Centre for Net Positive Health & Climate Solutions

Health and Climate Narratives Taskforce: Literature Review 1

Framing Responsibility in Climate & Health



Hawkins, C.
Butler, C.
Dicken, J.
Lynch, R.
Mina, P.

netpositivecentre.com

UK Research and Innovation

University of Exeter

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Health and Climate Narratives Taskforce

The Net+ Centre is convening a Taskforce to explore how health-focused framings of climate change adaptation and mitigation can support positive outcomes for people's health, the environment, and society. Through rapid evidence reviews and participatory workshops running throughout 2026-7, the taskforce will bring together a diverse community of researchers, policymakers, and practitioners working at the intersection of climate and health.

The Taskforce will explore four cross-cutting themes: responsibility, time, evidence, and storytelling, concluding with ideas for resources and guiding principles that can support others.

The taskforce process

Ahead of each Taskforce workshop we will send a review, as well as questions to consider. Each one will focus on a different theme. It will take around 1 hour to read the whole document. There is a glossary of terms at the end of the document with hyperlinks to each key word, the first time they appear in the document.

The review & questions aim to:

- Give you an overview of the theme
- Reflect on research, theories and policy
- Provoke thoughts and discussions for when we meet
- Help shape discussions around:
    - How we might frame the health effects of climate change in communication and engagement
    - How we might communicate about the health co-benefits of mitigation and adaptation to climate change

Who has shaped this taskforce, and the reviews?

The team behind this taskforce come from a range of disciplinary backgrounds and are based within the Centre for Net Positive Health and Climate Solutions. We are social scientists, public health experts and arts and communications professionals. We are passionate about collaborative approaches which we believe are necessary to address complex, interconnected climate, health and social issues. We are interested in co-producing context-appropriate knowledge and interventions towards social, health and climate justice.

Who is on the taskforce?

The Taskforce involves a group of 15 professionals from across sectors, disciplines and levels of governance from science to art to policy. Members come from across the UK and work across national and local levels.

Theme 1: Responsibility

Executive Summary

Purpose of this review

This review explores how responsibility is framed in climate-health narratives: who is expected to act, with what authority, and with what resources. It asks how health framings can support climate action without shifting responsibility unfairly onto individuals, communities, local authorities or overstretched services.

Why this matters for the Taskforce

Health framings can make climate change more tangible, urgent and relevant. However, they can also narrow attention to individual behaviour or clinical responses unless they are clearly linked to structural inequalities, institutional responsibilities and wider systems of power.

Key messages

1. Climate-health framings shape who is seen as responsible for action.
2. Positive health co-benefit narratives can build support for climate action.
3. There is a risk of placing too much responsibility on individuals and communities without addressing unequal resources and power.
4. Local authorities, voluntary organisations and frontline workers often carry responsibility without sufficient capacity.
5. Corporate, state and institutional responsibilities need to remain visible.
6. A 'net-positive' approach can connect climate, health and social justice outcomes.

Two case studies in this review

- Heat-health governance: considers how responsibility is distributed across national government, local authorities, health systems, communities and individuals.
- Climate, mental health and economy: shows how individualised framings of distress can obscure wider socioeconomic and environmental determinants.

As you read, consider:

- How is responsibility currently framed in your sector or organisation?
- Who is expected to act on climate and health, and who has the resources to act?
- Where are responsibilities unclear, unfair or under-supported?
- What kinds of climate-health narratives could support shared, equitable and practical action?

Core workshop questions

1. How is responsibility for climate and health currently framed in your work or sector?
   (Who is expected to act — and how is that communicated?)
2. Where do you see mismatches between responsibility, power and resources?
   (Who is expected to act without the authority, capacity or support to do so?)
3. When are health framings helpful — and when do they risk assigning disproportionate burdens of responsibility?
   (What kinds of messages enable action vs. shift burden onto individuals or communities?)
4. What would a more shared and equitable framing of responsibility look like in practice?
   (How could responsibility be communicated and distributed differently across actors?)

How to use the review

The full review outlines evidence, theory and case examples behind these questions. You do not need to respond to every point. Please use it to identify examples, tensions and opportunities from your own work that can inform the workshop discussion.

Introduction

How are climate-health responsibilities imagined and narrated, and how does this inform action?

Responsibility is at the root of questions around the framing of climate change and health, shaping:

- Who is expected to act
- With what authority
- With what resources

It is also contested terrain. Both health and climate narratives have been critically assessed for overemphasising individual framings of responsibility for action, while obscuring state and corporate responsibilities. Though this is well trodden ground, it is directly relevant here, as any proposal to consider reframing climate change in terms of health and equity needs to address these individualising tendencies.

What do we mean by 'framing'?

We define framing as the selective emphasis of particular concerns over others. This is the process through which climate and health are defined, communicated and organised (1). It also informs the level at which action is taken (2), for example individual or state level.

This review considers:

- The current context of multi-level climate and health governance in the UK
- Evidence from research, theory and policy
- Questions for the taskforce to consider in the workshop

To illustrate this in practice, we also consider two case studies:

1. The first outlines emerging roles and responsibilities in **heat-health governance in the UK**. This case study points to key challenges related to the framing and distribution of responsibilities across interconnected health and climate crises. These occur at institutional, community and frontline levels. Recurring themes include limited resourcing, public perceptions, and gaps between 'talk and action'.

2. The second case study considers framings of **individual mental health responsibilities** in the context of climate-related distress and socioeconomic inequalities. This opens up questions around broadening frames of responsibility to encompass complex interconnections between environment, society and mental health.

Throughout this review, we also consider:

- The potential of effective health-related narratives around climate.
- How **corporate and state responsibility** for climate change has been framed.
- Responsibilities of **intermediary actors** such as local authorities and community organisations who operate across and between sectors.
- Framing of **individual responsibility** for responding to - and preparing for - the health effects of climate change.

Our critical approach

To understand 'responsibility' across sectors and levels, the personal and political, we use feminist and 'eco-social' approaches. These help us to consider interconnections between human and more-than-human health, and link responsibility and justice (1–4). These approaches broaden framings of climate-health responsibilities and situate them in the context of political, socioeconomic and relational processes. This can highlight both disproportionate responsibilities for (self) care and adaptation/ mitigation, as well as people's capacity for engaging in practical responses and cooperative initiatives that can enable and empower individuals and communities.

Overall, we hope this can prompt discussion around how to equitably frame individual and collective responsibilities in climate/health action going forward. We may also want to consider the framing of responsibility over *time*, connecting with the theme of our next workshop.

Context

The health impacts of climate change

Climate change has long been recognised as the biggest global health threat of the 21st century (5). Despite increased awareness and commitments to a health-centred response to the climate crisis, global action has been insufficient (6–8). In the UK, climate change impacts, such as rising temperatures, extreme weather events, food insecurity and changing patterns of infectious disease, are already affecting people's health. There are increasing and disproportionate impacts on underserved communities.

The UKHSA's 2023 report on the 'Health Effects of Climate Change' (HECC) assesses extensive evidence outlining the urgent need to adapt policy and practice to prevent further adverse effects (9). In the context of long-term austerity and widening health inequalities in the UK (10), exacerbated since Covid-19, climate impacts will likely deepen entrenched inequalities. This requires interventions that explicitly address the needs of those most affected.

The climate policy context

When compared with longstanding policy areas, such as welfare, climate adaptation and mitigation governance is a relatively new policy field with emerging 'ambitions, responsibilities, procedures, routines and solutions' (11). A recent expert study on 'integrating climate and health policies in the UK' noted enduring challenges around siloes and resource constraints (12) as expanded in the case studies below.

Integrating health as a co-benefit

There is significant untapped potential in integrating health as a *co-benefit* of climate adaptation and mitigation across sectors (12,13). The HECC report notes opportunities to 'embed climate in public health practice, and health in climate planning', with the potential for 'win-win strategies' or 'maximising co-benefits' (9: 16). This includes 'multisectoral action' for targeted adaptations, such as interventions for specific climate, health or social risks, situated in high-priority settings or targeted for specific groups. Interventions could include, for example, optimising co-benefits of urban nature-based solutions (NBS) for human and environmental health (14).

Reframing climate-health can be seen as an opportunity for establishing stronger cross-sector alignment and locally embedded systems, redefining and reorganising responsibility in ways that strengthen equitable and sustainable responses and enhance community capacity.

Health services, climate change and inequalities

A key multisectoral co-benefit of climate adaptation and mitigation is in easing pressure on health services. The health sector itself also has significant climate responsibilities, with public health agencies and the NHS both key players in climate adaptation and mitigation policy.

The Lancet Countdown 2025 notes increasing adaptation and positive momentum in the reduction of health sector GHG emissions towards net-zero health systems (8). Health professionals are expected to promote climate action with health benefits (8), being 'among the most trusted members of society', with potential to act as advocates for increasing public up-take of 'climate-friendly behaviour' (15).

However, this overlooks issues of mistrust and uptake in public health services (15), particularly among historically excluded communities in the UK (16). Further, there is inevitably mixed engagement among health professionals and practitioners, including local authority public health officers (12,17). This needs to be understood in the context of wider structural factors, including resource shortages, limited capacity and conflicts with other urgent issues (12,17). There is a need to take these factors into account and how they might inform up-take of responsibility for climate action in the health sector.

This is especially true in a context of worsening inequality and related public health outcomes, placing burdens on the NHS and, in turn, its carbon footprint. This highlights the compounding effects of inequalities in worsening health, societal and environmental outcomes and strengthens the case for solutions that address climate change, health and equity together.

Public engagement in climate and health

Recent findings show that there is an increasing public interest in the relationship between climate change and health, reflected in a notable rise in related internet searches, particularly since 2020 (18). Public opinion can be a significant determinant of climate policy change (19,20). The ways that climate and environmental issues are framed has been shown to influence public engagement (19). This means that the framing of climate communications has been an important area of research across disciplines.

There is a growing yet fragmented evidence base on the effectiveness of health frames of climate messaging in bolstering support for personal and political action (15,21–25). This might include messaging on the health impacts of climate change, or the health benefits of climate action (21). Where climate change might be perceived as distant or intangible, health impacts are considered to 'make it personal' and immediate, with potential to motivate public pressure on policy change (15). Some key studies on this are outlined in the following section.

Defining Framing

Framing can be understood as the selective emphasis of particular concerns over others, in decision-making, messaging, and research (15). A frame shapes how issues are defined, understood, what kinds of responses are seen as appropriate, and who is perceived as responsible for action. Frames are not static or fixed. They are continually in the process of being remade through discourse and practice.

The ways climate change is framed in public messaging has varying influence on perceptions. Framing effects are often polarised along political lines (26,27), for example, with left and green ideologies more likely to be aligned (26,27).

In the UK, some note how industry, government and NGOs appear to engage in 'framing contests' around the future of decarbonising economic systems. This is despite widespread awareness of the urgent need to limit climate warming (28). For example, fossil-fuel companies, the largest emitters of greenhouse gases (GHGs), have been found to engage in green rhetoric, while still operating under 'business-as-usual' (29). This is a form of strategic framing with worsening impacts on climate and human health around the world (6).

Positive health-related climate messaging

Research has shown that positive health-related climate messaging can be more effective in eliciting public support for climate policies than messages centred on environmental degradation and related metrics (25). This study suggests that positive health framings 'can help build public support and overcome the divisions in global climate politics' (25). In particular, information about the health co-benefits of mitigation policy has been found to elicit more positive public responses than information about the catastrophic risks of climate change (21,22). Some studies have found this to be especially true among people unconcerned about climate change (23,25). However, notably, other studies show limited impact of health framings on climate policy support (24).

A recent systematic review of 54 studies on health framings of text-based environmental messaging found that health frames generally boost support for climate action (21). Messages that emphasise a 'gain frame' and the health benefits of mitigation action were often found to be particularly clear and helpful, enhancing awareness of personal climate risks and health-protective behaviours (21). However, findings also suggest that health frames may not be sufficient to motivate broader mitigation behaviours oriented towards societal or planetary benefits (21). This review highlights a gap in the evidence base regarding the impact of scale on the effectiveness of health framings (21). They also recommend research which explores a user-centric, co-design approach to messaging (21).

Climate-health messages including personal stories, lived experiences and actionable recommendations across levels have been found to be particularly effective (21). This is supported by the Climate Outreach report, 'Britain Talks Climate & Nature 2025' (30), which highlights people's priorities and concerns around climate change in the UK. This report suggests that clear, well-framed communication about how climate action helps us improve other aspects of our lives in tangible ways can break through distrust and resistance.

Limits of health co-benefit frames

Health co-benefit frames also carry potential limitations, including in terms of how responsibility is envisaged, distributed and enacted. How health is defined is not free from politics, inequalities or issues of trust (15). Dominant framings of health often focus on individual behaviours and 'lifestyle choices' rather than unequally distributed 'life conditions' (31) that have a major impact on our health. This might include determinants of health such as access to quality food, housing, or secure employment.

This focus on individual responsibilities can conceal the roles of state, corporate and institutional actors. This can put disproportionate burdens on individuals, families and communities. As philosopher Isabelle Stengers argues, there is a 'privileged irresponsibility' among state and industrial actors who perpetuate 'irresponsible economic growth, whatever the cost' (32). Notable here is recent research on changing carbon behaviours that found upstream (policy-level) action was significantly more effective at enacting change than individual behaviour change (33).

While this critical debate on the distribution of climate responsibilities is crucial, we also want to go beyond it by recognising that responsibility is not only imposed on people; people and organisations also choose to take responsibility willingly. That might include adopting sustainable consumer habits, taking part in climate-health action or offering mutual care (34). For this, the focus shifts from questions about *where responsibility should sit* to considering *how responsibility can be better aligned with power to act*.

Defining Responsibility

Responsibility is a core theme in many social science and humanities disciplines, including anthropology (35,36), which often focuses on how responsibility is defined, recognised and enacted in practice. From this perspective, responsibility unfolds and emerges through relationships and interactions (35–37); it is always evolving and being redefined. This definition can help us to attend to the various ways that people take up responsibilities. For example, the state may reallocate healthcare responsibilities onto individuals and their families, but beyond that, there are also various ways that people take up responsibilities to care for themselves, their communities and environments (35).

A recent paper in Nature Climate Change offers a framework for climate responsibilities that goes beyond the individual vs system binary, by recognising the role of individual agency within wider systems (38). While agency is unevenly distributed, this shifts the idea from framing interventions to change minds – to improving conditions so they are enabling of climate action.

This offers a practical frame for intervention, but does not consider the role of non-humans within systems, such as non-human animals and ecosystems. In the context of climate impacts on health, there is a need to bring social-ecological relations into the frame (39). For example, greening river catchments can help to protect from flooding events with impacts on the landscape, biodiversity and human health (39), which relies on the interplay between plants, animals, microorganisms, policymakers, environmental stewards, local communities, and infrastructures.

Feminist Science and Technology Studies (STS) and eco-social approaches to responsibility bring multispecies relationships to the fore (2,40). STS scholar, Donna Haraway presents the concept of 'response-ability' (2). This is the capacity to respond meaningfully and render others capable of responding. This shifts attention from behaviour change towards cultivating the conditions that make 'multi-species flourishing' possible.

These conditions include the narratives, infrastructures, institutions, knowledge systems and professional practices that enable care, prevention, and adaptation. This might include subsidies, incentives, organisational policies facilitating the adoption of low-carbon behaviours (38). Or it might include ideas around reconfiguring social spaces and practices with sustainability and accessibility in mind (41); for example, cooling nature-based solutions in deprived urban areas that enhance wellbeing while also offering employment opportunities. Taken together, these perspectives suggest that framings of climate-health responsibility need to move towards a relational understanding of responsibility that is grounded in interdependence, cooperation, and care in the context of a changing climate.

Key messages

1. Climate-health framings shape who is seen as responsible for action.
2. Positive health co-benefit narratives can build support for climate action.
3. Health frames risk placing too much responsibility on individuals without addressing inequalities.
4. A 'net-positive' approach can connect climate, health and social justice outcomes across multiple levels and species.

Case study 1: Multi-Level Heat-Health Governance and Responsibilities in the UK

The UK is among countries with the highest heat-related mortality (42) and this is projected to rise (43). Heatwave events have risen in frequency and intensity in recent decades. Record temperatures, such as the summer of 2022, saw temperatures exceed 40°C for the first time. The Office for National Statistics (ONS) and UKHSA estimated that there were 3,271 excess deaths across England and Wales during heat periods (44).

Extreme heat disproportionately affects older adults (45,46), people with underlying health conditions (47), and those living in London and urban areas (48). There is a need for adaptation, for example, through governance, institutional reforms, urban planning, nature-based solutions, and resilient health infrastructure (49).

UK governance of heat and health has historically centred on emergency response frameworks as opposed to prevention. 2017-19 parliamentary debates within the House of Commons' Committee on Climate Change (50) revealed ambiguity around leadership responsibility for co-ordinating heat adaptation across government.

A policy report from the Grantham Institute following the 2022 heatwaves, based on interviews with national and local government representatives', notes a 'lack of integration between national and local heat risk policies', with a 'lack of ownership and responsibility' for heat risks, and insufficient resources (47).

In 2023, the UKHSA published the Adverse Weather and Health Plan (AWHP), which has been reviewed and updated annually since (see latest iteration (51)). The AWHP was developed by scientists and public health experts in UKHSA's Centre for Climate and Health Security (CCHS), which was established to lead climate health activities and collaborations across academia, local authorities and other public sector organisations. The AWHP outlines coordinated roles across media, cabinet, NHS, local authorities, social services and voluntary organisations for communicating risk across public services. It also outlines extensive organisations responsible for public health in the event of adverse weather, summarised in the endnotes for reference[i]. The equity review published alongside the original AWHP (52) acknowledges variable evidence on risk by population. There is also an on-going NIHR process evaluation around the local implementation of the AWHP focused on NHS and social care organisations in England.

A 2024 report by the independent think tank, Green Alliance, focussed on extreme heat and health governance in the UK (53). This notes that while central government coordinates national climate adaptation policies to protect people's health, local government has:

"an important responsibility for the majority of adaptation policy delivery and emergency responses to extreme weather. However, many authorities lack adequate powers and resources to deliver adaptation at the pace and scale needed" (42: 18)

They also found gaps between departmental adaptation responsibilities and possibilities for action. This burden of responsibility at a local level may also apply to the voluntary and community sector (VCS), who are encouraged in the latest AWHP 'to develop their own local plans' and connect with local authorities to identify gaps and opportunities in planning (51). Based on the Covid-19 response, these are the organisations likely to take on significant responsibilities to ensure emergency resources reach people at risk, particularly for historically marginalised or excluded communities.

Related stakeholder research on the perceived effectiveness of the plan found the heat risk governance approach to be siloed and lacking coordination, particularly in relation to leadership, institutional structure, roles and responsibilities, and funding and resources (54). While emergency communications may cascade along formal lines, messaging may not reach the 'final tier' such as frontline healthcare workers. There is then particular responsibility on 'local actors to interpret the alerts and then take decisive action' (43: 5).

Stakeholders participating in this research also noted concerns regarding public perceptions. While awareness of heat risks has increased over the years, this 'does not necessarily translate into people taking protective action' (43: 5). This is partly attributed to a public perception of hot weather as something positive. This is evident in the ways that heatwaves have often been visually framed in the UK press, with images of crowded beaches - which may not be sufficient for prompting adequate responsible action across levels (55). Additionally, it was noted that heat may have more 'intangible' individual or household level health impacts, unlike other severe weather events like floods, further shaping public perceptions.

While stakeholders in this study noted the importance of a primarily health-centric approach to heat impacts, they also argue that health framings may draw attention away from other key sectors like transport, water and energy, which have distinct heatwave impacts and frameworks for responses. The research concluded that '[i]n the web of institutional arrangements, it becomes the responsibility of the local actors to distil inputs from different sectors… into their local strategies' (43: 6). The focus on health can thus put local actors from other sectors in a disadvantaged position during heatwave responses. This supports their recommendation to broaden the cross-sectoral framing of heat impacts beyond the domain of 'health'.

Across these assessments, researchers and participating stakeholders, observe that local authorities play a critical role in translating these national guidelines into contextual strategic action and response. Yet resource constraints shape how responsibility is distributed in practice. The complexity of heat-health governance, including decision-making and public communications, imparts burdens of responsibility on local actors - to distil various inputs from across sectors, and adapt them for relevance in their local contexts, while handling complex trade-offs between sectors. This can be seen as an issue of how problems are framed, which connects with how responsibilities are assigned, resources distributed, expertise assembled, and responses aligned across sectors (11).

So what?

Heat-health can place too much responsibility on particular agencies or local actors without adequate power, funding or cross-sector coordination. The Taskforce may want to consider how health framings can create challenges for recognising shared responsibilities. This case study may also open conversations about the distribution of role-responsibilities, and the opportunities and challenges of cross-sector working in climate-health action more broadly.

Case study 2: Climate, Mental Health and Economy

There is a growing evidence-base detailing how climate impacts, such as heat and floods, affect mental health. For example, research has found a 10% increase in hospital attendance and admission for mental illness during heatwaves (56). Demand for mental health support has also been found to increase after flood events, which are linked to subsequent increases in PTSD, depression and anxiety.

As well as increases in acute stress due to extreme weather, the 2025 UKHSA report on Climate Change and Mental Health (57) discusses 'eco-anxiety' and 'solastalgia' which are associated with distress about climate change and anticipatory climate risk. Overall, these mental health impacts of climate change are predicted to have a disproportionate impact on agricultural communities, children and young people, and first responders to weather events.

The UKHSA's Health Effects of Climate Change (HECC) report notes a lack of evidence in climate change and mental health relating to individual risks, behaviours and barriers to uptake of interventions (9: 20). This emphasis on individual risk and behaviours leads to a focus on individual-level clinical interventions such as cognitive behavioural therapies (CBT), self-help or group-based therapies and engagement in climate action.

Framing individual mental health responsibilities for unequal climate distress thus locates action at the individual-level, which in turn reproduces self-directed responsibilities. This perspective aligns with existing mental health practice and climate action and thus offers practical routes for intervention. However, on its own, this individualised frame may not incorporate environmental exposure, economic precarity, and social inequality, which shape both mental health outcomes and the capacity to engage with such interventions.

In the UK, the rising cost of living since Brexit and Covid-19 has had an unequal impact, particularly on younger people and lower-income earners (58). Growing evidence links economic factors and mental health disorders in the UK. ONS data, for example, has highlighted associations between depression and the cost-of-living crisis (59). From this perspective, adverse mental health can be reconceptualised not only as an issue of individual behavioural risk, but as an outcome of unequal environmental and socioeconomic risks. Anthropological research shows how this broader context is also often foregrounded in how mental health is defined, experienced, understood and managed (e.g. 60). As well as being integral to health and wellbeing, mental health often offers a salient category for articulating difficult experiences, such as financial or ecological distress, social disconnection and injustice, and for advocating for government accountability and adequate provisioning.

Alongside clinical and behavioural interventions, a co-beneficial framing of climate and mental health may illuminate opportunities to reduce inequalities and build capacity, as well as systems-level and preventive approaches. This may include better resourcing of mental health systems, targeted 'co-beneficial' interventions for specific at-risk populations (such as in flood response and long-term recovery), or adequate support for effective social protection, community-based programmes and climate activism enhancing wellbeing.

This can be informed through cross-disciplinary research which centres the unequal health impacts of climate change, and mental health consequences of related uncertainty. Social and participatory methods can play an important role in understanding, managing and preventing mental health outcomes of social inequality (61), and in co-producing alternatives. This is particularly pertinent in preparing for future interconnected health, climate, and economic crises, and to disrupt intensifying inequalities in the UK.

So what?

Mental health is environmentally and economically situated. Emerging UK policy-focused research offers an opportunity to broaden framings of mental health responsibilities accordingly. The Taskforce may want to consider effective and equitable

framings of climate-related mental distress that can support alternative responses alongside clinical or individual approaches.

Conclusion

These two case studies highlight how the framing of climate-related health risk shapes the allocation of responsibility in practice. For example, the heat governance case illustrates how health framings of adverse weather can mobilise institutional and public responses, but with the potential to overlook the crucial roles of other related sectors (54). There are particular burdens of responsibility at the local-level, including local authorities and frontline healthcare providers, who also manage trade-offs around how heat-health risks are framed in emergency responses and public communications.

The second case study reveals how mental health responsibility is often framed - and unevenly distributed - at the individual and community-level. This shows individual behavioural framings can obscure the structural and socioeconomic conditions that shape both exposure and capacity to respond. In both cases, broadening the frame to incorporate cross-sectoral responsibilities and structural inequalities is both analytically and practically generative, opening different possibilities for intervention, resources, and shared responsibility.

The concept of 'response-ability' (2,2) - cultivating the conditions for collective, meaningful responses towards 'multi-species flourishing' - points towards a practical framing grounded in interdependence, cooperation, and care. 'Net-positive solutions' may emerge from this kind of collaborative thinking, enabling responsiveness across levels of action.

Glossary of terms

Climate adaptation is about making changes to the way we live, work, make, and do things to reduce risks and maximise opportunities. In health contexts, this might include adapting hospital buildings to stay cool in summer heat or planting trees to cool homes in an urban area prone to heat risk.

Climate mitigation are actions taken to reduce the causes of climate change.

Co-benefits are multiple positive outcomes that arise from a climate action. These typically occur across multiple domains, simultaneously. For example, urban greening that reduces heat risk may also improve mental health, biodiversity, and employment.

Framing is the selective emphasis of aspects of an issue over others. This shapes how it is understood, who is seen as responsible, and what responses appear appropriate or possible (15).

Liveability is environmental, social, economic, and political conditions under which life can flourish for all species (4).

More-than-human is a term used across feminist Science and Technology Studies, environmental humanities, and eco-social thinking. It is used to challenge human-centricity, draw attention to the agency of non-humans such as animals, plants and ecosystems, and emphasise the interdependence between them.

Net-positive encompasses the co-beneficial or 'triple-win' possibilities of taking actions that cut crosses climate, health, and social inequalities.

Responsibility has diverse interpretations. In everyday usage, it is often linked to the allocation of individual roles or accountability. In this review, we draw on an anthropological definition of responsibility as relational and enacted, emerging through relationships, practices, and institutional discourses.

Responsibilisation is the process by which responsibility for managing risks is transferred from states and institutions onto individuals and communities - often without the allocation of power or resources. This is a well-documented tendency of neoliberal governance (31), with relevance to both health and climate policy

Response-ability draws from the influential ideas of feminist Science and Technology Studies scholar Donna Haraway (2). This concept describes the capacity to respond meaningfully including cultivating the conditions, relationships and practices that make collective, attentive response possible.

End notes

[i] Below is a topline summary of responsible organisations outlined in detail in the AWHP (2026, pp.51-68), including:

- The UK Health Security Agency (UKHSA) for overarching adverse weather and health plans. UKHSA also have a regional health protection role.
- Cabinet Office for central response coordination.
- Department of Health and Social Care (DHSC) for delivering health adaptation plans, and coordinating health and social sector responses.
- Office for Health Improvement and Disparities (OHID) for bringing evidence for policy, with a focus on health improvement and equalities. OHID also support regional health improvement functions.
- NHS England for NHS preparedness and response, including links with adverse weather alerts, and support for integrated care systems (ICSs).
- Met Office for weather warnings, cascaded via UKHSA to government departments, health and social care sectors, local authorities and the public.
- Local Government devolved responsibilities for delivering policy at the local level.
- Ministry of Housing, Communities and Local Government (MHCLG) for delivering housing and building safety, especially to improve conditions and prevent overheating in buildings and ill health.
- Department for Environment, Food and Rural Affairs (DEFRA) as lead for flood events reporting and relief plans and coordinating working groups across government agencies to develop climate strategies.
- Integrated Care Systems (ICSs) for protecting the delivery of vital public services during adverse weather events.
- Local Authorities for local planning.
- Social care providers for adult and children's social care.
- Local resilience forums (LRFs) for coordinating multi-agency responses during severe incidents.
- Local Health Resilience Partnerships (LHRPs) supporting health sector's contributions to multi-agency planning through LRFs.
- Directors of Public Health (DsPH) for local authority planning and responding to emergencies that risk public health, including adverse weather events.
- Health and Wellbeing Boards (HWBs) for long-term strategic preparation for health impacts of climate change mitigation and adaptation.
- Care Quality Commission (CQC) for appropriate emergency planning among regulated care providers.
- Ministry of Defence (MoD) for critical resilience in the case of adverse weather events.
- Department of Energy Security and Net Zero (DESNZ) for energy resilience in the event of weather hazards.
- Department of Work and Pensions (DWP) for administering welfare payments and benefits, and for distributing public health messages during adverse weather events.
- Environment Agency (EA) for regulating industry, waste, preserving ecology and riverways, and managing flood risk.
- Other organisations: Health Safety Executive (HSE), Ministry of Justice (MoJ), Department for Transport (DfT), Department for Education (DFE), Department for Transport (DFT), Scientific Advisory Group for Emergencies (SAGE), Medicines and Healthcare Regulatory Agency (MHRA), Natural Hazards Partnership (NHP), academic and professional partnerships, Faculty of Public Health, Voluntary and Community Sector (VCS), business and retail sector, the public.

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Contact: Dr. Charlotte Hawkins, c.hawkins3@exeter.ac.uk