Role and Functions of an Australian Centre for Disease Control

Submission

9 December 2022

australian healthcare & hospitals association

the voice of public healthcare

OUR VISION

A healthy Australia, supported by the best possible healthcare system.

OUR MISSION

To conduct research, educate and influence the healthcare system to achieve better health outcomes, improved patient and provider experience, greater equity and sustainability.

OUR GUIDING PRINCIPLES

Healthcare in Australia should be:

Effective

Accessible

Equitable

Sustainable

Outcomes-focused.

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INTRODUCTION

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide input on the 'Role and Functions of an Australian Centre for Disease Control' Consultation Paper (henceforth, the Consultation Paper).

AHHA is Australia's national peak body for public hospitals and healthcare providers. Our membership includes state and territory health departments, Local Hospital Networks (LHNs) and public hospitals, community health services, Primary Health Networks (PHNs) and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high-quality healthcare to benefit the whole community.

AHHA supports the introduction of an Australian Centre for Disease Control (CDC) and commends the government on taking on the ambitious task of establishing a long-awaited independent agency to provide leadership on communicable and non-communicable disease prevention, promotion and protection.

The scope of the CDC as outlined in the consultation paper is large. To ensure the best chance of success we encourage the Department of Health and Aged Care to refine this scope, clearly defining a distinct purpose and set of principles that will allow the CDC to lead, amplify and enhance existing capabilities, rather than duplicating existing functions. Objectives must be achievable and aligned with reasonable timeframes for implementation.

AHHA would be pleased to continue to work with the Department of Health and Aged Care as it refines the scope of the Australian CDC, defining its purpose, principles and objectives, in addition to providing input to the design and development of the CDC functions.

The following submission provides our response to the consultation questions relevant to the expertise of AHHA and our membership.

FUNCTIONS OF THE CDC

1. What decision-making responsibilities, if any, should the CDC have?

- Should the CDC directly take on any existing responsibilities, or provide a coordinating and/or advisory function only? And if so, would that be sufficient for responding to health emergencies?

2. What functions should be in and out of scope of the CDC?

- What should the role of the CDC be in promoting or coordinating a One Health framework?

3. What governance arrangements should be implemented to ensure public confidence in the CDC?

- How can the CDC balance the need for the CDC to be responsive and accountable to governments, while also providing trusted, authoritative, and evidence-based advice?
- What aspects of independence do you believe are important to the successful function of the Australian CDC?
- How should the CDC be organisationally structured to best meet the needs of Australia's federated society?

The CDC should have a strategic coordination and advisory function. It is integral that the advice of a CDC is independent and evidence-based, is publicly transparent and is considered by national, state/territory and local levels of government in relevant public health and emergency situations to ensure the accountability of decision-makers. The CDC must become a central credible intelligence agency, with an understanding of the existing capabilities, data and evidence, and the authority to bring this all together to coordinate a consistent national approach to national health threats and emergencies when required. The CDC must become a trusted voice that governments, organisations and communities can turn to for up to date, evidence-based advice in response to the protection, prevention and promotion of health threats and their impacts.

The functions of the CDC should build on the Canadian approach, adopting a broader remit that other international CDC institutions to include preventive health and health promotion.

Public health functions and services need to be strategic and coordinated, yet flexible, to ensure effective prevention, detection and response approaches that reflect local need.

An Australian CDC should:

- provide the independent leadership necessary for a whole-of-systems approach to implementation of the National Preventive Health Strategy.
- demonstrate global leadership in communicable disease planning and response capabilities and be appropriately positioned to respond to a diverse range of threats both within Australia and beyond Australian borders. To do so, the CDC must have the capacity to consider current and

future communicable disease threats in the context of global health surveillance, security, epidemiology and international evidence.

- strengthen Australia's disease control evidence base through working closely with the Australian research community, government research agencies, peak health institutions and international experts to collaboratively identify and support the investigation of research priorities.
- support existing state and territory disease control measures by coordinating a cohesive approach to diagnosis, screening, reporting, case management, contact tracing, forecasting, and trend monitoring.
- work with the states and territories to establish clear lines of authority, areas of responsibility, and response activation protocols to ensure rapid, integrated outbreak responses. Engagement and partnerships with health, social, community and environmental institutions must all be prioritised to ensure their expertise and potential is fully utilised.
- capitalise on existing relationships and promote productive ways of working, avoiding duplication and reforming inefficient processes to ensure disease control bureaucracy is reduced. This includes data and technology systems and guidelines, for example, the optimisation of data capture, sharing and standardisation.
- ensure actions undertaken in response to a communicable disease threat is reasonable, proportionate, equitable and informed by evidence. This includes transparently considering the legal and ethical issues that balance the protection of individual liberty with public health responsibilities, such as in relation to the imposition of restrictions, police powers to enforce public health directions and resource allocation measures (e.g. PPE, medical equipment).
- prioritise the development of effective communication strategies to inform clear public messaging outlining the rationale for disease control measures, the benefits of compliance, and the consequences of non-compliance. Communications should be tailored to diverse audiences.
- work closely with governments, PHNs, the Australian Health Protection Principal Committee (AHPPC), private enterprise, and all relevant stakeholders (for an effective One Health approach) to consider the broad economic, social, environmental and equity impacts of disease control measures, to collaboratively and transparently develop solutions that protect health and promote equity.

A CDC needs to achieve a level of independence from the responsible minister and government, with accountability and transparency identified in the enabling legislation.

Governance arrangements need to be in place to hold the CDC to account to:

- States and territories, as they have responsibility for public health responses.
- A diverse representation of experts in heath, environment, community and social services sectors to adhere to an evidence-based One Health focus.
- People and communities, to ensure focus on meaningful outcomes that matter to the public.

In terms of organisational structure, an Australian CDC should be modelled on the Public Health Agency of Canada and the European Centre for Disease Prevention and Control, as they both operate across different levels of government and diverse nations/states/territories.

A COORDINATED AND NATIONAL APPROACH TO PUBLIC HEALTH

4. How can the CDC best support national coordination of the Australian public health sector?

- How can the CDC ensure effective collaboration and exchange of information with relevant stakeholders, including engagement with the private sector?

5. What lessons could be learned from Australia's pandemic response?

- How can the CDC best ensure linkages with all sectors relevant for preparedness and response – including primary care and the animal and environmental health sectors?
- Are there any national, state and territory or international reviews that would be of assistance in designing the CDC?

An Australian CDC needs to strike the right balance between promoting national coordination whilst allowing regional flexibility that enables placed-based responses that address unique local needs. The CDC should learn from the experience and response of PHNs during the COVID-19 pandemic and recent natural disasters when designing this coordination function, drawing on their experience in performing national coordination functions tailored and responsive to regional/local need.

In addition, the timely sharing of quality data, supported by interoperable technology is important for effective and meaningful coordination during a crisis or emergency. See response to questions 6-10.

Lessons from the European Centre for Disease Prevention and Control (ECDC) on how to build and maintain effective information sharing and exchange mechanisms should inform the design of an Australian CDC, as suggested in the Consultation Paper, since this is a recognised strength of the ECDC.

All sectors relevant for preparedness and response must be engaged early and often by a CDC. Planning and preparedness activities, including discussion- and operation-based exercises must involve stakeholders from all impacted sectors. During an outbreak or emergency, plans may go out the window necessitated by the context of the situation, but the working relationships, shared knowledge and networks created during planning and preparedness will increase the quality and outcomes of the response.[1]

[1] Comfort, L K, Boin, A, & Demchak, C, C 2014, *Designing resilience: Preparing for extreme events*, University of Pittsburgh Press.

Australia's pandemic revealed the need for:

- Timely data sharing and standardisation of data.
- Clear roles and responsibilities.
- Consistency and coordination of messaging from the highest levels of government down to the practitioners and responders on the ground.
- Trust with and responsiveness to people and communities.
- Greater utilisation of PHNs, accompanied by increased funding and resources for PHNs in recognition of their integral role in primary care public health and emergency response.

A DATA REVOLUTION

6. What are the barriers to achieving timely, consistent and accurate national data?

7. What existing data sources are important for informing the work of the CDC, and how could existing data bodies (national, state and territory) be utilised and/or influenced by the CDC?

- Is there data currently not collected in Australia which should be considered?
- What else is needed to ensure that Australia is able to identify emerging risks to public health in a timely way?
- Would the development of a national data plan with an agreed scope and/or an evidence-based health monitoring framework be useful?

8. What governance needs to be in place to ensure the appropriate collection, management and security of data?

9. How do we ensure the CDC has the technical capability to analyse this data and develop timely guidance?

10. How can the CDC ensure collaboration with affected populations to ensure access to, and the capability to use, locally relevant data and information, particularly as it relates to First Nations people?

Timely access to data

A substantial volume of data is collected across the health system, but in fragmented silos. Australia's data linkage capability has grown substantially over the past 50 years, overcoming challenges in stakeholder and community support, complex legal and ethical environments, cross-jurisdictional

collaborations and ongoing financial support.2 Population level insights and an understanding of variation also continue to improve through, for example, the work of the Australian Institute of Health and Welfare and the Australian Commission on Safety and Quality in Healthcare, as well as state-based agencies.

However, there are still many challenges to real-time access to information in Australia. One element of this is a national, cohesive approach to standards for electronic health records. It has long been recognised, for example, that electronic health records in primary care require:

- A defined data model that links related data elements
- Consistent data element labels and definitions
- Use of standardised clinical terminologies and classifications.[3] (Gordon, et al. 2016).

Such standards are important to harness technology in a way that is person-centred and across full care pathways. However, learning from data requires more than just the data. It requires teams to be supported to understand and interpret the data, for individuals as well as around communities and populations.

Interoperability is another necessary enabler.

Bringing together information from different sources in a way that is easy to understand and act on will be particularly important for supporting treatment decisions for people with chronic and complex health needs.[4] There should be no assumption that 'data speaks for itself'. It must be explored and understood with people and communities, clinical expertise and environmental context. Place-based needs assessments are required that bring together the many parts of the health system around health planning and the co-design of models of care to meet identified needs. These can be enabled through collaborative governance relationships between PHNs and LHNs (but involving the broad range of services and stakeholders), to enable a systematic approach to iterative, data-driven improvements in the planning, preparing and response to disasters, health threats and their impacts.

Primary care as a data source

General practice has been identified as 'not a core function' of CDC functions in the Consultation paper (page 16). However, it is critical to recognise that primary care is integral to an effective public health, emergency and crisis response. The CDC therefore has an important role in working with PHNs in linking with primary care data and creating a consolidated platform for sharing and displaying local population health data that could be used by communities.

[2] Smith, M. & Flack, F. (2021). Data linkage in Australia: the first 50 years. Int J Environ Public Health; 18(21):11339. doi: 10.3390/ijerph182111339

[3] Gordon, J., Miller, G. & Britt, H. (2016) Reality check – reliable national data from general practice electronic health records. Deeble Institute for Health Policy Research, AHHA, https://ahha.asn.au/publication/issue-briefs/deeble-institute-issues-brief-no-18-reality-check-reliable-national-data

[4] Hardie, T., Horton, T., Thornton-Lee, N., et al. (2022). Developing learning health systems in the UK: Priorities for action. The Health Foundation and Health Data Research UK. https://doi.org./10.37829/HF-2022-I06

The value of such an approach was demonstrated through the pandemic through use of GP practice software systems for real-time communicable disease surveillance and improved targeting of resourcing and responses. Two examples include:

- Gold Coast PHN's use of the digital solution Primary Sense, subsequently adopted by 10 PHNs. Primary Sense provides communicable disease surveillance through real time notifications of disease outbreaks as they are coded into GP practice software systems, and can be reported at PHN level. During COVID-19, this enabled Gold Coast PHN to maintain live heat maps of the Gold Coast outbreaks to inform planning and response.
- Gippsland PHN's use of POpulation Level Analysis and Reporting (POLAR) program. A model was developed that utilised pathology ordering, COVID-19 related diagnoses, indication of COVID-19 related concern and incorporated state based actual confirmed case figures. It was able to deliver real-time data feeds to practices, PHNs and other agencies. This allowed development of COVID-19 geographic risk stratification and supported PHNs to better target and respond with PPE allocation and pop-up clinic placement.[5]

As has the AIHW, the opportunity for the CDC to be a non-member participant of Primary Health Insights should also be explored. Primary Health Insights provides PHNs with a secure, private environment for the generation of new intelligence. Further work is now occurring to potentially enhance the ability to undertake predictive analysis and risk stratification at a practice and regional level lead to more pro-active and targeted care interventions at an individual and population level. Given current barriers[6] to accessing and using primary care data, this is likely to provide an important mechanism for accessing and analysing data to inform the work of the CDC.

[5] Pearce C, McLeod A, Supple J, Gardner K, Proposch A, Ferrigi J 2022, Responding to COVID-19 with real-time general practice data in Australia. Int J Med Inform. 157:104624. doi: 10.1016/j.ijmedinf.2021.104624. Epub 2021 Oct 29. PMID: 34741891; PMCID: PMC8564317.

[6] Canaway R, Boyle D, Manski-Nankervis J, Gray K and MACH (2020). Primary Care Data and Linkage: Australian dataset mapping and capacity building. A report from the Melbourne Academic Centre for Health for the Australian Health Research Alliance, Melbourne, Australia.

NATIONALLY CONSISTENT AND COMPREHENSIVE GUIDELINES AND COMMUNICATIONS

11. How can the CDC establish itself as a leading and trusted national body that provides guidance to governments based on the best available evidence, and participates in generating that evidence?

- To what extent should the CDC engage with the media, public messaging and health communications directly or via other existing structures such as Australian and state and territory health departments?
- What could the CDCs broader role be in increasing health literacy to support sustained improvements in health outcomes?

12. To what extent should the CDC lead health promotion, communication and outreach activities?

13. Are there stakeholders outside of health structures that can be included in the formulation of advice?

- What kind of mechanisms could be developed to support broader consultation on decisions when needed?

The COVID-19 pandemic has highlighted the need for an independent trusted voice on issues of disease control and prevention to provide credible guidance based on the best available evidence to governments, service providers, communities, and stakeholders. The CDC, established with a level of independence from government, should fulfill this role.

The following principles should inform the CDCs approach to communication and the development of national consistent and comprehensive disease control and prevention guidelines:

Credible – decision making must be transparent, take into account the best available clinical, epidemiological and public health evidence and be underpinned by authentic, collaborative relationships across all sectors, jurisdictions and stakeholders. Timely communication of emerging evidence to the health and community sectors in times of crisis must be a priority.

Harmonised – nationally consistent communication on issues relating to disease control and prevention must be underpinned by strategic communication priorities, agreed between all governments. This will prevent mixed messaging being communicated across the various jurisdictions creating public confusion. Communication must be reliable, while also recognising that information can and will evolve. Messaging must be accessible and equitable with trusted health and community voices engaged to co-develop communications to address the unique needs of (and reach) Australia's diverse communities and individuals. This should be underpinned by cross sector collaborations to promote accurate content.

Trusted – the CDC must have a level of independence from government to allow it to become a trusted voice on issues of disease control and prevention. It must become a coordination point for trusted accurate sources of information and advice. This will require developing relationships across the various jurisdictions, sectors and stakeholders, leveraging existing capabilities and supporting the integration of locally relevant health information.

Co-design – community engagement must be a key priority in the formation of CDC guidelines and advice and its approach to communications. Advice should be co-designed with communities to ensure that it is tailored to gender, preferred language, a diversity of educational and health literacy backgrounds, at-risk populations, and local culture. Diverse concerns of communities must be acknowledged, and community voices empowered to address those concerns (e.g., vaccine hesitancy within some CALD communities in response to COVID-19 vaccine was best addressed by upskilling local community members to provide vaccine information)[7]. Community members should be supported by the CDC to use their own strategies to communicate via trusted messaging systems where appropriate.

Efficient – The experience of receiving and accessing advice from the CDC for communities, health, social and community service professionals, governments, response coordination agencies and service provides should be simple, easily accessible and efficient.

WORLD-CLASS WORKFORCE

15. **How could a CDC work to ensure that our public health workforce is prepared for future emergencies, both in Australia and abroad?**
16. **How could the CDC support and retain the public health workforce in reducing the burden of non-communicable disease?**

An Australian CDC should support the development of a public health, community and emergency response workforce that support person-centred service delivery and community led emergency responses that are accessible and address population health, disease prevention, promotion and protection needs effectively and efficiently.

Leadership is needed to proactively redefine traditional ways of working to prioritise more coordinated response planning and service delivery that is respectful of and responsive to the preferences, needs and values of communities. For example, the primary care workforce has traditionally been left out of planning and preparing for disasters, health threats and their impacts. Given the unique local knowledge and established community relationships held by primary care this demonstrates an inefficient workforce approach.

This is supported by Recommendation 15.2 of the 2020 Royal Commission into Disaster Management Arrangements, which states:

[7] Abell, B 2021 'Evaluation of a collective response initiative to engage CALD communities in COVID-19 health communication', Australian Centre for Health Service Innovation, Available: https://www.refugeehealthnetworkqld.org.au/wp-content/uploads/2021/09/COVID-communication-report.pdf

> *"Australian, state and territory governments should develop arrangements that facilitate greater inclusion of primary healthcare providers in disaster management, including: representation on relevant disaster committees and plans and providing training, education and other supports"*[9]

Therefore, a key focus of the CDC should be to work with the Commonwealth, State and Territory governments to establish a coordinated strategic public health workforce approach that builds on existing workforce capabilities (e.g., state and territory emergency response capability and PHN local primary care coordination capacities), strengthening them through creating space for relationship building and workforce collaboration.[8] A key part of this should be a process of co-designing nationally consistent public health workforce priorities to ensure all jurisdictions are working towards the same desired outcomes.

Additionally, a priority of the CDC should be to protect the physical and mental health of the workforce, particularly those professionals responding to current and emerging disease threats and disasters. This should be achieved through both providing training and resources for the public health workforce, that does not supplant existing state and territory training, but further develops the capability of the public health workforce and ensures nationally consistent approaches including emergency responses (as outlined in the discussion paper on pg. 29). National emergency and scenario exercise programs would further strengthen Australia's workforce capacity to respond to both local and international health threats. Resources and support programs should also be developed and held by the CDC to support the workforce post disasters and urgent disease threats to address the mental health and emotional impacts of participating in emergency responses.

In addition, AHHA supports the proposed CDC workforce roles of mapping the public health workforce to better understand gaps, regulatory barriers and aid in future planning; and for the CDC to develop and maintain a permanent register, and training, for a reserve of public health workers who can be surged in times of crisis. Diversity of profession (including both clinical and non-clinical skills), expertise and experience should be a critical focus of any workforce recruitment and development.

[9] The Royal Commission into National Natural Disaster Arrangements, Royal Commission into National Natural Disaster Arrangements Report, October 2020. Available: https://naturaldisaster.royalcommission.gov.au/publications/royal-commission-national-natural-disaster-arrangements-report

[8] Comfort, L K, Boin, A, & Demchak, C, C 2014, *Designing resilience: Preparing for extreme events*, University of Pittsburgh Press.

RAPID RESPONSE TO HEALTH THREATS

17. **What role could the CDC play in greater national and international collaboration on One Health issues, including threat detection?**
18. **What are the gaps in Australia's preparedness and response capabilities?**
    - Could the role of the National Incident Centre be modified or enhanced?
    - What functions should a national public health emergency operations centre deliver to strengthen Australia's coordination of health emergencies?
19. **How can the CDC position Australia, mindful of global, regional and local expertise, to be better prepared for future pandemics, health emergencies, and other public health threats?**
    - What could our contribution to global preparedness look like?

The CDC should become a national central intelligence and coordination agency responsible for leading Australia's response to emerging and existing health threats. This should include coordinating with international agencies to build on existing and establish new, information and intelligence sharing networks.

A key element of the CDC role should include becoming a trusted source of truth where organisations, communities and individuals can go to access up to date evidence-based information and advice to enable them to response to emerging health threats safely and effectively. The CDC should also perform this role on a national and international scale, amplifying and sharing local expertise and best practice responses to health threats and disasters within the global and regional community to inform global preparedness.

Australia's capacity to respond to health threats and disasters should be informed by regular multisectoral, cross jurisdictional and integrated response planning and preparation activities that include all impacted parties (e.g., primary care). Providing regular opportunities for representatives across all jurisdictions, communities, regions, sectors and industries together to plan, build skills, share knowledge, practice responses and establish trusting relationships that can be called upon in times of disaster, will be critical. Creating space for problems and processes to be continually re-examined and reviewed will promote innovation, trust and continuous improvement, enhancing societal resilience and Australia's response capabilities.[9] The CDC should also ensure Australia is contributing to these types of activities within the international arena where relevant and appropriate.

The CDC should act as a central hub for collecting, analysing and sharing data, information and learnings from the global and regional community, that can be used to inform local planning and enhance Australia's response capability. In this way, the CDC could seek to establish a leaning system in pulling together data, experiences and evidence from various sectors, jurisdictions and nations in a

[9] Comfort, L K, Boin, A, & Demchak, C, C 2014, *Designing resilience: Preparing for extreme events*, University of Pittsburgh Press.

more organised way to facilitate shared learning and the rapid dissemination of emerging evidence and new ideas. [10]

LEADERSHIP ON PREVENTIVE HEALTH

21. How can the CDC foster a holistic approach across public health, including the domains of health protection, and promotion and disease prevention and control?

22. What role could the CDC have in implementing the goals of the National Preventive Health Strategy?

The Australian CDC should provide the independent leadership necessary for a whole-of-systems approach to implementation of the National Preventive Health Strategy[11]. AHHA supports the idea, outlined in the Consultation Paper, that an expert-led governance mechanism within the CDC could provide the platform for a whole-of-systems approach to prevention that is evidence-based, promotes health equity, and provides advice on current, emerging, and future priorities in prevention.

To foster a holistic approach across public health, cross-sector coordination and engagement is needed, informed by evidence, local and international experience and co-designed with people and communities. A life course approach to prevention that addresses the wider determinants of health is also required. To be regionally responsive, place-based preventive health solutions should be designed in partnership with local communities.

PHNs play a key role in population health planning, health governance and cross sector coordination. They have also demonstrated great capacity to effectively coordinate emergency and pandemic response over recent years. Governance and funding mechanisms are needed that build on the existing planning, coordinating, and commissioning capacities of PHNs to embed prevention as a core element of their work, as well as support the work of an Australian CDC.

The CDC should provide stewardship in assessing the efficacy of preventative health measures. This should involve the development of a framework and implementation plan for evaluating preventive health interventions consistently in terms of the outcomes they achieve for people and communities, as well as economic and environmental impacts or costs. In addition, a CDC should establish a central repository of evidence, resources and case studies that can be used for quality improvement and capacity building.

[10] Haride, T., Horton, T., Throton-Lee, N., Home, J., Pereira, P 2022, Developing learning health systems in the UK: Priorities for action, The Health Foundation, viewed 3 November 2022, https://www.health.org.uk/publications/reports/developing-learning-health-systems-in-the-uk-priorities-for-action

[11] Commonwealth of Australia (Department of Health) 2021, National Preventative Health Strategy 2021-2030, Available at: https://www.health.gov.au/sites/default/files/documents/2021/12/national-preventive-health-strategy-2021-2030_1.pdf

WIDER DETERMINANTS OF HEALTH

24. How could the CDC work in partnership with at-risk populations and associated health sectors, including First Nations people, people with a disability and older Australians, to ensure their voices are included in policy development?

- How could the CDC meet the intent of Closing the Gap?

25. How can the CDC best deliver timely, appropriate, and evidence-based health information to culturally diverse and/or at-risk populations?

26. How should the CDC engage across sectors outside its immediate remit (including portfolios with policy responsibility for wider determinants of health, culture, and disability)?

A CDC should leverage existing relationships, networks and engagement mechanisms of health, social, community and environmental stakeholders.

Numerous existing local organisations (e.g., PHNs, Aboriginal Community Controlled Health Organisations (ACCHOs), local government, community health services and more) have existing relationships and engagement mechanisms that could be leveraged by the CDC to inform both top down and bottom communication and information sharing processes

Harnessing these established place-based community consultation structures would allow the CDC to efficiently and effectively connect with communities to better understand need and how they are impacted by health threats and the wider determinants of health. They would also provide a credible and trusted mechanism to allow the CDC to deliver timely, appropriate, and evidence-based health information to culturally diverse and/or at-risk populations.

Leveraging existing partnerships will avoid duplication and mitigate the difficult and time-consuming task of having to establish trusting and meaningful relationships. It will also help to reinforce and strengthen these existing partnerships, maximising their outcomes and making them more meaningful to the people involved.

RESEARCH PRIORITISATION

27. Should the CDC have a role in advising on (or directly administering) funding or prioritisation of public health and medical research?

The pre-existing research funding bodies around the nation should be first acknowledged before the functions of these organisations are duplicated with the proposed CDC. Rather, the CDC, in collaboration with the research community, will be well placed to provide advice on macro challenges and opportunities facing the Australian health system.

In this regard, the CDC should act as a national coordinating and research prioritisation body, to contribute to advice to those areas of public health and medical research in the national interest. The CDC should be funded appropriately and this funding ring blocked, to provide this role.

In the wake of COVID-19, research focused on health systems and health economics is urgently needed to identify those patterns within the health system required to manage systems shock,

including natural disasters and existing longitudinal challenges (chronic diseases, increasing health system costs).

The CDC would be well placed to provide significant advisory insight in the advancement of public health and medical research in Australia.

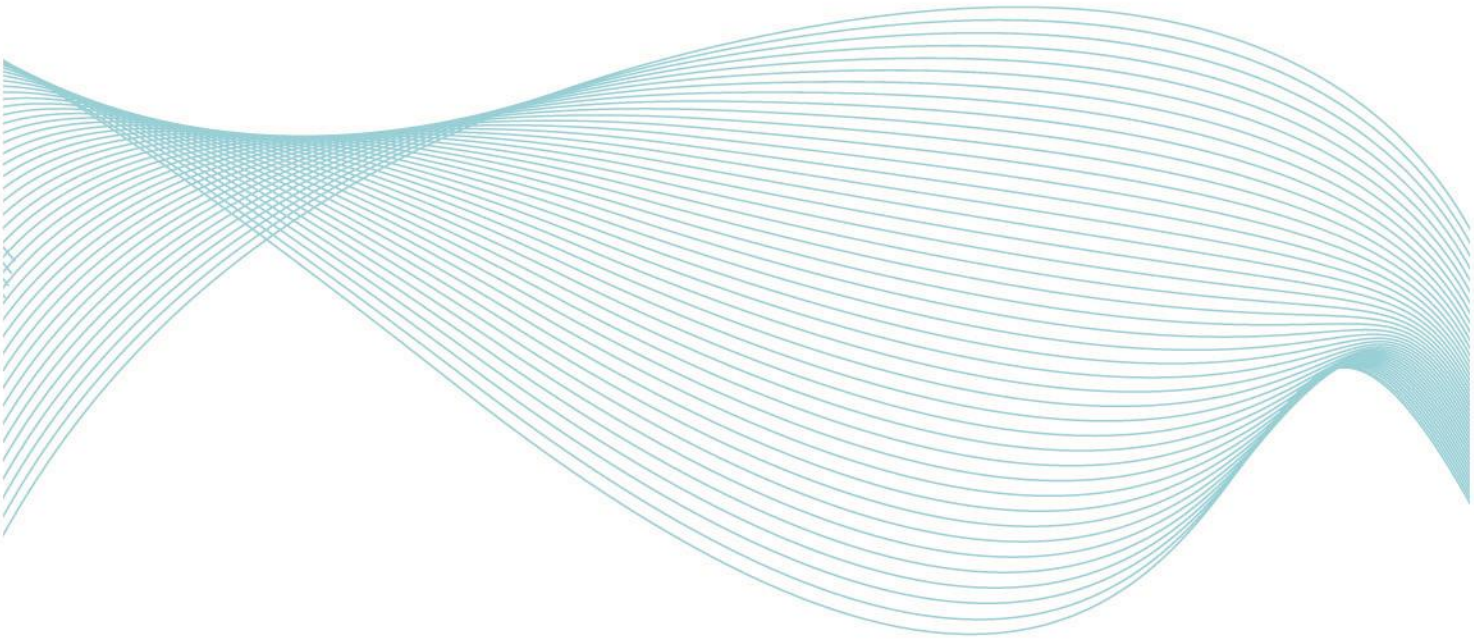
THE CDC PROJECT

28. How could the success of a CDC be measured and evaluated?

Evaluation and measurement must be a fundamental component of the design and implementation of an Australian CDC, embedded from its inception, not added retrospectively as an afterthought. Evaluation processes and timelines must be fixed within governance structures to ensure accountability with regular reviews of targets and metrics mandated to promote continuous improvement.

Measurement targets and metrics should be co-designed with communities and stakeholders to ensure that they are meaningful and focused on the outcomes that matter to people and communities; and that measurement of these outcomes is achievable and does not create unnecessary additional administrative burden for those involved in data collection and reporting.

It will also be important to ensure that the measurement targets and metrics complement, and do not duplicate, existing metrics and targets (e.g., National Preventative Health Strategy). Where relevant, the CDC should seek to adapt and build on existing measures to establish national consistency, with everyone working towards shared outcomes.



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