifaceted health promotion responses which

incorporate political advocacy and to provide direct responses to the health impacts of climate change. They also identified that an effective response would be facilitated by working together as a sector and with other relevant partners in response to climate change. It felt that peak organisations such as VHA and/or VCOSS could coordinate this collective action.

### **Recommendations**

The following outcomes would strengthen the capacity of metropolitan community managed CHSs to respond to climate change:

- environmental working groups established within CHSs;
- greater funding for climate change actions and particularly for funding of infrastructure improvements;
- commitment for environmental policies and strategies such as energy targets and building standards to be applied to CH;
- identification of climate change as a Victorian health promotion priority by DHS;
- greater level of information and resources to be made available to CH including:
  - information on the effects of climate change with particular focus on health impacts;
  - clear and concise, evidence based information on effective strategies for decreasing environmental impact within CHSs; and
  - a simple environmental self audit tool for use by CH.
- development of an robust advocacy campaign particularly in relation to social justice issues, public policy, legislation and national and international responses to climate change.

In order to progress the achievement of these outcomes a sector wide and/or cross sector working group should be established. This work could potentially be coordinated by peak organisations such as VHA and/or VCOSS.

## Table of Contents

Introduction .....	9
Background .....	9
Causes of Climate Change.....	10
Current Effects of Climate Change.....	10
Future Effects of Climate Change .....	11
Effects on Human Health.....	12
Effects on the Economy.....	13
Responses – Adaptation and Mitigation.....	13
Social Justice and Social Responsibility .....	14
Community Health .....	15
Methods .....	15
Data Collection Instrument .....	15
Sampling Strategy.....	15
Recruitment Strategy .....	16
Data Collection Process .....	16
Data Analysis .....	16
Results and Discussion .....	17
Understanding of Climate Change .....	18
Current Policy and Practices .....	22
Scope of Possible Action .....	27
Barriers to Action .....	28
Conclusion .....	32
Recommendations .....	33
Appendices .....	34
Appendix One .....	34
Appendix Two .....	36
Appendix Three.....	37
References.....	38

## Introduction

Climate change is arguably one of the greatest environmental challenges in recent history and is likely to have significant impacts on lifestyles, economy and health in the future. An adequate response to this important issue requires timely and robust actions at an international, national, state and local level.

The impact of climate change on human health is predicted to be substantial and of a predominantly negative nature<sup>1234</sup>. Climate change is clearly an issue of considerable relevance for the health sector. The Community Health (CH) sector as a major provider of primary health care in Victoria has an important role to play, particularly at a local level.

Community Health Services (CHSs), like all in the community, have a social responsibility to decrease their own carbon imprint and thereby assist in mitigating the effects of climate change.

The aim of the Climate Change Action in Community Health project is to determine the capacity of metropolitan community managed CHSs in Victoria to respond to climate change.

The objectives of the project are to:

- determine the current understanding of climate change within metropolitan community managed CHSs;
- document the extent to which CHSs currently implement policy & practices that respond to climate change; and
- identify the barriers affecting the capacity of CHSs to respond to climate change.

It is anticipated that the results of this project will inform action that can be taken to increase the capacity of the sector to respond to climate change in the future.

## Background

The Intergovernmental Panel on Climate Change (IPCC) was created in 1988 by the World Meteorological Organisation and the United Nations Environmental Program in order to provide an objective body to evaluate information relating to the causes, implications and responses to global climate change<sup>56</sup>. The IPCC has undertaken four major assessments of global climate change, the first in 1990 and the most recent in 2007. These reports are based on a rigorous review of published scientific information and have clearly outlined the

existence of climate change, its causes and its current and future impacts<sup>78</sup>. The certainty of these findings has increased with each of its assessment reports, as further information has become available.

### ***Causes of Climate Change***

The IPCC recognises both human and natural causes of climate change. Its fourth and most recent assessment report has however found that it is “very likely” (defined as being more than 90%) that most of the increased average global temperatures since the middle of the last century, have been due to increased global greenhouse gas (GHG) emissions as a result of human activity<sup>8 p10</sup>.

GHG emission levels have grown by seventy percent between 1970 – 2004. Carbon dioxide emissions increased at faster rate of eighty percent. Carbon dioxide is the most significant GHG. Its marked increase is attributed principally to the use of fossil fuels, such as coal, oil and natural gas, and the clearing of land. Its emissions constituted seventy seven percent of all GHG emissions in 2004<sup>9</sup>.

Methane and nitrous oxide are also important GHGs. The increase in methane is predominantly due to agricultural practices and also fossil fuel use. More than one third of the global concentrations of nitrous oxide are caused by humans, though agricultural activities<sup>8</sup>.

### ***Current Effects of Climate Change***

Climate change is already occurring. Climate change findings and trends observed in the late twentieth century include:

- temperatures have increased by an average of 0.13 degrees Celsius per decade over the last fifty years;
- eleven of the twelve years between 1995 – 2006 were among the warmest in terms of global surface temperature since record keeping began in 1850;
- greater extremes of weather with fewer cold days and nights and more hot days and nights across most of the globe, and more sustained and intense heat waves and droughts;
- average temperatures in the Arctic have increased at double the global rate in the past century and the area covered by the Arctic sea ice has decreased by 2.7 percent per decade since 1978;
- increase in extreme weather events such as cyclones in some regions;

- altered patterns of precipitation and winds;
- more frequent episodes of heavy rainfall;
- increased ocean salinity in low latitude areas; and
- sea levels have risen by an average of 3.1 millimetres per year from 1993 – 2003<sup>8 pp6-8</sup>.

Contributing factors to rising sea levels include the melting of glaciers and ice caps, loss of ice sheets of Greenland and Antarctica and most significantly an increase in ocean temperatures which causes seawater to expand. Heavy rainfall episodes are consistent with the greater quantities of water vapour that can be held by warmer air<sup>8</sup>.

### ***Future Effects of Climate Change***

If GHG levels are not decreased, it is “very likely” that the globe will continue to increase in temperature causing the current impacts on the climate to worsen into the next century<sup>8 p13</sup>. Using a number of different scenarios of world development, the IPCC predicts that by the end of this century global surface temperature will have increased by between 1.1 – 6.4 degrees Celsius and that sea levels will rise by between 18 and 59 centimetres<sup>8 p13</sup>.

Secondary impacts of climate change will include significant changes to natural ecosystems, coastal systems, agriculture, forestry and water and food security. For example, it is predicted that if average temperatures increase by more than 1.5 – 2.5 degrees, twenty to thirty percent of all animal and plant species will be at risk of extinction<sup>10 p9</sup>.

In Australia, areas such as Great Barrier Reef and Queensland Wet Tropics are predicted to suffer considerable loss of biodiversity by 2020, and others such as Kakadu wetlands, alpine areas, and southwest Australia have been identified as being at risk. Reduced water security and a decline in food and forestry production are likely scenarios for the Southern and Eastern parts of Australia by 2030 as a result of predicted drought and fire. Coastal areas such as Cairns and Southeast Queensland may be at increased risk of storms and coastal flooding by 2050<sup>10</sup>.

Data produced by CSIRO<sup>11</sup> suggests that Victorian temperatures will increase at a marginally faster rate than the global predictions, particularly in the north and east of the state. Other CSIRO findings for Victoria include:

- an increase in the annual number of days over 35 degrees by 1 – 3 days by 2030, and 3 – 13 days by 2070;

- average rainfall to decrease over most of the state and water supplies to be decrease by 4 – 15% by 2020 and 10 – 40% by 2050;
- worsening drought risk particularly in the second half of the century;
- increased incidence and severity of bushfires;
- increased solar radiation due to less cloud cover; and
- average snow seasons to decrease by between 5 – 40 days by 2020.

### ***Effects on Human Health***

Human health has already begun to be affected by climate change however the impacts will appreciably increase in the future. Climate change will result in altered rates and distributions of some infectious diseases<sup>4</sup>. The incidence of food borne diseases is known to increase with related increases in ambient temperature. Vector borne diseases such as malaria, dengue fever, Ross River virus and Barmah Forest virus are likely to become more common<sup>1,3</sup>. In Australia we have already seen the southward movement of some of these diseases and this will continue. Water borne diseases are likely to increase as the amount and quality of drinking water decreases in response to increased temperature and droughts. Conversely extremes of weather may also result in heavy rainfalls which are also associated with contamination of water sources<sup>1</sup>.

Changes to global temperatures and precipitation patterns resulting in droughts, increased agricultural pests and diseases, and possible salinisation of soil will have significant impacts on agriculture and food and water security<sup>4</sup>. Increased rates of malnutrition and diarrhoeal disease are predicted<sup>10</sup>. Air quality could be decreased due to a mixture of causes including changes in temperature, wind and precipitation. The incidence of respiratory and cardiovascular illnesses is therefore projected to increase<sup>4,10</sup>.

Rates of heat related morbidities will increase and are likely to result in significant increases in mortality<sup>3,4</sup>. Victorian data<sup>11</sup> suggests that there will be between 582 – 604 annual heat related deaths by 2020 compared to 289 in 2006. Decreased cloud cover and resultant increased solar radiation in Victoria will also have potential impacts on skin cancer rates.

The potentially devastating health effects of extreme weather events include injuries, spread of infectious diseases, stress related disorders, poor access to safe food and water, homelessness and loss of life<sup>4</sup>. Rising sea levels will have a significant impact on agriculture and on fresh water sources but also will cause vast numbers of people living in low lying

areas around the world to be displaced<sup>2 4</sup>. It is likely that our close neighbours in small Pacific Island states will be affected in the near future. For example, the Caterets in the South Pacific are predicted to be the first island chain to be devastated by rising sea levels, and are estimated to be completely below sea level by 2015<sup>2 12</sup>.

### ***Effects on the Economy***

Climate change has the potential to cause considerable economic impact. Although there are varying estimates of what this might be, there is strong economic evidence to support the benefits of urgent action.

In 2006 the British government commissioned Nicholas Stern, former Chief Economist and Senior Vice-President of the World Bank, to assess the economic costs of climate change. The Stern Review found that it would cost approximately one per cent of the global Gross Domestic Product (GDP) annually in order to stabilise the carbon emissions to a level which will overcome the most extreme impacts of climate change. Emission levels in 2050 would need to be at least 25% less than today in order to achieve this, and significant responses to climate change would need to commence promptly. Conversely if no action is taken, the review finds that the cost of climate change will be between 5 – 20% of GDP annually<sup>13</sup>.

The CSIRO in Australia, advocates for a cut in emission by 2050 of at least 60% compared to figures for the year 2000<sup>15</sup>. Using these targets economic analysis has estimated that if there is early action (by 2013) the cost to Australia will be a modest 0.1% of our GDP. To put this in context, under this scenario Australia will be three times richer in 2050 than we were in 2002, despite this cost. If action does not begin until 2022, the cost will increase three fold to 0.3% of Australia's GDP which will have a more significant effect on our economy<sup>14</sup>.

### ***Responses – Adaptation and Mitigation***

If GHG emissions were decreased by 60% by 2050 in comparison to 2000 levels, temperature increases are predicted to be restricted to 1.5 – 2.9 degrees Celsius in this century. This would avoid some of the most devastating effects of climate change however there would still be significant changes in our environment. Even if GHG emissions were halted today it is thought that temperatures would still increase by between 0.2 – 1 degrees by the end of this century<sup>15</sup>. Responses to climate change therefore need to incorporate timely actions to both adapt to and mitigate against the effects of climate change.

Adaptation refers to “the development of additional capacity within communities to cope with the many environmental, social, economic and health impacts that climate change will

bring"<sup>16</sup> p<sup>9</sup>. An example of an adaptive response is the State governments proposed strategy to develop a Victorian Heat Wave Emergency Plan<sup>22</sup>.

Mitigation refers to actions which diminish the effects of climate change by decreasing GHG levels. This includes actions to reduce emissions from energy use, to improve agricultural and waste management practices and to increase forestation<sup>9</sup> p<sup>14</sup>. The IPCC identifies a range of recommended strategies for mitigating the effects of climate change. Whilst international and national actions such as the developments of climate policies, agreements, regulation methods, standards and charges and increased research and development are strongly advocated, they also find that local actions play a role in the mitigation of climate change. Actions that result in lifestyle or behavioural change, and management practices that educate, reward, monitor and document and implement climate change actions can be effective in reducing energy use<sup>9</sup> p<sup>17</sup>. Local or regional level voluntary activities can result in decreased GHG emissions and can stimulate innovation however, the IPCC find that these are of limited benefit unless they form part of a broad array of strategies<sup>9</sup> p<sup>29</sup>.

### ***Social Justice and Social Responsibility***

The impacts of climate change will not be equal across different populations. The vulnerability of a population to climate change is dependent on the geography of where they live and on the material, economic and technological resources and systems of government of the country in which they reside<sup>2</sup>. The developed, industrialised nations are by far the world's greatest producers of greenhouse gases, however ironically climate change is likely to have the greatest impact on the poorest of the world's populations in developing countries<sup>1</sup> 7 16. For this reason, climate change will increase health inequities across the world.

Even within developed countries like Australia, those on lower incomes and those with poorer access to health care are likely to suffer more significantly from climate change<sup>1</sup>. For example, costs of food, water and energy are predicted to increase, causing growing issues of food insecurity and decreased access to essential services for those on low incomes<sup>17</sup>.

Disadvantaged sections of the community living in rental properties and low cost accommodation are more vulnerable to heat related morbidity and mortality as they have less control over their choice of housing and less access to cooling options such as air conditioning and insulation. People on low incomes are less likely to have insurance on their

homes and property and therefore may suffer greater impacts from extreme weather events<sup>18</sup>. Climate change is therefore a significant social justice issue.

Australia ranks seventeenth in the world for its GHG emissions and has one of the highest per capita rates of emissions. Australia is also the largest exporter of coal in the world and therefore also contributes to the growing level of GHGs produced by other nations<sup>16 pp2 & 4</sup>. In 2005-06 Australia was responsible for almost 30% of the total world coal exports<sup>19</sup>.

As one of the wealthier nations of the world, and a significant contributor to global GHG emissions, Australia has a social responsibility to undertake effective responses to climate change. Much of this duty sits with our Federal and State governments however arguably all members of Australian society have a social responsibility to take action.

### ***Community Health***

Climate change is an issue of considerable relevance for the Victorian CH sector which utilises a primary health care approach incorporating illness prevention and health promotion. CH embraces the social model of health and thereby aims to address the medical, biological, social and environmental determinants of health<sup>20</sup>. It has a strong record of working in partnership with others sectors, and the community, in order to address these determinants. This work is underpinned by a commitment to social justice. CH strives to address health inequalities by providing responsive and accessible services to those most disadvantaged in the community. CH has a mandate to provide local responses to health and wellbeing issues that affect their communities of interest<sup>21</sup>. Through its health promotion approach it also responds to local health needs by advocating change external to the local area, both at a State and Federal level.

## **Methods**

### ***Data Collection Instrument***

A telephone interview questionnaire was developed which addresses the aims and objectives of the project (see appendix one). The instrument was tested and found to take thirty to forty minutes.

### ***Sampling Strategy***

Metropolitan community managed CHSs in Victoria were identified as the target group. Rural CHSs and those CHSs managed by acute health services were excluded because

they are likely to face different issues and barriers and be subject to different government policies. The project aimed to undertake telephone interviews with at least forty percent of these CHSs, with approximately proportional representation from each of the regions in order to be representative of the sector.

### ***Recruitment Strategy***

The Chief Executive Officer (CEO) at each of the CHSs was contacted via email by the Project Sponsor (Vera Boston, CEO, North Yarra Community Health) in May 2007. A project information sheet (see appendix two) compiled by Kristine Olaris was sent to each and involvement requested. CHSs were asked to identify a contact person in their organisation who would be best placed to respond to questions relating to the project objectives and would be available to participate in a confidential telephone interview. It was also requested that the contact person undertake internal consultation with others in the organisation prior to the interview if required to facilitate an organisational response.

Voluntary participation was the only practical recruitment strategy; however it did create an inherent risk of selection bias. In particular, there was a risk that those CHSs who were most committed to the issue might get involved and those who were not taking much action on climate change might not nominate. In order to lessen this effect, CHSs were advised that all interviews were confidential and that no references to particular CHSs would be made in this report.

Once organisations had agreed to be involved and nominated a participant, they were sent an Interviewee Information Sheet which outlined the topics to be covered in the telephone interview (see appendix three). This was given to the participant at least two weeks prior to their interview to encourage consultation.

### ***Data Collection Process***

Interviews were planned to take place over a two week period in June 2007, in order to minimise the likelihood of any changes in the external environment which might have an impact on the results. Interviews were transcribed as accurately as possible, at the time of the interview.

### ***Data Analysis***

As the majority of the data collected was qualitative in nature, data analysis was largely undertaken manually thorough immersion in and thus familiarity with the written records of

the interviews. The content of the interviews was analysed in the search for rich descriptions, categories, commonalities, differences and themes, and particularly for relationships that linked patterns of responses. Descriptive analysis of quantitative data was undertaken where it produced a meaningful addition to the qualitative data.

## Results and Discussion

The recruitment process took two weeks longer than planned. The initial email out was repeated and was also supported by follow up phone calls, and reminders at CEO meetings until an adequate number and representation of CHSs were recruited. A number of those recruited did initially expressed concern that they did not have much to contribute due to the limited work being undertaken in response to climate change in their organisation. This potentially offset the possible selection bias identified in the methods section of this report.

Twelve CHS (52%) agreed to participate in the project. All regions were represented with the greatest number from the largest North and West Metropolitan Region, and the highest proportional representation from the Southern region where 100 percent of CHSs participated. See Table 1 below.

	North & West Metropolitan Region	Eastern Metropolitan Region	Southern Metropolitan Region	Total
Participating CHS	5	3	4	12
Total number of CHS	12	7	4	23
% Participating	41.7	42.8	100	52.2

**Table 1 – Regional breakdown of participating CHS as a percentage of all metropolitan CHSs**

Representatives from organisations who participated in the interview were mostly either CEOs or members of senior management (see Table 2). Middle managers or staff members who participated were also members of internal environmental committees, as was one CEO.

CEO	Senior Manager	Middle Manager	Staff member	Total
5	5	1	2	13*

**Table 2 – Respondent's Position within Organisation**

\*One organisation put forward two people for their interview – the CEO and a staff member who was a member of their environment committee. This is counted as one response/interviewee elsewhere in this report.

In five of the twelve interviews, the respondent had undertaken consultation with others in the organisation prior to the interview. Generally, those who had not were of sufficient seniority within the organisational structure to be able to speak from an organisational perspective.

The first interview took place on 26/6/07 and all were completed within a three week period. Over this period “The Great Global Warming Swindle” was screened on television. This highly discredited program argues against human activity as the major cause of climate change. This screening occurred prior to the final three interviews. It is the opinion of the author that this did not have a significant effect on the results of these interviews, although one of these did contain the only reference in the project to natural factors of as one of the causes of climate change. Apart from this one response, these interview results were not discernibly different to others.

There were no other significant changes in the external environment over the interview period that would have influenced the responses of the interviewees.

### ***Understanding of Climate Change***

Climate change is defined by the IPCC as “a statistically significant variation in either the mean state of the climate or in its variability, persisting for an extended period (typically decades or longer)”. The IPCC includes both natural and human causation as a part of its definition; however its reports have consistently found that the most substantial changes to our climate are being brought about by human activities.

The United Nation Framework Convention of Climate Change confusingly differs. It restricts its definition of climate change to “a change of climate which is attributed directly or indirectly to human activity that alters the composition of the global atmosphere and which is in addition to natural climate variability observed over comparable time periods”<sup>7 p4</sup>.

When asked to give their own definition of climate change, most of the CHSs interviewed demonstrated a reasonable understanding of climate change. This is displayed by the choice of words that were used to define climate change. Some examples include:

*“significant change in climate over a period of time”*

*“the impact of human activity on the climate and environment of our planet...leading to changes in weather patterns, increasing average temperatures and impacts on species”*

*“the increase in greenhouse emissions, principally by people, which is impacting on temperature and climate .... not the normal ebbs and flows of climate”*

*“our natural environment is heating up and becoming more volatile”*

*“not just an isolated event – it is a pattern over time”*

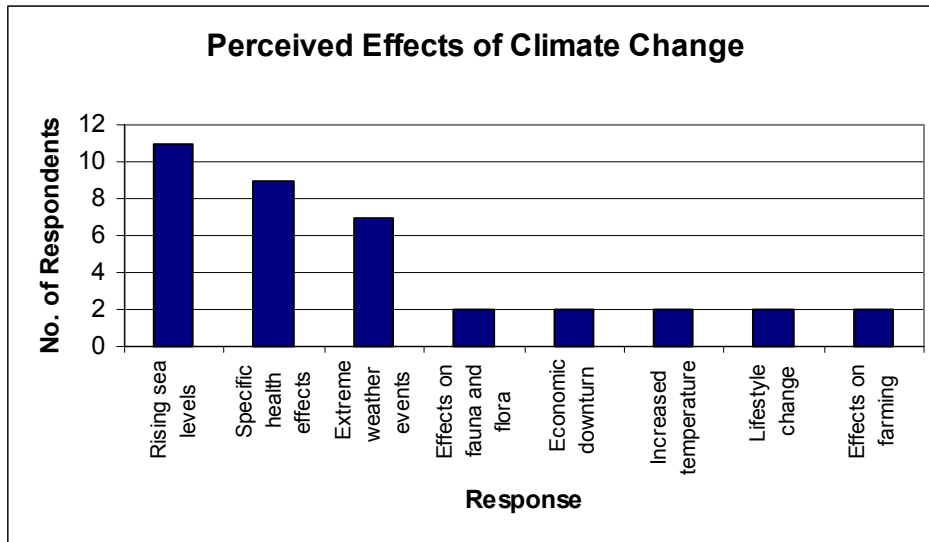
Only one respondent could not give a definition of climate change at all and this person also had difficulty naming causes and effects of climate change. Many people expressed a lack of confidence in their own understanding and uncertainty in their level of knowledge.

Most participants had a good understanding of the link between fossil fuel use and climate change. Eleven of the twelve CHSs referred to increased fossil fuel use and/or their bi-products as a major causative factor. Many made specific references to carbon dioxide or carbon emissions. Only one person explicitly mentioned any other GHGs, naming water vapour and methane. No respondents referred to agricultural activities or deforestation as a cause of green house gas emissions. This may be reflective of the metropolitan base of those interviewed.

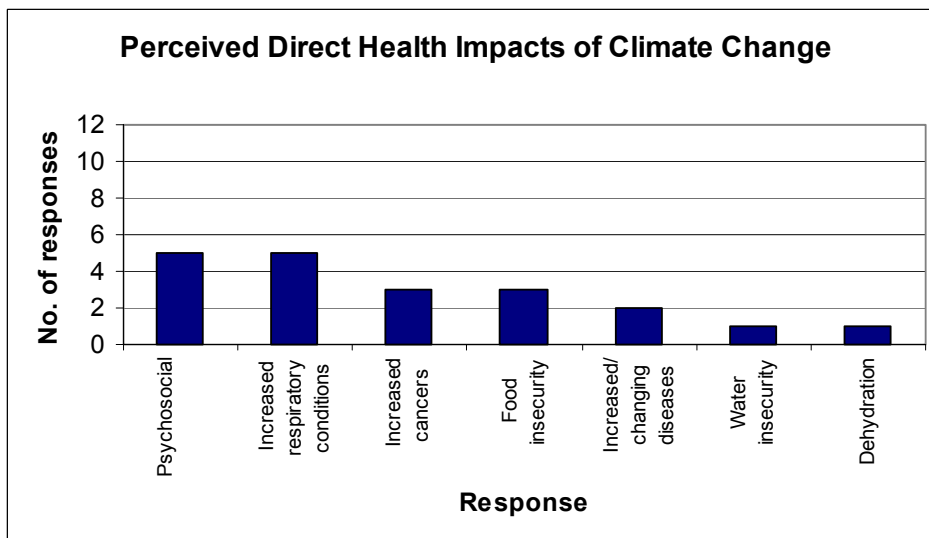
Half of the respondents also spoke of lifestyle factors, using descriptions such as living in a “disposable society” and the rise of “consumerism”. Only one person spoke of natural causes of climate change, and this person commented that for this reason climate change is partly “out of our control”.

When asked about the effects of climate change, interviewees on average named four factors (with each individual direct health impact named counted separately). An overview of responses is displayed in Figures 1 and 2.

The most commonly noted impact was that of rising sea levels, described with references to melting ice caps, resultant flooding, death and migration issues. Two interviewees erroneously commented that rising sea levels were not occurring as yet.



**Figure 1 – Perceived Effects of Climate Change**  
*Note: More than one response was allowed per respondent*



**Figure 2 – Perceived Direct Health Impacts of Climate Change**  
*Note: More than one response was allowed per respondent*

Direct health impacts appear as the next most frequently mentioned item. This response is broken down in Figure 2 which shows that in total seven different direct health impacts were named by nine CHSs. The most common health impact noted was psychosocial effects, which is possibly reflective of the strong focus on the social model of health in CH. The combined responses from the CHSs covered most of the major health impacts of climate change, however generally those interviewed only named one or two specific health impacts. No specific reference was made to a rise in infectious diseases although general comments

about increases or changes in diseases were given by two CHSs. Of the three responses relating to increased cancers, two referred to melanomas.

Extreme weather events were another commonly cited effect. This included comments on infrastructure damage, droughts, floods, storms and bushfires. The IPCC states that the likelihood of extreme weather events such a drought, floods and cyclones are greater than fifty percent likely to be due to human causes<sup>8</sup>. This lesser level of certainty of the scientific community, and possibly some scepticism, may have influenced the responses of some CHSs. This is demonstrated by comments such as “the current drought, although I’m not sure if this can be attributed to climate change or not” and “Tsunamis? – although these are not necessarily related in my opinion” and “its difficult to know if it’s directly related but there appears to be more extreme weather conditions around the world”.

Interestingly only two CHSs mentioned increased temperatures as an impact of climate change, which the IPCC reports as “unequivocal” and being more than 90 percent likely to be due to human activity<sup>8 pp5&10</sup>. It is unclear why this was not mentioned as an effect (and was also only referred to by three CHSs as a part of their definition of climate change) however it may reflect the increased use of the term “climate change” instead of that of “global warming” by politicians and the media in recent years.

Effects on fauna and flora, economic downturn, lifestyle change and effects on farming were each mentioned by two respondents.

The understanding of climate change in those in the metropolitan CH sector is therefore probably at a similar level to that of the general population. CHSs were reasonably able to define climate change, and had a good understanding of the major cause of climate change. The understanding of the effects of climate change was quite broad but not particularly in depth, even in the area of health. Many people interviewed openly expressed that they were not confident in their level of knowledge. This is not surprising given the complexity of the issue and the fact that climate change has not as yet registered as an area of focus for CH, as will become evident later in this report.

All participating CHSs answered “yes” when asked if climate change is an important issue for CH. Most CHSs gave more than one reason that they believed this. Ten of the twelve CHSs assigned its import to the issue’s alignment with the work and principles of CH. This

was described varyingly either specifically as being “in line with community health principles”<sup>\*</sup> or more generally by making reference to the fit with the health promotion and social justice approaches taken by the sector and the mandate of CHSs to respond to issues affecting the health and wellbeing of their communities of interest. Four of the ten stated that they viewed climate change as a social justice issue, and that they believed its effects would be greater on the low income sections of the community with whom they most worked.

Ten CHSs also felt that climate change was an important issue for CH because of the health implications. Of these, six made reference to the social model of health and/or the links between health and the environment, and four referred to direct health impacts.

Five felt that CHSs have a social responsibility to respond to climate change within their organisation. They gave reasons such as that they wanted to “be a good organisational citizen” and to be “responsible and accountable” to the environment, or that they perceived it as “everyone’s responsibility”. Two organisations gave social responsibility as the sole reason for climate change being an important issue for CH.

### ***Current Policy and Practices***

In order to ascertain if climate change action was embedded at a strategic level within CHSs, they were asked whether or not they had:

- a governance level policy relating to climate change;
- an organisational plan which refers to the issue;
- a person or committee who is assigned responsibility for action;
- any systems of monitoring, measuring, reporting or reviewing climate change action areas; and
- any resources assigned to climate change within their organisation.

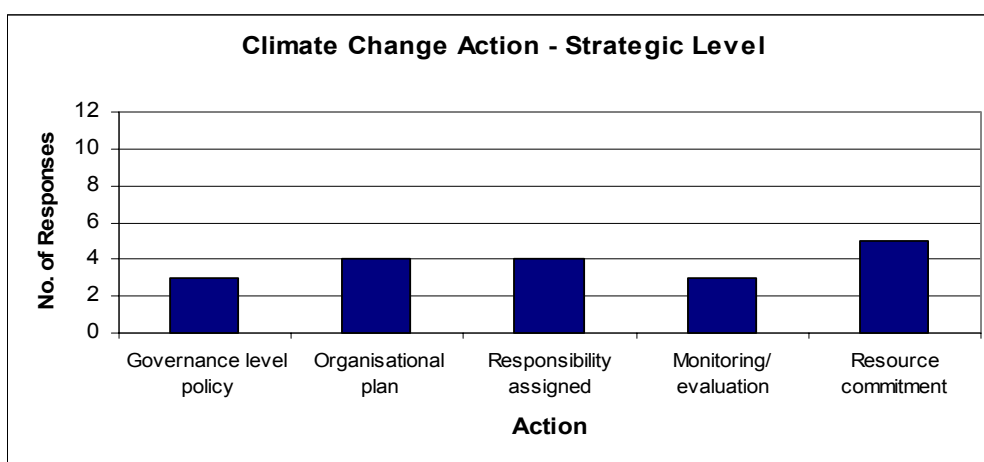
Responses indicate that climate change is not being addressed at a strategic level by many CHSs (see Figure 3). Five CHSs answered “no” to all five of the above questions and none

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<sup>\*</sup> Community Health Principles are clearly understood by the sector. They incorporate the need to provide a comprehensive range of services that accessible, relevant, and responsive to the needs of the local community. CH principles promote accountability to the local community. This includes the participation of the community in the planning and management of CHSs. They highlight adherence to the social model of health and the need for services to be delivered in an integrated, multidisciplinary and holistic manner. CH principles also include a strong commitment to health promotion and to the empowerment of individuals and communities. They are underpinned by a commitment to social justice.

answered “yes” to all of them. Many responded that action within their organisation was being driven strongly “from the ground up” and as such a systematic and strategic response had not as yet occurred. Three CHSs scored four out of five and one scored three out of five.

Three CHSs had a governance level environmental policy however one of these reported that their policy needed updating and one had only recently had their policy endorsed. Two organisations made reference to environmental sustainability within their strategic plans and two had organisational environmental plans.



**Figure 3 – Climate Change Action - Strategic Level**

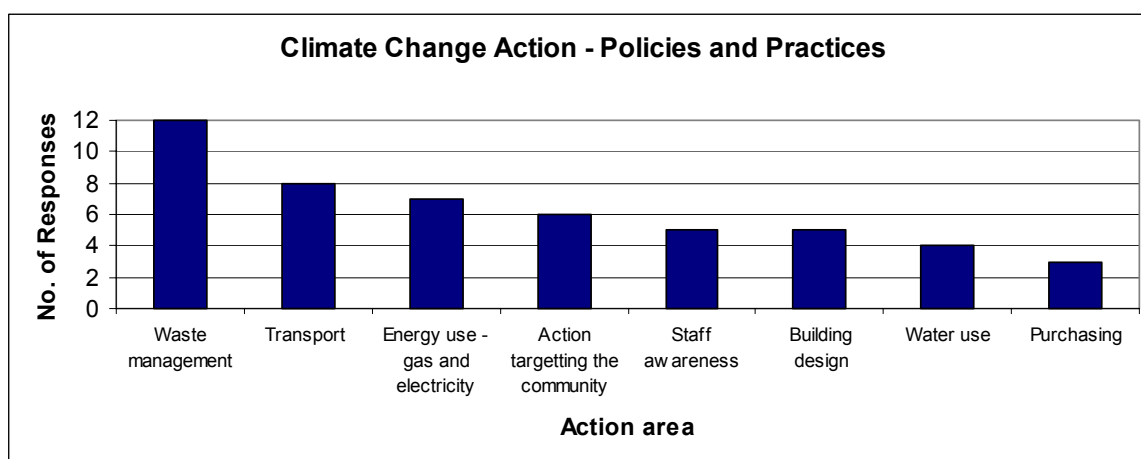
Four CHSs had assigned responsibility for climate change within the organisation and in all cases this was to an internal ‘green’ working group. These all had high level management involvement or feedback mechanisms. Another CHS had an environmental working group and was about to develop processes for the group to be given formal responsibility.

None of those interviewed reported systematic monitoring or evaluation of environmental activities within their organisations although three did occasional monitoring of aspects of the organisation’s response such as reviewing power costs or paper use.

Resource commitment was mostly described in terms of staff time to attend internal working groups. Only one organisation had an explicit recurrent budget assigned to climate change action and this was only \$1000, although this organisation has also included funding for other environmental items in its capital budget for the year. Others commented that when an environmental action was identified it was funded from program budgets, or by internal budget bids for spending when annual budgets were being developed. Significant climate

change actions were generally only able to be undertaken when external grants were available.

It became clear, however, when asked about climate change policies and practices, that many CHSs were taking action in a number of areas (see Figure 4). All CHSs had some practices in place around waste management. Waste paper was collected for recycling by ten of the CHS, and most also utilised a range of strategies for reducing use, and reusing of paper. Six of the CHSs also purchased recycled paper for use. Kitchen recycling was utilised by seven agencies and composting was practised by four. A range of other practices were less commonly mentioned including recycling of printer and toner cartridges, mobile telephones and computers. Two CHSs had a waste management policy.



**Figure 4 – Climate Change Action - Policies and Practices**  
*Note: More than one response was allowed per respondent*

The next most common action area was that of transport. Three organisations had liquefied petroleum gas (LPG) vehicles as a result of funding through the Home and Community Care program. Two agencies were paying to carbon offset their fleet and another had plans to do this. A number of CHSs had practices and structures in place to encourage staff to ride bikes. One Community Health Service (CHS) was in the process of setting up a trial staff bicycle fleet. One CHS had received funding from Travel Smart to assess the transport profile of their staff and encourage and support use of sustainable transport. Car pooling was generally encouraged, however this was only formalised in one agency.

Actions to decrease energy use were also reasonably common. Seven CHSs described practices in this area. These included actions such as having notices or email reminders to increase awareness about switching off lights and computers when not in use, installation of

timers and sensor lighting, purchasing low energy appliances and obtaining electricity from one hundred percent renewal energy sources.

Six CHSs reported undertaking limited work in the community on the issue of climate change. Some activities included involvement in local tree planting days, promotion of reusable shopping bags and participation in a local transport advocacy group. Two CHSs were involved in environmental programs on public housing estates through their involvement with their local Neighbourhood Renewal program. One CHS had organised bicycle education courses for public housing residents and had also facilitated a community education session on “greening your home”.

Staff awareness actions were mostly described as informal and often led by staff. They mostly consisted of “green tips” circulated via email, staff meetings and staff newsletters. Some described more formalised campaigns on issues such as transport and turning off computers and lights. One CHS had invited a speaker from another organisation with good environmental practices, to talk to their staff about environmental sustainability. Three CHSs commented that they supported and promoted the participation of their staff in Ride to Work Day.

Seven CHSs had made some environmental alterations to their existing buildings or incorporated environmental planning into the design of new buildings. The most substantial actions such as solar panels and water tanks on new buildings were undertaken by agencies which had received external funding for these. CHSs with no specific funding had made smaller changes such as undertaking electrical work to separate some lights onto individual switches and building staff showers to encourage bike riding. A number of CHSs had plans for new buildings which incorporated environmental building design however were not confident that this would be funded.

Four CHSs were taking action in relation to water conservation. This mostly consisted of simple actions such as signs in staff rooms to remind staff to be careful with water use, installation of dishwashers and mulching of gardens. Two CHSs had water tanks at some of their sites and two had applied for grants for water tanks.

The majority of CHSs did not have purchasing policies or practices in place that would encourage consideration of climate change when choosing and buying goods. The three

that were taking action reported having policies that referred to purchasing although none were confident that these were being adhered to due to decentralised purchasing systems. Three CHSs had identified the need for a 'green' purchasing policy as a future action area in their organisation.

All CHSs were taking action in some areas, although the magnitude and scope of the actions varied considerably. On average CHSs reported four areas with policies and/or practices that addressed climate change. A strong relationship was evident between agencies with environmental working groups and those undertaking systematic climate change action (see Table 3). All CHS with such a group were taking action in a greater number of areas than the average (between five to seven areas).

	Participating CHSs											
	1	2	3	4	5	6	7	8	9	10	11	12
<b>Environmental working group</b>	x	x	x	✓	✓	✓	x	x	x	x	✓	✓
<b>No. of Policy or Practice Action Areas</b>	6	3	2	5	7	6	1	4	4	3	6	5

**Table 3 – Relationship between CHSs with Environmental Working Groups and the No. of Climate Change Action Areas**

Only one CHS without a working group also rated higher than the average. This organisational had been successful with a number of funding applications and was taking action in response to these. This included conversion of vehicles to LPG, a water tank grant and funding for buildings works that was generous enough to include environmental planning. Many agencies reported taking action in areas where external funding was available.

Many agencies also reported that some environmental practices were being led by staff and were not necessarily formalised nor embedded into the organisation. This was particularly in the area of staff awareness raising. Composting and household recycling was another area that was sometimes reliant on staff to drive. For example, three CHSs reported having composting only at sites where staff were interested and one relied on staff to take the waste home to compost.

### ***Scope of Possible Action***

CHSs were asked two questions which related to the possible scope of action that CH could be taking on climate change, one which related the CH sector and one which asked about their own organisation (see questions 1e and 3 in appendix 1). These were asked in order to be able to identify barriers to this action. The answers to these two questions are combined below.

There were four major areas that were commonly reported as areas for climate change action in CH. The number of CHSs nominating this is written in brackets after each area listed. These were to:

- decrease their organisation's impact on the environment (12);
- take a multifaceted health promotion approach to the issue (11);
- provide a direct service response to members of the community affected by climate change (5); and
- be involved in collective action (5).

All CHSs wanted to be doing more internally to decrease their organisation's impact on the environment. Many reported a desire to develop a more strategic response to climate change by developing and embedding policies, structures and plans to ensure a sustainable and integrated approach at all levels of their organisation. Many aspired to be undertaking more significant practices that would decrease their contribution to climate change such as purchase of hybrid cars, solar power and hot water, and improving the energy efficiency of their buildings and services. Four CHSs were keen to have an organisational environmental audit undertaken. A few CHSs commented that by addressing climate change within their organisation, they would be providing leadership to the community.

As an integral part of the broader health sector, CHSs felt that CH should have an important role in responding to the impacts of climate change on the health and wellbeing of members of their local community. Involvement in a multifaceted health promotion response was strongly identified by eleven CHSs. There was differing opinions as to whether CHSs should have a lead or partnership role in this response but much agreement that a partnership approach needed to be employed. Local government, local agencies, schools, the community and VicHealth were named as some potential partners. A range of health promotion actions were suggested, including the development of a robust advocacy strategy. It was felt that this should incorporate debate and change at a macro level and actions

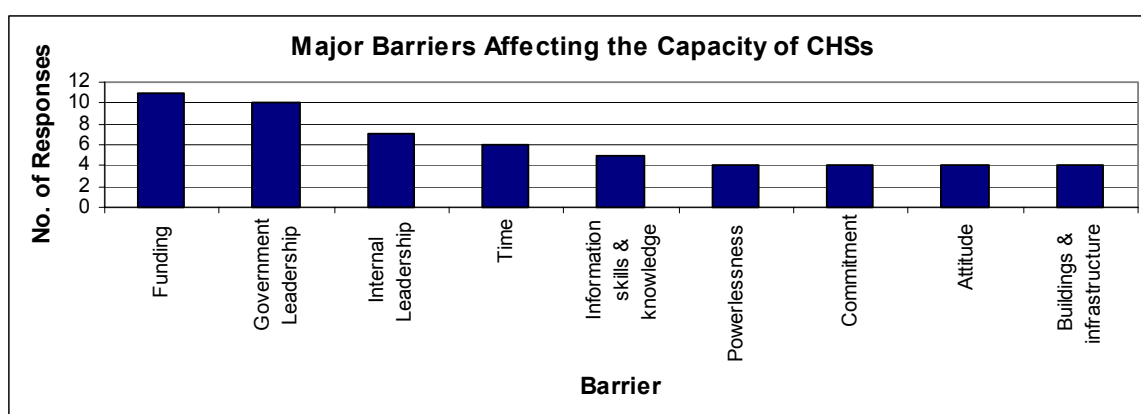
targeting areas such as public policy and legislation. Issues such as the ratification of the Kyoto protocol, development of sustainable energies, and improved public transport systems were identified as some possible areas to be targeted by an advocacy campaign.

Five CHSs reported that CH had a role in directly responding to specific health implications of climate change such as increases in respiratory diseases, and responding to psychosocial implications such as those felt by people affected by drought. It is perhaps interesting that more CHSs did not mention this role; however it is possible that this is because this would not constitute a significant change in function or structure within their organisations. For example CHSs are already providing health care to people with respiratory diseases and this service response would not necessarily need to be significantly different, although it is likely to be in greater demand.

Five CHSs commented that CH should be doing more work together as a sector, and with other key stakeholders. It was felt that collective action could strengthen local responses to climate change by enhancing buying power, knowledge, resources and research capacity and would give a stronger voice to advocacy and lobbying strategies. It was felt that this collective action could be coordinated by peak organisations such as Victorian Healthcare Association (VHA) and/or Victorian Council of Social Service (VCOSS).

### **Barriers to Action**

CHSs identified a large number of barriers affecting their capacity to respond to climate change. The most commonly reported of those are identified in Figure 5.



**Figure 5 – Major Barriers Affecting the Capacity of CHSs to Respond to Climate Change**

*Note: More than one response was allowed per respondent*

Funding was described as the “major hurdle” or “biggest barrier” for the sector. Most CHS felt that in order to move forward in a significant way, specific funding needed to be made

available to them, particularly in order to enable CHSs to decrease their own energy use. Many complained of an inability to afford capital improvements and purchases that would improve their energy efficiencies. The costs of building upgrades, solar panels and hybrid vehicles were mentioned.

A related factor that was also mentioned by the majority of CHSs was that of government leadership. All responses in this category were made in relation to the State government, although four CHSs referred to both Federal and State government and two referred to all levels of government. The focus on the Victorian government is not surprising as it provides the majority of funding to CH.

In relation to the Federal government, respondents expressed concern regarding the lack of public policy responses to climate change and the government's perceived scepticism about the issue. Frustration was voiced about the inability of CHSs to access LPG gas conversion rebates, and about tax legislation which results in a lower fringe benefits tax rate for fleet vehicles that have driven further.

Comments about State government centred on the lack of policy regarding climate change that is applied to CH, and the resultant lack of profile which climate change has attracted within the sector. CHSs felt that the issue was not being driven at the level of CH by the State government. The Victorian Government does have a strong commitment to environmental sustainability as documented in "Our Environment Our Future Sustainability Action Statement 2006<sup>22</sup>". Unfortunately very little, if any, of the strategies contained within this document or other State government policies refer to CH or have thus far been applied to CH.

One example cited was that of the lack of energy reduction targets in CH. The Victorian government has an energy reduction target of 20% by 2010<sup>23</sup>. DHS have applied these to their own departments; however the CH sector has not been incorporated into this strategy. The Victorian government has also allocated a significant amount of funding (\$7.2 million) for hospitals and aged care facilities<sup>22</sup> to become more energy and water efficient. Whilst these facilities are admittedly likely to be greater users of energy, the CH sector is also in need of assistance to improve their environmental sustainability and as yet CH has not been identified for this type of support.

Another example was the perception of a lack of environmental building regulations in CH. The capital management branch of DHS has developed sustainability guidelines<sup>24</sup> for healthcare facilities however these guidelines currently are not applied consistently to CHSs.

Additionally comments were made about the lack of identification of climate change as a Victorian health promotion priority and the absence of climate change targets or requirements in agency funding and service agreements. Health promotion guidelines<sup>25</sup> in CH recommend that the bulk of health promotion work undertaken by CHSs addresses state-wide health promotion priorities. Although these priorities include some topics of relevance to climate change such as “promoting physical activity and active communities”<sup>26</sup> there is no specific reference to climate change as a health promotion action area. Guidelines do allow a maximum of 30% or \$50,000 of the agencies health promotion budget to be used on issues outside of these priorities, however agencies are encouraged to keep this figure as low as possible. CHSs have access to considerable information and support in areas that are stated health promotion priorities.

The two comments relating to local government indicated a belief by those respondents that local government should be taking a lead at a local level. A lack of adequate local government recycling arrangements in some areas was also reported.

Internal leadership and support was also seen as an area for strengthening by a majority of CHSs. They clearly recognised the need for strong high level management support in order for their organisation to improve their responses to climate change. This correlated with the earlier stated desire of many CHSs to develop a more strategic response to climate change, and also with their belief that a lack of support and direction from government had resulted in the issue of climate change not being given due priority within organisations.

Lack of time was reported by fifty percent of CHSs. Most of those who spoke of the lack of time qualified their responses by references to competing interests and demands. One person said that there are “so many issues we need to be across in CH, it (climate change) needs to be able to rise above the noise”. Others made the link to the issue of internal leadership by stating that as climate change was not identified as a priority in their organisation, it was unlikely that it would be given adequate time allocation.

Five CHSs reported that a significant barrier was the lack of skills, information and knowledge about climate change in their organisations. They felt that despite the high quantity of information available, there was a lack of clear and concise evidence based information about effective strategies to enable decision making. Many were seeking to assess their organisation's environmental impact to inform the development of an organisation plan, but did not know how to go about this. Some had sourced self audit tools but had found them to be cumbersome and lacking in user friendliness.

Four CHSs also commented on a sense of powerlessness in relation to climate change. This was expressed in language such as "You need a sense that there are things that you can do" and "It feels bigger than Texas. What do we actually do, how do you break it down?" and we "need to be able to feel that we are going to make a difference – is saving a few buckets of water any use whilst industry continues to use such enormous amounts of water. We need to be a part of something bigger". There are potentially a range of underlying reasons for this sense of powerlessness. It is likely to have relationship with the previously described lack of clear information about climate change, and to the lack of information on the comparative usefulness of strategies. Insufficient funding for actions that are perceived to make a significant difference is perhaps also a contributing factor. It is also likely that the lack of government leadership on the issue, particularly Federal government, can make strategies at the grass roots level seem somewhat meaningless. These findings underline the importance of an advocacy strategy as a part of for CH's response to climate change.

A lack of commitment was cited by four CHSs. Two of those described this as a lack of "energy". This is related to climate change not being identified as a major focus within organisations, and therefore being seen as something that had to be done in addition to other prioritised areas. Conversely however four CHSs specifically noted that commitment was not an issue with comments such as "we have support of the majority of staff and management" and "staff are very committed – I think this is true across the sector and including management and Boards of Management".

A less commonly reported barrier was that of negative attitudes to climate change action. One respondent felt that the issue had a "hippy/greenie stigma" although they felt that this was beginning to be broken down and another that there was some "anti – zealot" feelings towards those championing the cause in their organisation, which was possibly related to the way in which the issue was being presented.

It is unlikely that negative attitudes are a significant issue in CH despite the small number of CHSs reporting this as barriers, unless a case could be made that staff within CHSs are more negative about climate change action than the general public. A survey undertaken in early 2007 by the Chicago Council on Global Affairs found that ninety two percent of the Australian public are in favour of strategies to combat global warming, the highest figure of any of the seventeen countries surveyed<sup>27</sup>.

Four organisations commented on ageing buildings and infrastructure. Reference was made to the lack of an adequate source of funding for buildings and infrastructure in CH. Additionally some organisations that were renting their buildings felt that this resulted in less control over their energy efficiency.

## **Conclusion**

CHSs are an integral part of the Victorian health system. The CH sector with its strong focus on health promotion, its record of working in partnership with others and its close connection with vulnerable sections of the community has an important role to play in responding to climate change.

The capacity of CH to respond to climate change is currently limited by a number of significant factors. Insufficient availability of specific funds for climate change action was identified as the greatest barrier. An inadequate level of government leadership was also perceived as a major impediment. This includes a lack of a broad Federal strategy around climate change which potentially can decrease the effectiveness of action taken at a local level. There also is a need for greater policy direction and support from the State government, which is the major provider of funds to CH. This lack of government leadership and direction has resulted in climate change not yet registering as a priority for strategic action by many CHSs.

The provision of clear information about climate change and related evidence based practice would also greatly assist the sector to increase its knowledge base and its ability to undertake effective action.

The metropolitan community managed CHSs in Victoria have however displayed an interest, a willingness and an ability to respond to climate change. All CHSs involved in this study

agreed that climate change is an important issue for the sector and expressed a desire to strengthen their responses in the future. CHSs have identified a range of action areas in which the sector should be involved. These are to decrease the environmental impact of individual CHSs, to be involved in multifaceted health promotion responses which incorporate political advocacy and to provide direct responses to the health impacts of climate change. They also identified that an effective response would be facilitated by working together as a sector and with other relevant partners in response to climate change. It felt that peak organisations such as VHA and/or VCOSS could coordinate this collective action.

## **Recommendations**

The following outcomes would strengthen the capacity of metropolitan community managed CHSs to respond to climate change:

- environmental working groups established within CHSs;
- greater funding for climate change actions and particularly for funding of infrastructure improvements;
- commitment for environmental policies and strategies such as energy targets and building standards to be applied to CH;
- identification of climate change as a Victorian health promotion priority by DHS;
- greater level of information and resources to be made available to CH including:
  - information on the effects of climate change with particular focus on health impacts;
  - clear and concise, evidence based information on effective strategies for decreasing environmental impact within CHSs; and
  - a simple environmental self audit tool for use by CH.
- development of an robust advocacy campaign particularly in relation to social justice issues, public policy, legislation and national and international responses to climate change.

In order to progress the achievement of these outcomes a sector wide and/or cross sector working group should be established. This work could potentially be coordinated by peak organisations such as VHA and/or VCOSS.

# Appendices

## Appendix One

### Climate Change Action in Community Health – Telephone Interview Questions

**Date of interview:**

**Name of organisation:**

**Name of interviewee:**

**Position in organisation:**

**Others consulted in preparation for this interview:**

**Brief outline of consultation process:**

#### 1. The following questions relate to your understanding of climate change.

a) Do you think that climate change is an important issue for Community Health? Why?

Yes

No

b) How would you define climate change?

c) What do you think are the causes of climate change?

d) What do you think are the effects of climate change? (prompt given for response on health effects if required)

e) What do you think Community Health ideally could be doing to address climate change? (ie as a sector)

#### 2. The next questions relate to the CHS that you are representing, and how it is responding to climate change.

Strategic Approach:

a) Do you have a governance policy that relates to climate change?

Yes

No

b) Do you have an organisational plan that relates to, or refers to actions to address climate change?

Yes

No

If yes, what type of plan (eg strategic plan, environmental plan)?

- c) Is responsibility for addressing climate change assigned within your organisation?  
Yes  No

If yes, to whom (eg person or committee)?

- d) Does your organisation monitor, measure, report on or review the organisations contribution to climate change or any progress toward practices that address climate change? eg energy usage  
Yes  No

Can you please describe this process?

- e) Does your organisation assign resources to practices to address climate change eg staffing, financial resources?  
Yes  No

If yes, please describe.

Policies and Practices:

- f) Can you tell me about any policies or practices that respond to climate change that your CHS has in place in relation to the following areas:
- transport
  - energy usage – gas and electricity
  - water usage
  - waste – reduce, reuse, recycle
  - purchasing
  - building design, if applicable??
  - staff awareness/education
  - education/other actions targeting the community
  - other

**3. What more would you like to be doing? (ie your organisation)**

**4. What are the barriers affecting your capacity to do this?**

## **Appendix Two**

### **Climate Change Action in Community Health – Information Sheet**

Kristine Olaris, Deputy CEO at North Yarra Community Health is undertaking a project which aims to determine the capacity of metropolitan stand alone Community Health Services (CHS) to respond to climate change.

The objectives of the project are to:

- determine the current understanding of climate change within metropolitan stand alone CHS;
- document the extent to which CHS currently implement policy & practices that respond to climate change; and
- identify the barriers affecting the capacity of CHS to respond to climate change.

Kristine is seeking to undertake phone interviews with representatives of at least 40% of metropolitan stand alone CHS. The commitment required by participating CHS will consist of:

- Identification of a contact person/people in your organisation who would be best placed to respond to questions relating to the above objectives.
- Consultation by the internal contact person with others in your organisation prior to the interview to facilitate an organisational perspective in responses. An outline of the types of questions to be asked will be provided at least 2 weeks prior to the actual interview.
- Participation by the contact person in a telephone interview which is envisaged to take no longer than 45 minutes and will be scheduled at a time that suits interviewees. Interviews will take place in the fortnight commencing Monday 25<sup>th</sup> June 2007.

Deliverables of the project will include a de-identified project report, and a paper to be submitted for publication. All participating CHS will receive a copy of the project report. It is hoped that the project report will be a useful advocacy tool for organisations and for the sector.

It is envisaged that there will be varying degrees of responses to climate change in CHS across the metropolitan area. In order to facilitate sharing of information, learnings and ideas generated through the project, participating CHS will also have the opportunity to be involved in a climate change workshop. This will be held after the completion of the project.

If you are willing for your CHS to be involved, please fill in the details below and return to [kristine.olaris@nych.org.au](mailto:kristine.olaris@nych.org.au) by **Friday 25<sup>th</sup> May 2007**.

**Name of CHS:**

**Name of contact person:**

**Position within organisation:**

**Phone:**

**Mobile phone:**

**Email:**

## **Appendix Three**

### **Climate Change Action in Community Health – Information for Interviewee**

You have been identified by your organisation to participate in this project. The project is being undertaken by Kristine Olaris, Deputy CEO at North Yarra Community Health. The project aims to determine the capacity of metropolitan stand alone Community Health Services (CHS) to respond to climate change.

You have agreed to participate in a telephone interview on ..... (date) at.....(time). It is anticipated that the interview will take approximately 45 minutes. As agreed you will be contacted on the following number.....

If for some reason you need to reschedule this interview or change the phone number that you will be available on, please contact Libby Walker [libby.walker@nych.org.au](mailto:libby.walker@nych.org.au)  
All interviews need to take place in the fortnight beginning Monday 24<sup>th</sup> June 2007.

Below is an outline of the types of topics that the interview will cover. In order to facilitate an organisational response to the interview questions, you may need to consult within your organisation prior to the interview.

- Interviewee ie your name, position in organisation
- Consultation processes - information about those who were consulted in preparation for the interview and how consultation occurred
- Climate change – what is it?
- Your organisation – what, if anything, is your organisation doing to address climate change? This might be at a strategic level (eg organisational policies, plans, structures) or at a practical level. Areas to be discussed at this practical level will include policy or action that relates to facilities and transport management, purchasing, building design, and also any other actions targeting staff or community.
- Barriers to your organisation doing more to respond to climate change - think broadly about this question – try to think of as many barriers as you can.

Thank you for your involvement.

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