Australian Nursing and Midwifery Federation

SUBMISSION TO THE AUSTRALIAN GOVERNMENT CONSULTATION ON THE ROLE AND FUNCTION OF AN AUSTRALIAN CENTRE OF DISEASE CONTROL (CDC)

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INTRODUCTION

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial, and political interests of more than 320,000 nurses, midwives, and carers across the country.

Our members work in the public and private health, aged care, and disability sectors across a wide variety of urban, rural, and remote locations. We work with them to improve their ability to deliver safe and best practice care in all of these settings, fulfil their professional goals, and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

FUNCTIONS OF THE CDC

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?*

The ANMF agrees with the Department's intention to establish a CDC that fulfills the following design principles: fit for purpose for a federated system, improved pandemic preparedness, 'all hazards' approach, access to quality data for decision and policy making, avoidance of duplication and maximisation of efficiencies, success through co-design and consultation, and establishment of a trusted national source of information and advice underpinned by effective governance and certainly of funding. Likewise, the details proposed within the CDC's draft Mission Statement and Purpose are also sound. The ANMF highlights however, that while sound, the length, detail, and complexity of the Mission and Purpose Statements could be simplified and streamlined further when the exact scope, form, and function of the CDC is decided and finalised.

The ANMF agrees with the need and benefit of establishing an Australian CDC as well as with the statement that the functions, scope, and benefit of a CDC will be dependent on a budget and governance structure that is sufficient, sustainable, and fit for purpose.

As described in the Discussion Paper, a key aim in the establishment of a CDC is to avoid duplication and maximise efficiencies. This might involve taking on responsibilities that are currently under the purview of other organisations or bodies. The ANMF recommends that though environmental scanning and evaluation occur to identify what responsibilities could be better managed by the proposed CDC. As noted, these are those what would benefit from national coordination models and approaches.

The ANMF highlights that in some cases, the provision of advice will not be sufficient to engender the necessary changes and reforms that Australia needs in order to be prepared for future health risks. For example, during the pandemic a great deal of advice was produced by the Aged Care Quality and Safety Commission, the Australian Department of Health, and the State/Territory Departments and Ministries of health among others regarding the use of personal protective equipment (PPE). Much of this advice was inconsistent or unclear and further, in many cases wasn't supported by regulation and enforcement. This means that many sites across aged care and beyond are still not adequately compliant with best evidence-based practices. The proposed CDC will need to work with both health and work health and safety (WHS) regulators to ensure that there is enforcement of identified safety standards within the health and related sectors to ensure the safety of workers and patients/residents/broader community.

The ANMF supports the suggestion that the proposed CDC should provide a coordinating and advisory function. Policy and regulatory levers, both Federally and in each State and Territory, should allow for adequate response to health emergencies while maintaining current independence of health services. Any existing activities the proposed CDC directly takes on should be to add value where improvements in coordination and efficacy are needed.

The ANMF agrees that current decision-making responsibilities fulfilled though the health sector committee model's Australian Health Protection Principal Committee could be effectively coordinated in the future through the proposed CDC and that the potential benefits of this approach could be consistent with those described on page 18 of the Discussion Paper. As identified, success in this regard will be in part dependent on the capacity and willingness for the proposed CDC to engage genuinely and effectively with multiple stakeholders and knowledge users. Here, it will be of critical importance that the proposed CDC establish and sustain clear, formal, and regular engagement with organisations, peak bodies, and representatives for Australian and international nurses, midwives, and personal care workers. This is the largest group of health care professionals in Australia and the largest component of the healthcare workforce working at the front line of disease protection, control, treatment, and care. The ANMF looks forward to working closely with the Department to further guide and inform policy and planning regarding the proposed CDC's decision-making, coordination, and advisory capacities to ensure a sustainable, effective, and future proof approach to responding to health emergencies and other disease risks facing Australia and our international community.

In relation to newly emergent threats to health and wellbeing, the COVID-19 pandemic highlighted the need for coordination and collection of health data, surveillance of health systems and indicators for health, and evaluation and analysis of data. The ANMF recommends that the proposed CDC should include responsibility for this within its function and capacity. There is a need for real-time healthcare workforce data and projections, however, this is understandably not an intended core function of the proposed CDC. The proposed CDC should include an emergency preparedness and response role. With an appropriate structure, and a requirement for roles to be held by nurses and midwives, there would be the appropriate experts to lead and advise in health emergencies. The COVID-19 pandemic exposed a grossly inadequate national medical stockpile, requiring response from states and territories. There continue to be serious concerns for the availability of, for example, appropriate personal protective equipment in private residential aged care. Government needs to address this and a CDC, with the appropriate structure and composition, should be responsible for this.

The ANMF recommends the following further decision-making responsibilities;

- That the proposed CDC must possess a standard advisory function to the Federal Health Minister and other State/Territory ministers through the Council of Australian Governments (now National Federation Reform Council (NFRC)/National Cabinet).
- Currently, coordination appears to involve a range of stakeholders at the national and state level with a range of jurisdictional issues. It could be said that in the absence of an existing CDC, the State and Commonwealth Chief Health Officers have become the 'de facto' CDC. However, their policies often vary based on political influences as we found during the COVID-19 pandemic. A CDC would aim to be independent from political interference and the proposed CDC should take on a coordination role for national disease outbreaks as well as a screening role for performing risk assessment for future pandemics or outbreaks and the establishment of standards for the management of disease outbreaks. This would also enable a baseline against which to measure the effectiveness of responses, support consistent messaging around guidelines, and prevent ambiguity over health measures (e.g., use of masks and personal protective equipment, quarantine requirements, etc.)
- The proposed CDC should also engage in reviews of legislation to ensure that State/Territory legislation complements Commonwealth legislation to be able to work more effective and address any jurisdictional issues (e.g. border restrictions).

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?

An appropriately and well-resourced CDC should have the capacity for and responsibility of promoting and coordinating a One Health framework. Likewise, there is clear connection between the health and wellbeing of the Australian community, our shared environment and the health of animals. The proposed CDC must be appropriately resourced to collect data on, evaluate, advise, and educate, and implement strategies with respect to a One Health framework. The ANMF agrees with the proposed CDC functions as described in Table 1 (page 18) of the Discussion Paper and recommends that based on Australia's poor performance regarding protection of older people and staff in the residential aged care sector, the proposed function around 'emergency response in long-term care facilities' should be moved from 'possibly in scope' to 'in scope'.

As it is understood that the proposed CDC is unlikely to be able to take on every activity immediately upon establishment, the ANMF recommends that the list of 'in scope', 'possibly in scope', and 'not a core function' activities be periodically reviewed to ensure that priorities remain current. The ANMF also highlights that while activities such as 'workforce reform' and 'other workforce issues' are currently listed as 'not a core function', the proposed CDC would be a valuable and effective advocate for provision of evidence-based advice and information for how Australia should proceed with widespread workforce reform as a necessary part of preparedness for future threats to One Health.

The proposed CDC should provide governance and oversight of the One Health Framework, consisting of human health, animal health and the environment, to relevant parties, including Federal, State and Territory health services to assist in enhancing coordination and health outcomes. It is important that this does not place additional burdens on an already stretched health care system. For the proposed CDC to function effectively, in collaboration with health services, State and Federal Government need to ensure the health system is adequately staffed, funded, and resourced. Likewise, the CDC needs to be adequately staffed funded and resourced.

Important activities the ANMF also recommends be considered as 'in scope' are:

1. Planning and coordinating a national public health response to health disaster management, which includes communication and messaging of the health response and acting as the 'source of truth'.
2. Public health including general public health promotion and prevention strategies.
3. Health data collation, analysis, and reporting.
4. Health care improvement including evidence based practice.

Activities the ANMF suggest might not be considered within the scope of the proposed CDC are:

1. Single State/Territory disease outbreaks should be managed by the affected State/Territory (with involvement of the CDC or CDC Branch Office). It should not be the remit of the proposed CDC to coordinate a State/Territory response, however, the CDC must be involved due the national implications.
2. Natural disaster management (e.g., bushfires), as there are already agencies that deal with such matters. However, coordination with these agencies on the health impacts of natural disasters on an advisory basis (e.g., long-term effects of smoke inhalation) could be within scope.

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 ANMF highlights that in order to ensure public confidence in the proposed CDC, a clear evidence-based ethos and approach must be implemented and adhered to. Here, it is unclear how the need for the proposed CDC to balance government responsiveness and accountability against the provision of trusted, authoritative, evidence-based advice has been characterised. We are uncertain why these two concepts have been posed as somehow in opposition to one another. The proposed CDC needs to operate in an evidenced based framework that is guided by the latest science and research and communicates this in a timely and clear manner. To this end, and to ensure the proposed CDC maintains its aims and objectives, it is important that the CDC be independent of undue political influence while still being accountable to the Australian Government and the Australian public. Further, the ANMF highlights that in areas where evidence is scant or emerging (as with the COVID-19 pandemic), the CDC would be well placed to develop evidence informed precautionary principles to be applied in relation to controls for emerging diseases in the absence of comprehensive or equivocal empirical evidence.

The ANMF seeks genuine commitment from Government to setup a well-resourced and sustainable CDC that can effectively carry out its functions and responsibilities, without being hampered by uncertain and/or insufficient funding. Trust in the CDC to provide evidence-based policy and recommendations is paramount to ensuring public confidence is built and maintained. Reporting requirements to government are reasonable and necessary, and public disclosure of such reports paramount to ensuring transparency. To underpin the culture of accountability and trust this is so important for the success of institutions/agencies such as this.

The proposed CDC must include nursing and midwifery positions in both the administrative and executive arms (however titled) of the agency. Nurses and midwives are the largest healthcare workforce in Australia and deliver care in all settings, across all locations. There must be sufficient positions dedicated to those who hold registration with the Nursing and Midwifery Board of Australia. Nursing and midwifery positions must include positions in, governance/executive/leadership, education, research, administration, planning, quality and risk, and other areas. Nurses and midwives already engage with counterparts at an international level and are well placed to hold positions responsible for international engagement and coordination. The ANMF also highlights that positions to executive and committee (however titled) of a CDC should be independent, and not by ministerial appointment or recommendation.

The ANMF considers independence from government and sustainable, sufficient funding to be extremely important to the successful function of the proposed CDC. Future governments should not be able to undermine the credibility of the proposed CDC in ways similar to what was reported in the United States under the previous Republican Government. It is vital that the proposed CDC is immune from political interference. This could be achieved by establishing the CDC as an independent statutory authority, so that it cannot be directly influenced by political parties. However, it should have public reporting requirements to enable transparency, and accountability by reporting back to the Federal and State Health Ministers (through National Cabinet or an associated process).

It is important that the voices of all states and territories are heard, and that the proposed CDC effectively collaborates with all states and territories. In terms of how the proposed CDC should best meet the needs of Australia's federated system, it will be vital that all States and Territories, including external territories (i.e., Ashmore and Cartier Islands, Australian Antarctic Territory, Christmas Island, Cocos/Keeling Islands, Coral Sea Islands, Heard and McDonald Islands, and Norfolk Island) be engaged in a manner that ensures equity and appropriateness to each context. This might necessitate the proposed CDC establishing 'Branch Offices' or teams to represent these different groups.

WHY DO WE NEED A CDC? A COORDINATED AND NATIONAL APPROACH TO PUBLIC HEALTH:

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?

In order to ensure effective collaboration and exchange of information across the necessarily wide range of multidisciplinary and multi-sector stakeholders needed to achieve the mission and intent of the proposed CDC, clear and workable governance structures, collaborative agreements, and legislation will need to be put in place including legislated requirements on public reporting and consultation. The ways that the proposed CDC will be able to work with external stakeholders is likely to be quite different, as many stakeholders will be from disparate areas and disciplines. The proposed CDC will need to be flexible and have the capacity to engage across a variety of disparate areas, so thus will need a range of in-house expertise and networks.

The ANMF highlights that in order to engage effectively, it must be ensured that key stakeholder/expert groups have a strong voice within the CDC. This means that large groups of the healthcare workforce, most of who are nurses, midwives, and assistants in nursing/personal care workers/aged care workers must be represented. We recommend therefore, that nursing/midwifery have clear representation within the CDC.

The COVID-19 pandemic has demonstrated that Australians expect government to play a key role in protecting, advancing, and advocating for the health of all Australians. There are urgent challenges facing our healthcare system, particularly with respect to access and delivery of primary health care, private residential aged care, and disability services. Fragmentation, and privatisation of the Australian healthcare system has negatively impacted the community's ability to engage with and navigate healthcare services, and arguably a decline in the standard of health service received. To ensure the proposed CDC is effective in engaging with all relevant stakeholders there could be consideration for an agenda of legislative reform that would ensure private providers are transparent in operations, and accountable to regulators/regulatory requirements, and policy as set by a CDC. Further consultation on this would be required.

The ANMF highlights that the proposed CDC could provide value by acting as a conduit to improve communication and coordination between relevant State/Territory, Federal and international stakeholders, including unions, advisory and regulatory organisations, the private and public sectors, and academia and research to work together, in response to pandemics and to address other issues impacting on health such as the ongoing impacts of climate change and other aspects of health within the proposed CDC's remit. The proposed CDC needs to ensure it engages with a broad range of community groups including Indigenous, CALD and people with disabilities communities. The Department of Health Stakeholder Engagement Framework is a useful tool the proposed CDC could use to guide and inform the engagement process.

The COVID-19 pandemic demonstrated and highlighted the need for a CDC given the large number of Commonwealth and State/Territory stakeholders in the response. The proposed CDC should be established and promoted as the peak public health body in Australia, with links to the health sectors in States and Territories. Queensland used to have a State-wide public health unit, however this was dismantled during the term of Premier Campbell Newman. The responsibilities were then delegated to individual Hospital and Health Services when the system of devolved governance was introduced. The ANMF recommends that that State/Territory-based public health units need to be reinstated, in part to support the proposed CDC. The ANMF also recommends that the Communicable Diseases Network Australia (CDNA) needs to either report into the proposed CDC or become a branch of the CDC. It must be adequately funded and resourced to carry out its functions. However, this should come with an expansion of its scope, as CDNA currently only reports on diseases, not conditions (e.g., adverse events following immunisation or lead poisoning). This would include monitoring Long COVID.

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?

While the proposed CDC will not be responsible for workforce issues, the ANMF highlights that workforce issues do not exist in a vacuum and impact response to emergencies and pandemics. When setting up the proposed CDC the Government needs to be holistic in its approach to ensure there is capacity for the CDC to be effective when coordinating a response to pandemics and other health issues within its scope. Beyond the need for a surge workforce, the pandemic highlighted already existing systemic issues around lack of suitably qualified staff to provide care related to core business, let alone effectively and safely respond to a pandemic. While these issues exist across the health care system, the aged care sector can be used as an example. The ANMF, in our submissions to the Royal Commission into Aged Care Quality and Safety, highlighted the issues and what needs to be addressed to equip the sector to respond to a pandemic, including: assessing gaps in workforce numbers and training, including the likelihood that more staff would be necessary to deliver care during the pandemic; access to PPE and training in its proper use; lack of clinical skills, especially in infection control; deficits flowing from the absence of skills related to infection control in the case of personal care workers that are taken for granted in the health sector; the challenges of achieving high level infection control in a homelike setting; deficiencies in governance and managerial ability; the significant operational differences between aged care facilities and hospitals; the challenges associated with the interface with the State/Territory health sectors. Learnings from the pandemic include the need for a pandemic response plan, across all health sectors and beyond, which the proposed CDC could coordinate. The response plan needs to take into account existing workforce challenges, including staffing levels, skills mix, training needs and knowledge deficits. The proposed CDC should report to Government and stakeholders about the deficiencies that limit effective and timely response.

It became evident early in the pandemic that a national response was required. This led to the establishment of the National Cabinet, which in some ways could be said to have functioned like a quasi-CDC. Also, there was a need to establish networks or communication pathways with key stakeholders, for example, through regular meetings or reporting requirements. Had a CDC been in place, these communication pathways would have likely existed already.

In developing the CDC it will be important to ensure that all appropriate and available evidence is identified and assessed against the criteria and principles of design that have been outlined. This will include the undertaking of robust and rigorous evidence synthesis to ensure that no important evidence, locally produced or otherwise, that would be of assistance in the development of the CDC is overlooked. There is a significant body of literature that has been published over the course of the last few years that provides useful insight into the many and wide-ranging aspects of disaster and pandemic preparedness, and a thorough assessment of this evidence will guide the successful development and function of a national and coordinated approach to disease control. This work should be undertaken by independent and experienced evidence synthesist and policy analysts.

The ANMF also highlights that Appendix C of the Discussion Paper does not appear to include sufficient representation from the nursing and midwifery workforce. The Australian Nursing and Midwifery Federation, as a leader in representing the industrial and occupational health and safety interests of members but also as a peak professional body, is well placed for continued engagement and consultation on the proposed CDC.

A DATA REVOLUTION

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

Jurisdictional issues across the States/Territories and country appear to be one of the main barriers to achieving timely, consistent and accurate national data. It has been identified in the consultation paper that there exists a lack of cohesiveness between electronic systems and between federal, state and territory systems. The National Notifiable Disease Surveillance System not being interoperable with the states and territories is correctly identified as an impediment to achieving timely and accurate data. The CDC could take the lead and play a vital role in setting up a fit for purpose system of disease surveillance that can provide, in real time, information to inform and assist timely response to disease outbreaks and to better inform and evaluate policy and programs to improve health outcomes. There are currently multiple disparate systems for data collection and hence the datasets cannot be easily integrated or analysed from a national perspective. For example, the National Notifiable Diseases Surveillance System (NNDSS) notes that the information it receives is of varying quality and completeness, because “notifications come from various sources, including clinicians, laboratories and hospitals” and “states and territories have different ways for these sources to report cases.” There is therefore a need to scope out and identify the data gaps, and what systems or processes need to be developed to enable standardised reporting across jurisdictions. It is suggested that an early task of the proposed CDC would be to develop a plan to address data collection and accuracy of data needed for the CDC to achieve its remit.

The proposed CDC would work with the Australian Digital Health Agency in overcoming technological barriers to achieving timely, consistent, and accurate national data.

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?

The Discussion Paper suggests the proposed CDC could provide "a sustained funding model to enhance the capability of public health laboratories and public health units to fully integrate microbial genomics data and metadata into surveillance systems for analysis at jurisdictional and national levels". Enhancing these capabilities and interfacing them with a CDC would be a good use of existing resources in a manner that enhances the identification of emerging risks in a timely manner. The ANMF agrees that the development of a national data plan with an agreed scope and/or an evidence- based health monitoring framework be a useful task for the proposed CDC. The proposed CDC providing access to analysis of data from existing data sets including immunisation, aged care, hospitals, primary care, My Health Record, MBS and PBS, ABS census and mortality data, economic and employment data would be useful to inform policy, program development and improve use of available resources. As the Discussion Paper suggests, "a single national surveillance and outbreak management system, with national identifiable data and local connections to every jurisdiction, allowing for greater national consensus, enhanced detection and investigation of multi-jurisdictional disease outbreaks, and consistency in reporting. This would include appropriate governance and security of collected data and allow for clearer identification of outbreaks and trends for all infectious diseases in long-term care and other at-risk settings and potential linkage with other health data such as use of treatments or access to primary care". This would dramatically improve the current, fragmented system.

In the Victorian context, there is the Health Legislation Amendment (Information Sharing) Bill 2021, (note recent caretaker period). This Bill recognises that consolidation of patient medical and health history is essential to safe and quality care. There are additional protections contained within this Bill for vulnerable groups. Review of this Bill is recommended and the opportunity for analysis of deidentified data via this or other means would be a suitable activity for the proposed CDC.

The ANMF also recommend that data on Long COVID be collected as a matter of priority. Further, the ANMF suggests the development of an automated 'red flag' system that is able to quickly and efficiently identify standard deviations (e.g., increased frequency of notifications) and the current system can be a slow and time-consuming manual process.

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

The ANMF highlights that data security is rightly a significant concern among the community following the data breaches from Optus, Medibank, and WhatsApp. The proposed CDC must be able to provide the public with a high level of assurance that their data will be secure, especially given the proposal to access MyHealth records as part of their data collection and analysis.

The ANMF also highlights that the proposed CDC needs to be adequately staffed to provide timely advice and include staff qualified in data analysis. It is important that when developing guidance, that broad consultation occurs with relevant stakeholders across industry and government. Experts across disciplines, including nursing, midwifery, allied health, and medicine and beyond healthcare should be utilised, a multidisciplinary team within the proposed CDC would be useful in assisting with data analysis and guidance development, but not at the expense of broader consultation where appropriate.

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

To ensure that the proposed CDC has the in-house technical capability to analyse relevant data and develop high-quality, timely guidance the organisation will require a suitable budget, staffing, and information technology and systems, and linkages/networks with external stakeholders, data sources, and organisations. Likewise, if and where the proposed CDC may commission external expertise to undertake projects around data analysis and guidance, these requirements would also be necessary. The proposed CDC must offer competitive salaries to recruit people with the expertise and ability to analyse this data. Australia struggles with retention of a highly qualified workforce in STEM, as many leave for better offers overseas ('brain drain'). Further, appropriate resourcing to build, implement, and maintain technical systems is required for experts to interpret data and provide timely guidance.

It will be important that the proposed CDC has well established links and collaborations with multidisciplinary experts to ensure that the knowledge and evidence able to be provided by diverse expert perspectives can be properly considered and synthesised. Here, it will be important for the CDC to genuinely engage with a diverse range of experts including across nursing, midwifery, allied health, and beyond healthcare entirely (e.g., occupational hygienists). How this is managed and maintained (e.g., via committees, steering groups, advisory networks will need to be carefully planned, coordinated, and sustained.

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

Consultation and stakeholder engagement is key – that is, "Nothing about us without us." Nurses and midwives are already embedded in, and lead, health care systems that deliver care to all populations in Australia. Continued engagement with nurses and midwives, as well as those with lived experience, will ensure there is a collaborative and considered approach to data collection. Aboriginal and Torres Strait Islander health practitioners must be included in this consultation. There must be early engagement with First Nations people and organisations to ensure that the proposed CDC can effectively ensure appropriate collaboration with Aboriginal and Torres Strait Islander people.

The ANMF highlights that a First Nations Voice to Parliament would be an ideal way for Aboriginal and Torres Strait Islander people to provide advice to regarding policies and projects that impact their lives. Currently, policy making does not have a systematic process for Aboriginal and Torres Strait Islanders to provide advice. This often results in policy that is made *for* Aboriginal and Torres Strait Islander people rather than *with* them. Constitutional recognition through a Voice to Parliament will enable the provision of real and practical advice on how laws and policies can best improve the lives of Aboriginal and Torres Strait Islander people. This will be fundamental to the ability of the proposed CDC to effectively delivery timely, appropriate, and evidence-based health information to First Nations people. When Aboriginal and Torres Strait Islander people who know and understand the best way to deliver real and practical change in their communities have a say through the proposed Voice to Parliament, Australia will be better placed to close pernicious gaps that still exist (and in some cases, are widening) between Indigenous and Non-Indigenous Australians. In addition, the ANMF highlights that there must be acknowledgement that a 'one-size fits all' approach is not always preferable, and that having a combination of both national and local solutions to problems would enable more targeted and effective interventions.

Internet access is also an important issue to consider in terms of collaborating with diverse populations. The use of a publicly accessible website would be necessary way to ensuring collaboration with the broader population and specific population groups (in addition to disseminating information). It is important to recognise that access to the internet and online portals is not equal across society or between groups. Data regarding disparities of access between group is lacking. Unfortunately, the 2021 Census did not ask the question on internet access in households with a rationale that it was not necessary given increased mobile internet usage on personal devices outside the home. This is problematic, especially given there are locations where access to reliable mobile phone reception is problematic, particularly (but not exclusively) in rural and remote areas. In addition, access to both home internet and mobile internet cannot be assumed as universal due to economic factors. In the 2017 Census, 83.2% of households had at least one person access the internet from the dwelling. This could have been through a desktop/laptop computer, mobile or smart phone, tablet, music or video player, gaming console, smart TV or any other device. The Productivity Commission found that, nationally, in 2014-15, 73.5 per cent of Aboriginal and Torres Strait Islander people aged 15 years and over accessed the internet in their home and that there are no comparable data on home access to the internet for non-Indigenous people. This means that estimating a trajectory to achieve parity is not currently possible.

Specific groups, including First Nations peoples, could be targeted via the website or via other means. Beyond addressing access disparities to the internet for at risk groups to maximise collaboration, other modes should be undertaken including establishing relationships with Indigenous and other community groups, organisations and leaders (e.g., Land Councils and Corporations, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), various CALD community groups/leaders). Until access to the internet is truly universal, opportunities to collaborate face to face and via other non-electronic means cannot be replaced.

NATIONAL, CONSISTENT, AND COMPREHENSIVE GUIDELINES AND COMMUNICATION

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?

To be effective, the proposed CDC must establish itself as a leading and trusted national body that provides guidance to governments based on the best available evidence and an evidence-informed precautionary approach in the absence of a strong evidence base. The ANMF recommends that the CDC should be active in its engagement with the media, public messaging, and direct health communications as well as via other existing structures such as Australian and state and territory health departments and through engagement with other stakeholder groups including health professional bodies. As a bastion of evidence-based information and guidance, the proposed CDC should take on a role in guiding increasing health literacy. It is important that education be provided via public health campaigns of which the media would be a part of.

The ANMF recommends that the proposed CDC could provide a national 'one-stop shop' for trusted public health information and advice to governments as a basis for policy and decision making. The proposed CDC needs to be responsible for consistent national messaging in the event of a public health emergency. It is especially important for health professionals to have clear and consistent messaging as we know they will be at the front line of any health emergencies now and into the future. The ANMF holds concerns in relation to mixed messages around workforce issues. Our experience during the COVID-19 pandemic was that there was confusion and inconsistent messaging around healthcare worker paid leave entitlements and workforce remuneration. While this is not an area that the proposed CDC is likely to have jurisdiction over, there needs to be clearer in the event of future health emergencies and the CDC would be well placed to advise on how to effectively communicate such information clearly and consistently and in line with the best available evidence.

As noted above, the proposed CDC needs to be adequately staffed to provide timely advice and include staff qualified in data analysis. It is important that when developing guidance, that broad consultation occurs with relevant stakeholders across industry and government. Experts across disciplines, including nursing, midwifery, allied health and medicine, and beyond should be utilised, a multidisciplinary team within the CDC would be useful in assisting with data analysis and guidance development, but not at the expense of broader consultation where appropriate.

The way in which the proposed CDC is structured, funded, and resourced will impact upon its credibility as a leading national body. It is also vital that the proposed CDC establishes partnerships with other organisations or agencies at the government level, however, remains apolitical. We suggest looking to the Public Health Agency of Canada to inspire the Australian CDC model (in addition to the US CDC), given the similarities to our healthcare system and population demographics and density.

In terms of the proposed CDC's broader role in increasing health literacy to support sustained improvements in health outcomes, health literacy should include providing evidence-based, timely advice on future and emerging risks (e.g., Japanese Encephalitis)

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

The proposed CDC must identify and engage with groups already active in leading and delivering health promotion, communication, and outreach activities to recognise where the proposed CDC would be able to add value or take the lead where there are identified gaps. The proposed CDC should lead health promotion and outreach activities with decisions on which campaigns are delivered based on the scope of the CDC, and prioritisation based on urgency and analysis of need by CDC nurse/midwife and other health practitioner researchers and advisors as well as experts beyond health.

The proposed CDC would be well placed to disseminate information to improve health literacy and health outcomes in the Australian population. This could be achieved by a public facing CDC website. In addition to the use of a website, CDC-driven health information and health promotion initiatives, statements and advertorials could be broadcast via print and visual media as well as social media modalities. The proposed CDC should also work in partnership with national, State and Territory Health Departments and Ministries and other key stakeholders in developing and distributing content to improve health outcomes. Analysis of relevant data and research by the CDC will inform the development of key messages and allow for key priorities to be identified. The CDC should lead CDC identified health promotion, communication, and outreach activities of national significance, however State and Territory Ministries and Departments of Health, public health and health promotion units, and peak workforce bodies and unions should be consulted and engaged.

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?*

As recognised in the Discussion Paper, engagement with stakeholders beyond health will be foundational to the effectiveness and impact of the proposed CDC (e.g., unions, emergency services, Australian Defence Force, Community Groups, Multi-Cultural Groups, etc.,). The proposed CDC must identify and engage with these stakeholders early to establish fit for purpose mechanisms to support broader consultation on advice, policy, and decision-making. It is unclear from the consultation paper how the proposed CDC would interact with State and Territory governments, and CDC branches (if developed and instituted at State/Territory level). It is recommended that there are clear requirements for engagement and consultation on decisions with state and territory counterparts.

The ANMF highlights that unions, including the Australian Nursing and Midwifery Federation (and its State and Territory branches), should be included in the formulation of advice. In addition, nursing and midwifery specialty professional bodies should also be included. Where appropriate, focus groups representing the general-public, could be consulted in the formulation of messaging. Additionally, target groups, including First Nations peoples should be consulted. Other stakeholders that should be included are those who influence, or are involved in, goods and services that impact on the social determinants of health. This fits with One Health frameworks and includes, but is not limited to, Federal, State/Territory and local departments of planning and environment, Department of Agriculture, Fisheries and Forestry, Department of Climate Change, Energy, the Environment and Water.

NATIONAL MEDICAL STOCKPILE

What has your experience, if any, been of accessing supplies from the National Medical Stockpile (either before or during COVID-19), and can you identify any areas which the CDC could expand or improve on?

The ANMF highlights that our members working in aged care experienced considerable challenges accessing appropriate and timely PPE in the quantities required to provide safe, effective care and to protect themselves and their colleagues and families. This is evident in multiple published reports and papers and from the experience of our members. Particularly in the early stages of the pandemic, there were issues with inconsistent guidance regarding donning, doffing, and disposing of PPE with information and resources regarding fit testing and checking being particularly problematic. ANMF members have also reported issues with quality of PPE from the national stockpile including P2/N95s that are not TGA approved or have expired, lack of reliability or consistency of stock making it difficult for providers to fit test their staff as they don't know what masks they will be getting, and problems with poor sizing (may receive only extra small or extra large masks, but nothing in more standard sizes that will fit staff. Here, a proposed CDC would be well placed to improve this situation by providing a single 'source of truth' that could be trustworthy, evidence-based, and able to provide clear, understandable, consistent evidence that evolves based on emerging knowledge and understanding of precautionary principles.

Healthcare professionals and staff including nurses, midwives, and assistants in nursing/personal care workers have accessed the national medical stockpile throughout the COVID-19 pandemic. As the COVID-19 Procurements and Deployments of the National Medical Stockpile Performance Audit report found, procurement processes for the COVID-19 National Medical Stockpile procurements were largely consistent with the proper use and management of public resources. Inconsistent due diligence checks of suppliers impacted on procurement effectiveness and record keeping could have been improved. In the absence of risk-based planning and systems that sufficiently considered the likely ways in which the National Medical Stockpile would be needed during a pandemic, Health adapted its processes during the COVID-19 emergency to deploy National Medical Stockpile supplies. Large quantities of PPE were deployed to eligible recipients. Due to a lack of performance measures, targets and data, the effectiveness of COVID-19 National Medical Stockpile deployments could not be established by the review. The proposed CDC would be well-placed to develop these performance measures, targets, and data for future reviews. Further, the proposed CDC could look to the results and outcomes of this report to determine where else the CDC could contribute.

In terms of the experiences from our Victorian members, the National Medical stockpile was grossly insufficient throughout the COVID-19 pandemic and to date. In Victoria, in the private residential aged care sector (as an example), there was significant risk to residents and workers when personal protective equipment could not be sourced. In addition to this, there was unclear guidance on best-practice and limited requirements and policy directing implementation of strategies and measures to mitigate risk.

The ANMF highlights that there needs to be defined roles between State and Federal government in relation to the National Medical Stockpile and procurement of supplies from the global market. We do not want to see a repeat of the State's bidding against each other for supplies. There needs to be a national coordinated approach with an algorithm to ensure that the distribution of required supplies (medicines, PPE) is equitable amongst all jurisdictions. Further, there needs to be considerations to ensure equitable access for our vulnerable populations, including aged care, disability, First Nations people, gender and sexually diverse people (LGBTIQ+), those in rural and remote locations, and other vulnerable and special needs groups. Further to this, a robust transparent IT system is required to ensure accurate stock take of all supplies.

During the pandemic, reports from members included issues of timely access to appropriate PPE and vaccinations. This issue improved over time, however frontline workers cannot wait to keep themselves and those they care for safe and is clearly a Workplace Health and Safety issue. Information related to pandemics attributable to new diseases can change rapidly. The proposed CDC would play a role in future pandemics by ensuring systems are in place to ensure rapid response to information in real time and prompt availability of required PPE, vaccines, and up to date advice. The Discussion Paper identifies the need for a centralised point of information and resource sharing for not only States and Territories, but key sectors such as aged care which have previously had to navigate an array of state and territory, primary health networks, and federal contacts. This, along with the CDC taking leadership over the coordination and distribution of PPE, vaccine and other reserves would improve response times. Gaps in policy and other contributors to delays need to be identified and corrected.

The ANMF highlights that it is important to note that Australia does not manufacture any of the medicines on the WHO's list of key drugs, which renders the nation vulnerable to disruption in supply chains (whether natural disaster, disease outbreak, geopolitical influences, etc.). As the COVID-19 pandemic has demonstrated, active government intervention in the economy is essential to both prepare for, and manage, system shock events. The proposed CDC should review and implement policies and structures regarding:

- Coordinating a whole-of-nation response to the issue of medicines supply involving all relevant levels of government, regulators, and other stakeholders.
- Analysis of supply chains to identify vulnerabilities and build system redundancy using all the levers available to government, e.g., policy, legislation, regulation.
- Considering the establishment of a national medicines stockpile (in additional to essential medical equipment).
- Reviewing regulatory requirements for suppliers regarding early notification of medicines supply issues.

WORLD CLASS WORKFORCE

How could a CDC work to ensure that our public health workforce is prepared for future emergencies, both in Australia and abroad?

The proposed CDC must be a vocal and influential leader for ensuring that the entire health workforce and related industries are prepared for future emergencies here and abroad. As noted in the Discussion Paper, the COVID-19 pandemic has pushed an already strained workforce to the brink, with many frontline workers burned out, traumatised, and considering leaving their roles, the health sector, or their professions entirely. Without immediate planning and action, Australia's health workforce will not be prepared in the likely event of a new pandemic or significant health emergency. Likewise, with a regional and global focus and linkages, the proposed CDC will enable our health workforce and the workforces of other countries to be better prepared and able to respond effectively to emerging health threats and to advance benefits in terms of health promotion and disease prevention. The ANMF recommends periodic (yearly or bi yearly) workshops on pandemic preparedness to ensure that this remains on the radar of those responsible for health care delivery nationally.

The ANMF highlights that in order to ensure the health workforce in prepared for future emergencies, it must be ensured that key stakeholder/expert groups have a strong voice within the CDC. This means that large groups of the healthcare workforce, most of who are nurses, midwives, and assistants in nursing/personal care workers/aged care workers must be represented. We recommend therefore, that nursing/midwifery have clear representation within the CDC. Consistent education packages and policy would ensure clear messaging and guidance for healthcare workers. Positions within the proposed CDC must be held by nurses and midwives, as stated above, to ensure policy is accessible to this workforce and education is appropriately delivered.

The Discussion Paper identifies that the proposed CDC would perform mapping of the public health workforce in order to better understand gaps, regulatory barriers and aid in future planning. This would be a good first step for the CDC. During the pandemic, the Australian Health Practitioner Regulation Agency alongside the relevant National Boards established temporary pandemic registers. The proposed CDC could be involved in the examination of a permanent surge workforce system. The Australian Health Practitioner Regulation Agency (AHPRA), National Boards, Unions, and Departments/Ministries of Health should all be involved in the consultation. Issues including the development of appropriate training, appropriate professional supervision and reporting structures to ensure professional obligations, standards for practice and codes of conduct are maintained must be embedded in any surge workforce system that is developed.

The ANMF also highlight that there is a need for healthcare staff to be educated in responses to pandemics through routine preparation and practice. The proposed CDC could work with National and State/Territory Health Departments to develop and promote education and training courses or packages for the healthcare workforce and healthcare system administrators.

As noted in the Discussion Paper, workforces beyond the health sector (e.g., food production and transport, border security/immigration etc.) also must be part of a comprehensive and proactive approach to preventing, preparing for, managing, and responding to health threats. It will be important that the proposed CDC engage closely with these wider industries and workforces to coordinate and guide timely, effective, and appropriate policies, decision-making, and action.

Other workforce considerations that are also apparent to the ANMF include the need for a single register of health professionals that can quickly identify recently retired workers in the event of a public health emergency. If recently retired or previously qualified health professionals want to 're register' it should be a simple, timely process that incurs no cost to the person and perhaps even provides financial incentives. No health care worker should be disadvantaged for offering to assist.

The ANMF also highlights that the Australian workforce needs more trained infection prevention and control (IPC) specialists, increased IPC training for all workers in key sectors, and a mandated, robust fit testing and checking system for all health care workers regardless of the sector they work in. It is notable and alarming that fit testing in even health and aged care is still very inconsistent. While acceptable practices are more common in public health sectors, safe evidence-based practices are less common in private healthcare and can be rare in aged care. This contributes to ongoing and comparatively very high rates of infection in residential aged care.

The ANMF also recommend the need for amendments to WHS laws to include WHS regulation on biological hazards as well as a detailed code of practice on management of biological hazards. In addition, there needs to be improved regulator capability (both health regulators and WHS regulators).

The ANMF also recommends that healthcare workers and staff in other sectors need to know that their health and safety is a priority for both the government and their employers. Here, precautionary principles for new and emerging diseases developed by the CDC would be key. There also needs to be greater acknowledgment that exposure to biological hazards also creates psychosocial risks for staff especially when workers know they are not appropriately protected; or are immunocompromised (or have loved ones who are). The proposed CDC would be a meaningful advocate and stakeholder in ensuring and supporting better workplace health and safety standards for many employees across a range of at-risk sectors.

How could the CDC support and retain the public health workforce in reducing the burden of non-communicable disease?

The proposed CDC must be a powerful advocate for the health, safety, and wellbeing of the entire health workforce and utilise the vast volume of evidence already existing to ensure that the workforce is optimally supported to deliver best practice preventive interventions are care for non-communicable diseases. Here, nurses and midwives including nurse and midwife practitioners and other advanced practice nurses and midwives must be able to work to their full scope of practice in order to be the most effective. Being able to work to full scope of practice will also have knock-on effects and benefits in terms of both better health outcomes and experiences for community members as well as better workplace satisfaction, career opportunities, and reduced intention to leave. This will be critical to ensuring a suitably sized and skilled workforce for the future. Further, the development of standards, guidelines, and treatment protocols for disease management could support the public health workforce.

To support the public health workforce in reducing the burden of non-communicable disease, the proposed CDC could work across sectors, including health, education, planning and transport, to work at improving the social determinants of health. It is well known that factors including the built environment, access to education, stable housing and income, access to healthcare, access to public transport, environmental factors including air and water quality, access to nutritious food and a cohesive and supportive community all impact on health outcomes. The proposed CDC could work across all relevant industries and sectors of society to improve these social determinants. Social determinants of health must be improved to ensure that individuals live, play and work in environments that support them acting on health promotion messages. A CDC could make a real impact in reducing the burden of non-communicable diseases.

The ANMF highlights that in order to support and retain the public health workforce in reducing the burden of non-communicable disease, it must be ensured that key stakeholder/expert groups have a strong voice within the CDC. This means that large groups of the healthcare workforce, most of who are nurses, midwives, and assistants in nursing/personal care workers/aged care workers must be represented. We recommend therefore, that nursing/midwifery have clear representation within the CDC.

RAPID RESPONSE TO HEALTH THREATS

What role could the CDC play in greater national and international collaboration on One Health issues, including threat detection?

The Discussion Paper suggests that the CDC could take a role in coordinating Australia's One Health collaboration through development and strengthening of One Health capacities in disease detection, verification, containment and response and that the CDC would be well placed to undertake integrated animal, human and environmental surveillance. The coordination of this would be an effective use of the CDC. In communicating and collaborating with "like" overseas organisations, the CDC will be well placed to anticipate health threats both domestic and international. The CDC would also be best placed to develop rapid risk assessments of new and emerging health hazards. The World Health Organisations manual on "Rapid Risk Assessment of Acute Public Health Events" refers to multidisciplinary risk assessment teams that include clinicians, epidemiologists, veterinarians, chemists and food safety specialists.

As Australia is the only OECD member country that does not have a CDC-like organisation, the development of such will aid international coordination. It will be critical to the success and benefit of the CDC that continuous collaboration with like organisations and stakeholders occur. This will be particularly vital to early threat detection, preparedness, and response. International collaboration will also be vital for sharing evidence and data and ensuring that Australia is equipped with the best and most up to date evidence. Further, international collaboration with a focus on 'One Health' will enable Australia and the proposed CDC to offer support and assistance to other countries, particularly those in our local region and especially where resource shortages and disparities in health are apparent. With increasing global connectedness, mobility, and trade, many contemporary and future issues will require a regional and global plan and response. Climate change-driven threats to One Health are clearly a significant concern internationally, and Australia must take the lead in our region and on the global stage to ensure these threats are mitigated.

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?

The issues around blurred jurisdictional boundaries and inconsistency of the pandemic response (restrictions and management of outbreaks, vaccine rollout and maldistribution amongst States and Territories) was prominent during the COVID-19 pandemic and highlights a gap in Australia's preparedness and response capabilities. Communication and messaging were often convoluted, as there were too many actors and sources of often inconsistent, unclear, and sometimes conflicting information and guidance. The National Incident Centre's (NIC) role could be improved by addressing these important communication issues – getting the messages out within certain cohorts within the broader population. Because there are currently so many bodies working in this space, a trusted national scale organisation like the proposed CDC would be well placed to mitigate these issues. The NIC performs many of the functions that a CDC performs. During the development of the CDC, a review of the NIC should occur to ensure there is no duplication of responsibilities. The NIC could be replaced by a Public Health Emergency Operations Centre (PHEOC) which would expand upon what the NIC already does. It would make sense for Australia to follow the World Health Organisation's "Framework for a Public Health Emergency Operations Centre". The PHEOC should be involved in; prevention and mitigation of hazards; enhancing readiness by planning for and stockpiling response resources; establishing related institutional and technical capacities and capabilities (e.g., laboratories, community clinics, and rapid response teams); implementing public health surveillance programmes; enhancing environmental health programmes; engaging communities; training staff and validating plans.

The ANMF highlights that as legal structure of the proposed CDC is outside the scope of this consultation it is unclear how the CDC would engage with other regulators and (such as occupational health and safety regulators, therapeutic goods administration, building authorities, etc.) to coordinate responses to health emergencies. Further information would be needed on this. Collaboration between these groups is recommended via clear and determined mechanisms.

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?

Engagement with regional and global governments, peak bodies, and other stakeholders with be critical to enabling optimal preparedness for future pandemics, health emergencies, and public health threats. Sharing knowledge, evidence, data, and guidance will be integral to meeting and responding to threats to health, so the proposed CDC would be a beneficial and well-coordinated keystone within this process. The proposed CDC could be at the forefront of lobbying for funding and resources into research in disease control and management, and act as a coordinator for national and international university collaboration.

With an effective CDC, Australia would have the opportunity to be a regional and global leader regarding preparedness for future health threats and emergencies. Here, Australia and its CDC would be able to add significant value internationally with an ethos of responsible global citizenship. Australia has a global responsibility to effectively contribute to global health threats that do not respect national borders or distance ensuring that people everywhere are able to achieve the best possible health outcomes. Though its international connections particularly the South Pacific and South East Asian region, an Australian CDC would have the potential to be a leading partner in assisting and collaborating with other nations and stakeholders to improve health and preparedness particularly in areas with fewer resources and health workforce capacity.

What role should the CDC undertake in international engagement and support internationally, regionally or domestically?

> *International engagement, coordination and intelligence sharing are central to the role of all international CDCs. What additional objectives should the CDC include? (for example leadership, technical engagement and capacity building, or other issues?)*
>
> *How can the CDC be utilised to strengthen pandemic preparedness internationally?*

In an increasingly globalised world, international engagement and collaboration is fundamental to any effective efforts to lessen the impact of threats to health. The ANMF agrees that the proposed CDC should engage internationally and support particularly our less well-resourced neighbours in the region. Here it is vital that the CDC support Australia as a relatively well-resourced nation to assist and support our less-well-resourced neighbours to protect their communities from health threats and risks. Neighbouring countries with more limited resources and healthcare systems would benefit greatly from the leadership and guidance of an Australian CDC though genuine partnership and collaboration and data/intelligence sharing. By providing capacity building services and technical engagement with other countries in our region, Australia will also be better placed to proactively address emerging threats to health and wellbeing domestically. The proposed CDC could review/oversee the development of data and information sharing networks, technical expertise sharing, and knowledge transfer programs in our region as well as globally. The proposed CDC should engage with like organisations around the world. As suggested in the Discussion Paper, the CDC should provide technical engagement, providing advice to, and working with, governments domestically and abroad to build capacity in response to health emergencies. The CDC should also focus on the Asia Pacific and Pacific region to share and receive data on health threats in our own region. The proposed CDC's data systems should be compatible with like organisations elsewhere to assist in sharing and receiving of relevant health surveillance data. The ability of CDCs to be able to work together in a cohesive way is vital in strengthening international pandemic preparedness. Reciprocal sharing of resources between countries is another way CDCs can strengthen response to pandemics.

LEADERSHIP ON PREVENTIVE HEALTH

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

To foster a holistic approach across public health and beyond, the proposed CDC must be able to have the capacity to genuinely and consistently engage with a wide range of stakeholder groups across government and non-government organisations. The broad and inclusive scope of the proposed CDC will necessitate having capability to engage across a wide variety of sectors and specialties, which will in turn demand that expertise and knowledge across each of these areas will need to be factored into the governance and in-house skills of the proposed CDC itself.

The ANMF highlights that in order to foster a holistic approach across public health, it must be ensured that key stakeholder/expert groups have a strong voice within the CDC. This means that large groups of the healthcare workforce, most of who are nurses, midwives, and assistants in nursing/personal care workers/ aged care workers must be represented. We recommend therefore, that nursing/midwifery have clear representation within the CDC.

The ANMF highlights that health protection came to the fore during the COVID-19 pandemic and includes: the control of infectious diseases, managing health emergency responses and identification of environmental health hazards. This, along with health promotion and disease protection and control is core business for a CDC. To foster a holistic approach, it is important that the CDC engage with a broad range of clinical disciplines, including nursing, midwifery, medicine as well as health promotion officers, statisticians, epidemiologists, the education sector. The social determinants of health must be considered. The CDC in the United States of America recommends coordinating chronic disease prevention efforts in four key domains of chronic disease prevention: 1. Epidemiology and surveillance, to monitor trends and track progress. 2. Environmental approaches, to promote health and support healthy behaviours. 3. Health care system interventions, to improve the effective delivery and use of clinical and other high-value preventative services. 4. Community programs linked to clinical services, to improve and sustain management of chronic conditions.

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

The proposed CDC could take on a valuable leading role in implementing the goals of the National Preventive Health Strategy and could advise on subsequent modifications or iterations of the Strategy beyond 2030. The aims, principles, enablers, and focus areas of the Strategy appear relevant and sound to the mission and scope of the proposed CDC. As with each area within scope of the proposed CDC, work will need to occur to engage with the groups already involved in implementing the goals of the Strategy to ascertain where and how the proposed CDC could best contribute. For instance, while the proposed CDC might be well placed to provide expert advice and guidance for policy across a range of sectors regarding improving access to and the consumption of a healthy diet as a fundamental component of disease prevention, the CDC would not be responsible for implementing interventions and initiatives to apply this in practice. This highlights that the proposed CDC is likely to need to be flexible and agile in the kinds of roles and functions it carries out depending on the particular sector and topic it would be working across. The ANMF recommends that particular attention and focus be placed on workforce planning, as we know that aged care and primary health care sectors are already facing staffing shortfalls.

The ANMF also highlights that the proposed CDC could provide leadership for an evidenced based whole of system approach such as utilising a program from the Australian Institute of Health and Welfare study "Australian Burden of Disease Study 2018". The CDC could also undertake health promotion programs with a goal to meeting the targets outlined in the National Preventative Health Strategy.

The proposed CDC should note, from the strategy, areas where there are health inequities. These include but are not limited to, Aboriginal and Torres Strait Islander People, those living in rural and remote areas, people experiencing socioeconomic disadvantage, people living with mental illness, people with disability, LGBTIQ+ people, and those from CALD backgrounds. These groups must be a focus of the proposed CDC as they can experience a greater burden of disease compared with the rest of the population.

Should the CDC have a role in assessing the efficacy of preventive health measures?

The ANMF recommends that the proposed CDC would be well-placed in coordinating and engaging with other stakeholder groups in assessing the effectiveness (as opposed to the efficacy, which refers to the performance of interventions under ideal conditions, which is seldom the case beyond high quality experimental studies), feasibility, and appropriateness of preventive health measures. As with many areas where the proposed CDC might not immediately begin work once established, the CDC itself might not have immediate capacity to undertake this type of work alone. Here, engagement with wider stakeholder groups including researchers, worker representatives/unions, and peak bodies will be necessary. As the proposed CDC develops and evolves, there will need to be an agile approach to taking on new and varied portfolios of work. It is unclear how the proposed CDC would meet aspects of the draft purpose, such "Gather and Analyse", without appropriate mechanisms to assess preventative health measures. Assessing efficacy of this would also assist in assessing the success of public health education/messaging for health literacy, and other initiatives implemented by a CDC.

WIDER DETERMINANTS OF HEALTH

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?

The ANMF highlights that a First Nations Voice to Parliament would be an ideal way for Aboriginal and Torres Strait Islander people to provide advice to government regarding policies and projects that impact their lives. Currently, policy making does not have a systematic process for Aboriginal and Torres Strait Islanders to provide advice. This often results in policy that is made *for* Aboriginal and Torres Strait Islander people rather than *with* them. Constitutional recognition through a Voice to Parliament will enable the provision of real and practical advice on how laws and policies can best improve the lives of Aboriginal and Torres Strait Islander people. This will be fundamental to the ability of the proposed CDC to effectively delivery timely, appropriate, and evidence-based health information to First Nations people. When Aboriginal and Torres Strait Islander people who know and understand the best way to deliver real and practical change in their communities have a say through the proposed Voice to Parliament, Australia will be better placed to close pernicious gaps that still exist (and in some cases, are widening) between Indigenous and Non-Indigenous Australians.

The first, and most important step, is to work in partnership with First Nations people, as they are the agents of their own change. Engagement must occur within a Cultural Safety framework and acknowledge cultural determinants of health. All staff should have training in Cultural Safety. Examples of training in the health sector include NSW Health have mandatory training called "Respecting the Difference". The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) offers a comprehensive online training course on Cultural Safety. In 2019 the Coalition of Peaks engaged with community leaders and representatives of Aboriginal and Torres Strait Islander organisations and communities across Australia. Consultation was to inform reform and a new agreement on Closing the Gap. It is important that the CDC utilise these reforms in all aspects of its work, including policy development, involving First Nations peoples.

Australia's Disability Strategy 2021 – 2031 includes outcome areas that mirror many of the social determinants of health, these being: employment and financial security; inclusive homes and communities; safety, rights and justice; personal and community support; education and learning; health and wellbeing; community attitudes. The proposed CDC must consider these, and other determinants when it engages with people with disability. Engagement should occur in all aspects of its work, in policy development and beyond, including planning, implementation and evaluation processes of health promotion initiatives and key messages.

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

Genuine, respectful engagement and partnership with culturally diverse and at-risk populations will be integral to whether or not the proposed CDC is able to effectively deliver timely, appropriate, and evidence-based advice to these special-needs groups. This engagement and partnership must occur from the very outside, so should already be happening. Here, the tight turn-around for invited written submissions for this consultation could very well be a barrier to genuine, thorough, and appropriate engagement. The ANMF recommends that the proposed CDC and the consultation around its planning must develop a best practice approach for engaging with and partnering with diverse at-risk groups as a priority.

The COVID-19 pandemic highlighted how important it is to work with cultural groups to deliver health advice and information in culturally appropriate ways and for health information to be available across the range of community language that exist in our multicultural community. The Australian Government formed the "Culturally and Linguistically Diverse Communities COVID-19 Health Advisory Group" to support the Australian Government in coordinating an evidence-based response to the COVID-19 pandemic. The group comprises of leaders from culturally, ethnically, and linguistically diverse communities and their representative organisations, health experts and medical and public health practitioners and unions (represented by the Australian Nursing and Midwifery Federation). The purpose of the group is to provide Health with advice on the experience of culturally, ethnically and linguistically diverse people and communities in relation to the COVID-19 pandemic. Partnerships between CALD leaders, communities and government are critical for effective health communication. Shifting behaviour in these communities requires moving beyond disseminating information to designing tailored solutions to the diverse needs and circumstances of people and communities. This must be at the centre of health communication and behaviour change strategies.

The ANMF also highlight that many other disadvantaged groups also exist throughout Australia including but not limited to gender and sexually diverse people, people with the experience of homelessness, care leavers, veterans, and more. Genuine collaboration and partnership with all these groups will be critical to the success and effectiveness of the CDC and its work. Design Principle 4 articulated in the Discussion Paper may not be met without inclusion of another principle that ensures culturally diverse, vulnerable and at-risk populations are a primary consideration in policy and education development and delivery.

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

As recognised in the Discussion Paper, the proposed CDC will need to engage widely and continuously with many sectors beyond its immediate remit. This will require genuine commitment, building effective and efficient governance and collaboration pathways, and early work to develop lines of engagement with each stakeholder group. A comprehensive environmental scan is recommended to identify all possible groups that must be engaged with and work must begin immediately regarding how best to embed dialogue and discussion with these groups. Engagement could take the form of many approaches depending on the topic/project or stakeholders involved including but not limited to; informal networks, project groups, committees, interdepartmental agencies, and through private sector collaboration.

Intersectoral collaboration will be key to the success of the CDC. Aspects of the One Health concept supports engagement across sectors. As part of the One Health concept:

- There is a clear need to establish a One Health governance mechanism to provide leadership and foster collaboration, coordination and communication between sectors and the community; this could be achieved by embedding a One Health coordination mechanism in a newly formed Australian CDC, facilitating cooperative and equitable engagement across sectors.
- Sharing of health intelligence information across sectors would enable timely risk assessment and early response to zoonoses (diseases that transmit from vertebrate animals to humans) and to other environmental hazards affecting humans, animals, and ecosystem integrity. This would require compatible information technology systems that facilitate joint analysis and dissemination while maintaining data confidentiality.
- Even though the primary role of doctors is to manage disease in their human patients, veterinarians are trained in recognising and managing risks posed by zoonoses, as well as implementing treatment in animal patients where indicated; inclusion of One Health in clinical training and continuing professional education would build workforce capacity of frontline service providers, strengthening knowledge and skills in relevant areas and also facilitating mutual understanding of the complementary skill sets of each profession.
- Integrated management of zoonoses would provide more efficient and cost-effective delivery of health services; formal incorporation of veterinarians into the health system as allied health professionals who have specialist training in zoonoses would improve both continuity of care and health outcomes through a more holistic approach to management of both human and animal patients; beyond zoonoses, referral could provide additional benefits in areas such as animal-assisted therapies and management of work, health and safety issues in animal industries.

- A One Health system would require shared regulatory responsibility for medications used in humans, animals, and horticultural industries, as well as management of the impact of pharmaceutical pollution on ecosystem health; of particular concern, environmental exposure of microbes to antimicrobials facilitates selection for antimicrobial resistance; this needs to be managed alongside antimicrobial stewardship programs in human and animal health to ensure continued treatment success.
- In a One Health system, investigation and response to zoonoses could be jointly financed by human and animal health sectors, proportionate to the impact on each sector; costs of veterinary interventions are largely born by animal owners, creating barriers to laboratory investigation; under a One Health system, costs incurred when ruling out a zoonotic disease or performing culture and sensitivity tests to inform antibiotic prescription in an animal patient could be considered an eligible cost under an expanded Medicare scheme, due to the implications for human health.

RESEARCH PRIORITISATION

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

The ANMF recommends that it would be beneficial for the proposed CDC should have a role in advising or directly administering funding and prioritisation of public health and medical research. Both functions (advisory and administration of funding/prioritisation) could both be within the purview of the proposed CDC. This could engender flexibility and maximise the potential for the CDC to be both responsible for the administration of strategically valuable research as well as advising on research priorities in other areas. This could also reduce duplication and research waste.

Because an All Hazards and One Health approach necessitates a broad scope and focus, it is also important to recognise that it is likely that research occurring beyond health and medical fields will also be valuable and necessary. Here, it might be that the proposed CDC administer grant funding schemes in particular areas (e.g., clinical research into newly emerging infectious disease prevention) and advise on priorities and funding for research that falls beyond the fields within the CDC's immediate scope (e.g., animal husbandry practices that influence health and illness). An effective and influential CDC would be able to assist advising other funding and research prioritisation schemes that might not yet effectively incorporate consideration of how diverse research fields might have important interrelationships with disease prevention and control.

THE CDC PROJECT – MEASURING SUCCESS

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

It will be vital that the proposed CDC have an accountable, transparent, and evidence-based approach to measuring success though high-quality evaluation. Key goals and targets will need to be monitored and regular reporting cycles established. Regular evaluations must take place in terms of the proposed CDC's capacities and capabilities. Importantly, the results of evaluation work need to be acted upon in an effort towards continuous improvement.

Do you have any additional general comments

The ANMF understands that it is not an intended function of the proposed CDC to monitor workforce reform and workforce tracking, however there is significant need for this as highlighted by the COVID-19 pandemic. Nurses and midwives were at the forefront of delivering healthcare in our most recent health emergency. The ANMF Victorian Branch highlights the less discussed aspect of this - being the nurses and midwives were also highly exposed to disease. This experience means nurses and midwives are well placed to take on key roles within the proposed CDC, and this workforce must be a focus of the work of the CDC.

Nursing and midwifery roles within the CDC must be ongoing within administration. Nursing and midwifery roles in the executive/committee must be embedded in the CDC's structure.

Recommendation to include in scope:

- Harm minimisation/alcohol and other drugs.
- Sexual and reproductive healthcare

The ANMF also highlights that the "Next steps" (p42) of the Discussion Paper, does not include nursing and midwifery groups. A recommendation on including nursing and midwifery groups (ANMF) should be put forward. The draft mission statement seems to focus on "nationally significant health threats". Health promotion, leadership, innovation, and inclusivity is not covered, or not the focus. We recommend consideration to reword this so that the mission reflects a focus on prevention and public health with a key function being response to health threats. Further, health threats may not affect the nation in its entirety and this mission statement should not limit the proposed CDC's response to a more local/isolated health threat.