Government climate and health equity priorities must prompt a deeper re-think of health and healthcare for the 21st century

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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,[1] 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*,[4] 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.

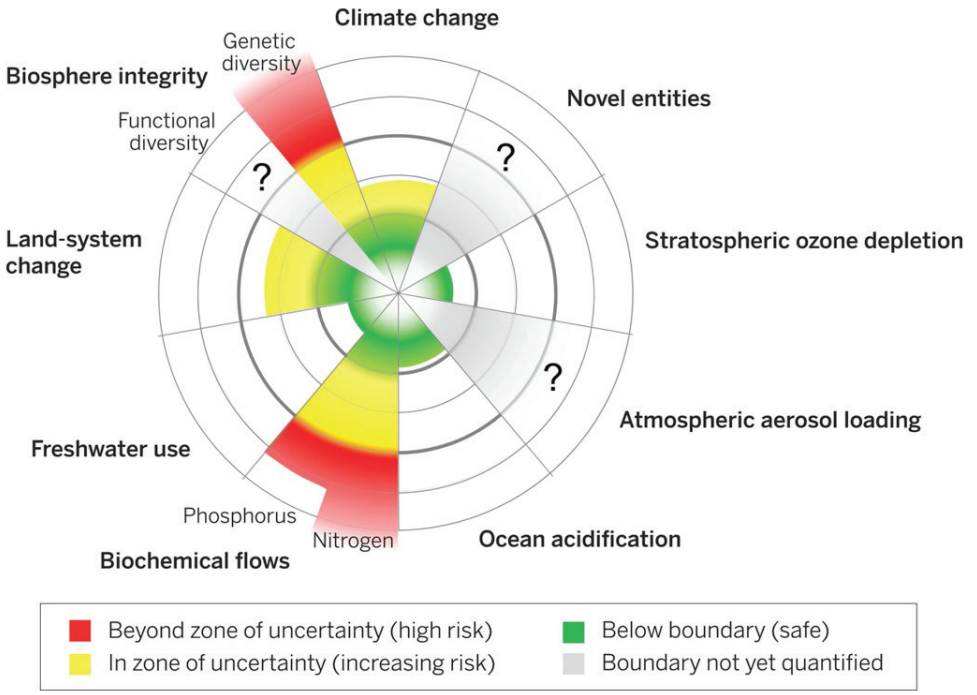
The Minister's letter, and Bennett and King's article, also represent a first step towards a crucial wider conversation about what we mean by 'health' and 'healthcare' in the context of a full planet—one in which successful human population growth has overwhelmed the ability of most other species to 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.



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air, biodiversity and the climate. A 'market' approach to health has led us to value individual 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.[9] 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-disciplinary endeavour to promote sustainable and equitable consumption, reduce population growth and place human health in the context of well-functioning natural systems.[10]

While these ecological approaches linking health, healthcare, equity and environmental sustainability feel new to Western health practice, they approximate and to some degree echo the unbroken fundamental 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 colonisation and colonialism, which have set up the social and economic structures of natural resource exploitation, constrained indigenous health development and overridden 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-structuring 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 knowledges, governance partnerships and self-determination.

Competing interests:
Nil.

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