It's time for Australian hospitals to be all-electric (and powered by 100% renewable energy)

Over 7% of Australia's total greenhouse emissions are estimated to be from health care,[1] with up to 30–40% of an Australian hospital's emissions derived from the facility's energy consumption.[2] Fossil gas can be almost half of a public hospital's energy supply, particularly in Victoria, New South Wales and South Australia.[3]

The health of present and future generations depends on significant cuts to greenhouse gas emissions this decade.[4] The health care sector has both the capacity and duty to lead this transition, with all-electric hospitals and 100% renewable electricity supply being part of the solution.

Several new large Australian hospital builds and redevelopments in Canberra, Adelaide, Melbourne and Geelong are planned to be all-electric with no gas infrastructure.[5] Doctors for the Environment Australia has produced a guide for clinicians to champion their organisation's next build to be all-electric.[6]

Encouragingly, Victoria has demonstrated the feasibility of such a policy by recently announcing that all new homes and public buildings including hospitals will be 100% electric in design from 2024.[7]

Switching to an all-electric design once development is underway, or retrofitting existing facilities, is possible but more challenging, and will require hospital planners and engineers to consider their options based on existing infrastructure, context, return on investment, and life cycle analyses. Ongoing advocacy is required to ensure that all future health infrastructure is all-electric and that plans to electrify existing structures are developed.

Decarbonisation of the sector also requires a rapid transition to renewable electricity supply for all health care facilities, particularly in NSW, Queensland, Western Australia and the Northern Territory as there has been no commitment to this goal in these jurisdictions. Encouragingly, Victoria has again demonstrated this is feasible by committing to supplying 100% renewable electricity to all its public hospitals by 2025[8] (electricity supplies in the Australian Capital Territory and Tasmania are already close to 100% renewable, with SA approaching 80%).

Beyond minimising the footprint of on-site energy usage, opportunities for a 100% renewable powered hospital include optimising carbon reductions from electric vehicle fleets and medical equipment. As single-use medical equipment is presently responsible for a significant portion of health care emissions, transitioning to reusable equipment (including personal protective equipment, gowns and drapes) that is washed and sterilised with 100% renewable electricity will be integral to reducing the sector's carbon and waste footprints, and will assist the sector in transitioning to a circular economy approach.[9]

Climate risk mitigation is health risk mitigation. We can lead by example and rapidly decarbonise the health sector. All-electric, renewably powered hospitals are an important, and feasible initial step.

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A brief intervention for improving alcohol literacy and reducing harmful alcohol use by women attending a breast screening service: a randomised controlled trial

To the Editor: Grigg and colleagues must be commended for their randomised controlled trial (RCT).[1] However, their conclusion that "the effectiveness of brief alcohol interventions for reducing alcohol consumption in women attending breast screening should be further investigated" deserves comment.

First and foremost, it is unacceptable that no national program for cancer screening has yet implemented evidence-based interventions to reduce the burden of avoidable causes of cancers (tobacco, alcohol, and obesity).

Second, although brief alcohol interventions can improve awareness of alcohol harms, in my opinion there is no rationale for investigating whether this could reduce consumption. Key considerations are:

- In the RCT by Grigg and colleagues, none of the secondary outcomes investigating alcohol consumption, even using subgroup analyses, supported a hypothetical effectiveness.[1]
- Although brief intervention is usually recommended, its effectiveness remains controversial.[2,3] It is time to acknowledge that "brief intervention" is a bazaar of techniques without a defined method. In contrast, motivational interviewing, a cornerstone of care,[4] is a well defined and effective technique that can be learned.

- How could a brief intervention be effective against the sophisticated marketing mix of the alcohol industry when public policies are so inadequate? No country has developed a comprehensive policy and key measures are typically avoided. Scotland is the only country to have recently implemented a minimum unit price (£0.50/8 g ethanol),[5] similar to that in the Northern Territory (AU$1.30/10 g ethanol).[6] This reduced the prevalence of hazardous drinking but not of harmful levels.[5] With respect to health warnings, the Canadian territory of Yukon was a worldwide exception when it mandated cancer warnings in 2017, but this only lasted a few months due to alcohol industry interference.[7] Ireland has approved extensive health labelling on alcoholic beverages, including cancer warnings and a calorie count, which is expected to come into force in May 2026.[8]

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In reply: Braillon[1] questions the rationale for investigating brief alcohol interventions for reducing alcohol consumption among women attending breast screening. Our recent trial[2] represents one example of the wider efforts to rethink potential applications of brief alcohol interventions[3] — in this instance, within a national breast screening program.

An e-health brief intervention was chosen based on meta-analytic evidence supporting their effectiveness in reducing alcohol consumption among community populations,[4] and with potential for wide-scale implementation. The intervention was adapted to address alcohol literacy and consumption in the context of breast cancer risk reduction and was co-produced with women to ensure its appropriateness for the breast screening setting.

The trial[2] found that alcohol was largely a blind spot in women's awareness of breast cancer risk factors. The brief intervention improved knowledge of the alcohol–breast cancer link, and alcohol literacy more broadly. As discussed in the article, although brief intervention trials typically include only participants drinking at hazardous levels, our universal approach meant that women drinking at all levels (including low risk) received the intervention, expanding its utility as a health promotion intervention while discretely targeting harmful consumption. While not powered to detect change in alcohol consumption, this preliminary study provides data on consumption endpoints (and rates of missing data and participant attrition), providing important estimates for future, scaled-up research.

We agree that brief interventions are not a panacaea for reducing alcohol consumption and related harms. As we emphasised, sustained, multifaceted strategies comprising alcohol policy measures, media/social media campaigns, and individual-level interventions are needed to address the numerous cognitive and social influences on alcohol consumption, and to counterbalance the actions of the alcohol industry. We argue that the utility of brief alcohol interventions warrants continued exploration, as a frontline intervention that can be implemented in diverse clinical settings, complementing other public health and policy measures to increase alcohol literacy and empower people to make informed decisions about their alcohol use and health.

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