CDC STAKEHOLDER ENGAGEMENT

Prepared For: Department of Health & Aged Care

Prepared By: James Wunsch

16 December 2022

Bastion™ Insights

Table of Contents

1. About this report

1.1 Background

Over the past three years, Australia has endured numerous public health emergencies: widespread and intense smoke inhalation from the 2019 and 2020 bushfires, the COVID-19 pandemic, and Japanese encephalitis virus (JEV). The protracted and intensive response period has pushed the national response capability to the limit. In response, the Australian Government made a 2022 election commitment to develop an Australian Centre for Disease Control.

Establishing a networked Australian Centre for Disease Control (CDC) will improve Australia's preparedness for the next pandemic and other health emergencies; boost response capacity; strengthen prevention, communication and national coordination and enhance collaboration across all levels of government and importantly, prevent non-communicable (chronic) and communicable (infectious) diseases. Strong partnerships from the outset with state and territory governments will be key to operationalise an effective CDC.

There is strong stakeholder interest in the establishment of a CDC, with many health institutions having already developed mature frameworks relating to their proposed role in a CDC.

1.2 CDC Discussion Paper

The Department publicly released a CDC Discussion Paper on 10 November 2022, inviting selected stakeholders to engage and provide comment either generally or in response to 28 guiding consultation questions.

1.3 Consultation workshops

To initiate the stakeholder engagement process the Department invited a range of stakeholders to attend facilitated workshops across Australia to ensure that area experts and specialists were appropriately consulted, and their feedback considered in the initial development and planning of an Australian CDC.

In total, 12 facilitated workshops were conducted from the 14th to the 29th of November 2022. All capital cities were consulted, covering every State and Territory. The facilitated workshops were 3 to 4 hours in duration and encompassed individual and group exercises with opportunity to provide feedback and discussion on initial reactions to the concept of an Australian CDC, benefits, mission / purpose, function and scope, what future success would look like for the CDC and any general comments / feedback. In addition to attending and participating in these workshops, attendees were reminded of the opportunity to submit a detailed written submission on the proposed scope and functions on an Australian CDC.

Encouragingly, many of the themes raised individually and as groups in the workshops were consistent with the findings summarised from the written submissions below.

1.4 Written submissions

The Department invited written submissions from organisations to gather feedback on the functions and structure of an Australian CDC. In addition, several organisations have sent their own submissions prior to receiving the formal request. These submissions have also been included in this broader synthesis piece.

This report provides a high-level summary of the 144 written submissions received from stakeholders across a range of advocacy groups, committees, industry representatives, medical colleges, NGOs, peak bodies, consultancies, research institutions/groups, unions and universities. These stakeholders specialise in a range of areas, including animal health, chronic/preventative health, communicable diseases, community health, environmental health, injury, medical and priority populations (including, but not limited to, First Nations peoples, people with disability, LGBTIQ+, CALD, migrants and refugees and people living with HIV). The diverse range of experts presented a spectrum of views, advice and experiences in public health. Each view has enriched this report and analysis of what an Australian Centre for Disease Control could look like, and we thank all of those who invested their time and expertise in crafting their respective submissions.

1.5 Constraints & limitation

The timetable laid out for the introduction of the CDC has truncated both the time stakeholders have had to develop and submit their written responses, as well as the time available for the review and synthesis of these submissions.

Encouragingly, there was far more similarity in feedback observed across the submissions than divergence of opinion. The broad themes observed also strongly mirrored feedback and comments observed at a series of 12 stakeholder workshops conducted nationally in November 2022.

While Bastion attests that this summary is a true reflection of the high-level themes captured across stakeholder written submissions, there is no doubt that more time would have allowed the surfacing of more granular viewpoints on the topics explored.

2. Functions of the CDC

- Encouragingly – and aligned with feedback observed in the workshops – nearly all written submissions received indicated strong support for the establishment of an Australian Centre for Disease Control (CDC). There is a strong expectation that the establishment of a CDC will drive much greater linkage and collaboration across the Australian health system and offer a genuine 'one source of truth' on how Australia responds to both communicable and non-communicable disease challenges into the future.

2.1 Decision making responsibilities

- With the significant health, economic and social impacts of COVID-19 still top of mind for all stakeholders there is an understanding and support for the initial functions of the CDC to focus on pandemic preparedness and response. However, many stakeholders argued that the burden of non-communicable disease means that preventative health also has to be within the remit of the CDC – not as a potential add-on into the future, but firmly entrenched within the agency's charter from inception.

- Interestingly, many stakeholders indicated that what should be within the direct remit/control of the CDC would vary depending on the prevailing circumstances:

    - In times of pandemics, many supported the CDC having a much more significant command and control role to ensure that decisions and actions were taken on the best available science and evidence (including directly commissioning its own research as needed, where gaps exist). This would drive consistency in both actions and messaging to foster community trust and buy-in (much of which was missing during the fragmented response to COVID-19).

    - In non-pandemic times, CDC would focus energies on rigorous data collation, analysis and advice provision across all aspects of public health, including advice on where research resources should be directed to drive improved population health outcomes. It is not expected to fund research investment directly, but rather to play the lead role in prioritising medical/health research investment based on sound, data determined needs.

- Perhaps the most consistent feedback across all written submissions was the critical importance of the CDC needing to drive a breakthrough on data linkage and usage at the national level. The CDC would be well placed to gain access to relevant data sets, collate and link these data sets, and facilitate analysis and understanding. Through leveraging this data and analysis, the CDC can drive timely, evidence-based advice or decision making.

- Some stakeholders expressed concern that a CDC with an advisory capacity only (at least in non-pandemic times) would lack the requisite authority or 'teeth' to drive improved health outcomes for Australians. To address this, some argued that the agency should table annual, evidence driven preventive health priorities in both federal and state/territory parliaments, at which point it would be incumbent on the relevant Health Minister to either accept these identified priorities or explain why this advice was not being followed.

- Several peak bodies and community-based organisations also commented that many parts of our health system are working well in delivering positive health outcomes for their clients, stakeholders or local communities. To this end, it was noted that any decisions on what is considered in or out of scope for the CDC needs to understand existing capacities and strengths and seek to connect with and leverage these, rather than control or potentially duplicate such roles or functions. For these stakeholders there is a strong call for the establishment of the CDC to adopt a 'do no harm' approach. When deciding what to specifically include in the direct remit of the CDC, several of these peak bodies and community-based organisations would like the CDC to consider how this will deliver value over and above existing arrangements.

- Ultimately, most stakeholders suggested that the CDC should be meaningfully connected to most parts of our health system, influencing policies and practices through expert, evidence-based advice – yet having limited direct control of existing roles and functions (except in pandemic contexts as flagged above). If the CDC seeks to take too much within its direct remit, some argue this will limit its capacity to operate in a lean and agile manner. Further, it risks replicating bureaucracy already appropriately managed with the Departments of Health at both the Federal and state and territory levels.

2.2 Functions in and out of scope

- There was broad agreement among most stakeholders with the proposed CDC scope as flagged in the discussion paper, albeit many feeling all 'possible' functions (those in grey) should be included within the agency's remit (if not on day 1, then at least within 2-3 years). Again though, this was qualified with comments that the CDC would connect with these functions to both receive data/information and then provide advice in a two-way dialogue, as opposed to actually taking ownership or control of such functions. Even among those functions deemed out of scope in the discussion paper (e.g. primary health care, hospitals, etc.), some stakeholders noted that the CDC should still play a critical advisory role in terms of identifying best practice and providing input on the development of appropriate standards, protocols, etc.

- The concept of the 'One Health' approach is broadly supported and is considered to appropriately recognise that pandemic threats can emerge right across our ecosystem. However, many stakeholders indicated that a genuine 'One Health' approach would require a significant elevation of animal and environmental health stakeholders and data sources to genuinely come to fruition (with a perception these stakeholders have often been seen as the 'poor cousins' to human and clinical health surveillance and analysis). With zoonoses comprising a large percentage of new and existing diseases in humans, it was commonly argued that an effective CDC needs very strong surveillance linkages with the veterinarian and environmental sectors. Many raised the example of Japanese Encephalitis as strong evidence for the need of a One Health approach to health care.

- Many stakeholders also noted that the impacts of climate change mean that environmental health (and the impacts of environmental change) is going to be increasingly important as we face increases in the incidence of natural disasters, such as floods and bushfires. Further, there are anticipated changes in water ecology and the associated threats of insect borne disease. First Nations peoples were often identified as being more heavily impacted by such changes and therefore require strong representation within the CDC to ensure their health needs are appropriately considered and planned for. Further, some environmental and community-based

stakeholders raised that First Nations peoples' land and sea management is world class and in order for the CDC to have effective One Health implementation, First Nations peoples should be in the leadership, governance and implementation of environmental advice.

- Community-based stakeholders commonly argued that the discussion paper doesn't focus enough attention on the community level. While such stakeholders appreciate the value a CDC can provide in terms of more consistent, evidence-based health direction or advice, they argue there is a clear need for a strong connection with local communities and a better recognition of the critical role they play in terms of providing a known and trusted point of connection for health services and advice. Again, such stakeholders expect to be engaged and consulted as the final scope and remit of the CDC is determined.

2.3 Name of an Australian CDC

- For many stakeholders, the term 'CDC' is an accepted reference point and acronym and very clearly positions the organisation's role to stakeholders and the international community. Although a minority were hesitant around the words 'control' and 'disease', there was still an acceptance that CDC clearly communicates what it needs to.

- Some stakeholders were concerned that CDC did not sufficiently signal a preventative health inclusion. To this end some stakeholder suggested the name should be the Australian Centre for Disease Control and Prevention (ACDCAP).

- Below were some alternative names suggested:
    - Australian Public Health Agency
    - Centre for Population Health Protection and Improvement
    - Australian Centre for Disease Prevention and Response
    - Centre for Disease Control and Prevention
    - Australian Centre for Disease Coordination
    - Australian Health Protection Centre

2.4 Structure, governance and level of independence

- In terms of structure, many stakeholders indicated the CDC could potentially have a 'hub and spoke' model with a Canberra based policy making hub. It will be of critical importance that the Canberra 'hub' be linked to a virtual 'hub and spoke' or centres of expertise, within all states and territories to ensure the CDC is genuinely national in scope and influence and that embeds its leaders within or close to nodes of expertise.

- Importantly, stakeholders noted that such a model needs to recognise the unique capabilities and strengths of each jurisdiction and leverage these, while also building capability to identify gaps and capitalise on opportunities. Done well, stakeholders envisioned this structure supporting more consistent decision making at a policy level and - through the sharing of data and expertise – can ensure all states and territories have access to and can implement measures based on the same evidence-based information.

- Stakeholders also consistently indicated that it was critical that the CDC have a degree of independence from – but still be ultimately answerable to – federal, state and territory governments.

- In terms of governance, many argued that the CDC needs to operate under the guidance of a strong, independent board that oversees recruitment to Executive and Leadership positions within the CDC. The board would need to have a sound understanding of the operations of the CDC. It was suggested that nominations for Ministerial appointment to the Board should come from both Board members themselves and the Australian Health Ministers meeting.

- The CDC was envisioned to include core discipline experts including epidemiologists, statisticians, public health practitioners, infectious disease physicians, virologists, occupational health scientists, behavioural scientists, communication experts, and bioethicists.

- The challenge of establishing the CDC in a way that fosters genuine collaboration within our federated structure was routinely noticed across the written submissions. Some ideas put forward across the written submissions included:
    - An independent statutory authority with designated powers. Under this model, a CEO and board of independent experts would develop advice based on evidence and present to government, which would then develop policy in response to the advice.
    - CDC could operate under a Governing Council, comprised of nominated Commonwealth, State and Territory experts and advisers.
    - A governance model similar to the European Centre of Disease Prevention and Control (ECDC) may suit the various responsibilities of the Commonwealth, States and Territories for Australia.
    - Some felt the Australian Institute of Health and Welfare (AIHW) model would be appropriate given it provides meaningful engagement with all jurisdictions through both governance arrangements and ways of working.
    - The Australian Strategic Policy Institute (ASPI) model is one of government ownership and funding, yet significant external stakeholder input and a level of independence. Some believed the ASPI model would allow the CDC to balance the need to provide independent, expert advice yet still have the ability to influence government policy.
    - Setting up the CDC as a body fully co-owned by all states and the Commonwealth, via a cooperative applied law scheme.
    - The CDC could be jointly funded by the states and Commonwealth, as per the existing National Transport Commission (NTC) model.

- Overall, stakeholders indicated strongly that both bipartisan support and surety of funding were both essential for the CDC to achieve success over the medium to longer term.

- While an independent and connected CDC is viewed as a potential ‘circuit breaker’ that would see a more unified national response to future pandemics (and preventative health interventions), many stakeholders noted that Australia is very diverse geographically, socially, economically, and culturally. To this end, there will always be a need for states and territories (or even local regions and communities) to be able to apply a ‘place-based’ lens on CDC advice or instruction. A ‘place-based’ lens ensures that actions are appropriate at the local community level by drawing on evidence-based, best practice to shape responses but also being entrusted to tailor this to the local needs and context.

3. A coordinated and national approach to public health

3.1 National coordination of Australian public health sector

- Stakeholders feel that a CDC offers considerable scope to drive significant improvement in coordination across the Australian public health sector, but this will require:
    - A focused and well-defined remit encompassing both communicable and non-communicable disease
    - Strong bipartisan support for its role
    - Security of ongoing and long-term funding

- The hub and spoke model identified above was consistently identified as the best means to foster genuine state and territory engagement and collaboration. Stakeholders indicated that engagement with other stakeholders will need to be predicated on a strong two-way dialogue. This would see the CDC collecting and collating information and data, but then analysing and regularly sharing this back with the sector to improve operations and public health outcomes.

- Stakeholders expect engagement through formal channels, such as specialist advisory committees, MOUs on issues such as data sharing, etc. Further, stakeholders recommended that the CDC actively considers and maps where existing expertise and capacity lies and has a willingness to seek advice or input as new issues or challenges emerge.

- The CDC should build and maintain relationships and links to existing committees such as the Australian Health Protection Principal Committee (AHPPC), Communicable Diseases Network Australia (CDNA) and other AHPPC sub-committees, and the Australian Technical Advisory Group on Immunisation (ATAGI).

- It was noted that the CDC ultimately needs to create an environment where stakeholders will want to voluntarily and routinely share data, rather than being coerced/forced to share information and data. This will be facilitated by a sound set of protocols underpinning data sharing/access and for the CDC to be open and transparent in its analysis and interpretation practices.

- Several stakeholders noted supply chain and logistical challenges to accessing timely and equitable medical supplies, including through the National Medical Stockpile. The CDC could play a central role in encouraging an expanded domestic production capacity to ensure timely and equitable access to medical supplies for all Australians.

- Workforce capacity mapping, identifying existing or potential shortages and partnering effectively with the health training and education sector (at all levels) was viewed as an important and practical way in which the CDC could demonstrate coordination and leadership across the public health sector. This would span both ‘business as usual’ workforce but also the need to stand up surge workforce capacity during times of pandemics.

3.2 Stakeholder observations on Australia’s pandemic response

- Stakeholders provided many observations of the nation’s recent experience in responding to COVID -19, many of which an Australian CDC has scope to leverage.

- Some of the most common observations include:

- Our understanding of the impact of different strains of the virus was reliant on overseas investigations and data rather than information generated in Australia.
- Jurisdictions took differing approaches to pandemic response at times – often base their critical decisions on different data sets or evidence. This had the effect of a patchwork of data and inter-jurisdictional comparisons that severely undermine public confidence and in turn compliance with public health messaging.
- Inadequate and/or inappropriate workforce allocation, particularly around leadership, led to inefficiencies. During the pandemic, there were limited leaders experienced in outbreak management. Further, many health workers were seconded into front line roles that didn't utilise their knowledge or skill sets appropriately. The public health workforce needs leadership experienced in pandemic response.
- Many of the response plans for pandemics were not useful. These clearly need revising and regular testing in the field to ensure they are fit for purpose.

- However, others pointed to aspects of our response that worked well, including:
  - Genomics to understand the transmission of COVID-19 worked extremely well at various stages of the pandemic. This genomic sequencing to monitor circulating variants must continue. Genomics as a key public health surveillance and investigation tool should be more widely used for other diseases.
  - Modelling to support decision making and forecasting was critical to the pandemic response and should prove more of a focus going forward for the CDC.
  - Novel methods of investigation and response, such as QR codes, patient administered tests, and self-reported data were very helpful. These tools and others could be used more widely for other infectious diseases.
  - New surveillance measures and data linkage was incredibly helpful to understand the impact of the pandemic. Some of these included, GP respiratory clinics, ICU data, data linkage at a state, territory and national level, and behavioural systems of surveillance. These systems were vital for pandemic modelling and pandemic response and should form part of routine surveillance for infectious diseases.

- Other stakeholders noted that COVID-19 has taught some very important lessons and identified gaps in preparedness. It has shown very clearly the political nature of public health and the fragmentation of public health nationally. It has shown that large public health problems need very large responses, that extend considerably beyond the health sector. It has also shown that the scale of actions needed to control disease can impose a very high price on society. It was argued that a CDC could help us work through these difficulties. Being independent of political influences and underpinned by robust data, there is scope for it to propose evidence-based policies that both optimize, and make explicit, the trade-offs between social disruption and disease control.

- Another consistent lesson identified by stakeholders was the challenges caused by the lack of a single source of evidence driven public health advice. This was observed to drive disparity in responses at the state and territory level often causing significant community confusion and angst. A CDC offers critical scope to be a trusted, independent single source of truth – critical in pandemic times but equally important in rigorously assessing what works and what doesn't to guide decisions on research investment and public health funding decisions.

- Some primary health care stakeholders – in particular GPs and pharmacy stakeholders – noted that their experience in the pandemic highlighted that these groups are often overlooked and can be better utilised given their direct interaction with the community at large. These stakeholders argued that they can be better leveraged across both communicable disease and non-communicable disease contexts including across functions such as health data collection and provision, provision of health care emergency advice, planning and support, and in the more effective distribution or delivery of services beyond the hospital/tertiary care context.

- Several stakeholders identified that national responses were often less effective at the local community level, given language and cultural barriers. A key learning here is to ensure that the CDC places a high priority on both building its own understanding of the diversity of the Australian community it seeks to serve (including First Nations peoples, those from diverse cultural or language backgrounds, etc.) but also leverages community organisations that understand their local communities and can facilitate greater engagement, understanding and uptake of required protective behaviours.

- Several stakeholders also noted how the COVID-19 response – with much public health capacity redirected to managing COVID-19 – was at the significant expense of patients needing care for treatment or rehabilitation for existing chronic conditions, or in the suspension of preventative health programs and activities. These stakeholders expect future pandemic preparedness to ensure how the full gamut of "business as usual" public health delivery can be continued, including through the use of alternate service delivery modes such as telehealth (where appropriate) or in-home care provision.

4. A data revolution

- As noted above, the ability to make headway on data linkage to ensure public health decisions are made on the analysis of accurate and timely data is perhaps the most critical goal that stakeholders anticipate a CDC being challenged with achieving. The positive connection between high quality data and better health outcomes was clear to all stakeholders.

4.1 Data barriers

- Stakeholders identified several barriers to achieving timely, consistent and accurate national data:
  - A lack of consistent data labels, collection practices, etc. across jurisdictions (e.g., no consistent data taxonomy)
  - A lack of integration of systems (of which stakeholders noted there are likely many)
  - Lack of consistent privacy legislation or data sharing protocols across jurisdictions
  - Lack of political will to date
  - State and territory legacy data systems needing to be unified/harmonized
  - Concern over data sovereignty for small incidence populations, especially among First Nations peoples
  - Complex or time-consuming manual data input systems

- Whilst the value of national data is clear, community-based organisations highlighted that data entry must be easy for the user to collect and submit, particularly if data collection is additional to their day-to-day role and responsibilities. For example, some aged care stakeholders were concerned that with staff shortages and work demands, data collection could take away from patient care. Furthermore, some community stakeholders were frustrated by having to input the same data for multiple collection sources during COVID-19. The CDC provides an opportunity to streamline data collection, making it easy for the user to access and input data.

- One stakeholder mentioned the important role of AI for real-time data, analysis and disease detection. However, local communities, who were seen as vital data collectors, were also believed to be most distrustful of AI. To ensure rapid data collection and analysis, trust in AI at the local level needs to be developed.

4.2 Existing data sources and bodies

- Stakeholders commonly indicated that the CDC would need to develop a national data plan as the first step in its capacity to potentially access, link and better utilise public health data across both communicable and non-communicable disease domains. Central to this is a robust assessment of what data 'stocks' currently exist in Australia's public health system – what data is collected, by whom, for what purpose, in what format, and how is it stored/used/shared/accessed etc.

- In line with the broader view that pandemic detection, preparedness and response is the first priority in the establishment of the CDC, initial assessment should focus on data sources that assist in surveillance, detection and response to emerging communicable disease threats – including those within the existing public health context and also those held by animal and environmental health stakeholders.

- In some public health data domains, stakeholders identified data sharing models that are working reasonably well but could still be enhanced or improved. For example, the National Notifiable Diseases Surveillance System (NNDSS) coordinates data on diseases that present a risk to public health in Australia. This helps identify trends in diseases, assess the impact of disease control programs and develop policies to reduce the negative effects of these diseases. However, some argue that the NNDSS does not adequately detect outbreaks of infection, and these are largely detected at the jurisdictional level. There is an opportunity for the CDC to enhance the operations of NNDSS to detect multi-jurisdictional clusters and outbreaks of infection.

- For non-communicable disease there is a strong hope among many stakeholders that the CDC can drive better data linkage. This will not only improve the efficacy and efficiency of current treatment approaches, but also facilitate a more robust social determinants of health analysis to inform targeted and evidence driven preventative health strategies and interventions.

4.3 Appropriate collection, management and security of data

- Most stakeholders did not put forward a definitive governance framework for the appropriate collection, management and security of data, but rather suggested that our specialist data agencies (ABS, AIHW) be consulted for guidance on best practice approaches.

- Other stakeholders suggested that we look to existing CDCs in other jurisdictions for guidance on how the governance arrangements they have for their data collection,

analysis and storage practices could be applicable (albeit noting Australia's federated structure may mean a more tailored approach could be required locally).

- Importantly, stakeholders noted that the data system utilised by the CDC should be able to maintain the utmost security of data but also enable easy access for approved parties to boost both collaboration and trust in the institution. Approved parties should come from a wide range of areas, including all levels of government and agencies, but also allow limited access for external organisations and researchers. University and researcher stakeholders were particularly eager for data access.

- One stakeholder identified that the Multi-Agency Data Integration Project (MADIP) system has a well-defined and rigid process for gaining access to the data available which could be drawn upon as an example by the CDC. This process includes state and territory review of data requests, which ensures that potentially sensitive or identifiable data is safeguarded. This ensures appropriate reporting and use of data specific to the local context (which is vital for smaller jurisdictions where disaggregated data is more likely to become potentially identifiable).

- Some stakeholders identified tangible examples of opportunities where data sets - if better linked - could inform communicable disease and public health policy. During the pandemic, inconsistent surveillance of COVID-19 deaths, ICU admissions and hospitalisations between states and territories could have been overcome if existing data systems had been better linked. The CDC should develop a data system that is timely and flexible that state and territory systems, and other existing systems (e.g. ABS, AIR, PBS, etc.), can easily integrate with and transmit data in both directions in real time.

4.4 Technical capability

- Stakeholders noted that workforce capacity needs to follow once the CDC's scope for data collation, analysis and reporting is well defined. Given expectations that data-driven advice and guidance is seen as foundational to the CDC delivering value, the CDC will need to recruit well qualified staff across the full spectrum of data capture, analysis and reporting.

- In terms of capacity to produce policy and practice evidence, this goes beyond training and recruiting data analysts/scientists. It requires people with methodological expertise across a range of disciplines, including epidemiology, biostatistics and health economics. It will be important that institutions collaborate rather than compete for these existing people-based resources. Additionally, appropriate training and education pathways are essential to secure an ongoing supply of skilled graduates ready to undertake this important work.

- Some of the work may need to be outsourced to universities/research institutions, or perhaps better still, would involve partnerships – i.e. combined agency-academic teams working on specified projects. Stakeholders note this model has been successfully used with the AIR-MADIP project. The expertise from academic institutions can also be harnessed to provide in-house training on how to best use the data to provide evidence for policy and practice. Furthermore, some university/research stakeholders were open to secondments during times of crisis.

- Stakeholders also noted an important caveat - that there needs to be other specialists in the CDC that are skilled in communicating these analysis outcomes in a non-technical, accessible manner for the general public. These specialists include, but are

not limited to, social and behavioural scientists, interpreters, CALD stakeholders and health promotion experts.

4.5 Locally relevant data and information, especially as it relates to First Nations people

- Stakeholders acknowledged the sensitivities relating to health-related data collection for First Nations people and other low incidence sub-groups in the broader Australian population, and routinely called for the CDC to leverage specialist agencies (such as the ABS and AIHW) to identify best practice protocols and approaches.

- Stakeholders directly representing the interests of First Nations people went further in their submissions, noting that under priority reform four of Closing the Gap, there is a commitment to ensuring that Aboriginal and Torres Strait Islander people and organisations have access to, and the capability to use locally relevant data.

- As part of this, state and territory governments are pursuing efforts towards Indigenous Data Sovereignty and Governance (IDS&G). In its creation, collection, access, analysis, interpretation, management, and use of data relating to Aboriginal and Torres Strait Islander people, the CDC will need to be guided by the principles of IDS&G.

- As determined by the Maiam nayri Wingara Data Sovereignty Collective these are the rights of Aboriginal and Torres Strait Islander people to:

    - Exercise control of the data ecosystem including creation, development, stewardship, analysis, dissemination, and infrastructure
    - Data that is contextual and disaggregated
    - Data that is relevant and empowers sustainable self-determination and effective self-governance
    - Data structures that are accountable to Indigenous peoples and First Nations
    - Data that is protective and respects our individual and collective interests (Maiam nayri Wingara, 2022).

- These principles should be embedded in the organisation's data governing frameworks. Consultation by the CDC with Aboriginal Community Controlled Health Organisations (ACCHOs) can provide Aboriginal and Torres Strait Islander expertise and knowledge to support a best practice approach to collection, reporting and use of data relating to First Nations peoples.

5. National, consistent and comprehensive guidelines and communications

- While enhancing the nation’s health data linkage and analysis capacity is a core driver of perceived value for the CDC, stakeholders also noted the timely dissemination of accessible guidelines and communications as critical for the CDC to establish itself as a trusted and authoritative organisation.

5.1 Establishment of a leading, trusted, evidence-based national body

- Stakeholders consistently identified a need for openness and transparency in data collection, analysis and reporting as a key driver of facilitating a position of trust and

authority within the Australian community. To this end, stakeholders argue that findings and recommendations from the CDC need to be made publicly available as soon as possible, along with access to the data used (de-identified if appropriate), the assumptions used to process the data and the methods used (e.g., computer programs).

- There must be enough details in CDC reports to enable a competent expert in the field to reproduce their findings and findings communicated in such a way that the community can easily understand and appreciate the resulting recommendations and their application.

- For stakeholders themselves, there is a need for the CDC to be explicit around what constitutes “best available evidence” – ideally through a published framework that sets the rules on this (e.g., is the bar set at peer reviewed academic papers, or lower than this?).

- Many stakeholders noted that consistency in messaging is critical in driving policy and in gaining the trust and confidence of the Australian public. The CDC should be seen as the primary provider of credible information to the federal and state governments which can be communicated via media outlets by key government spokespeople, such as the Chief Medical Officer or Minister for Health.

- A common view was that a CDC that is a viewed as the single source of truth across the leading health threats (both communicable and non-communicable diseases) at a national level will enshrine trust and credibility amongst the Australian population. This will assist population responsiveness during acute health emergencies requiring public health measures. Well-crafted and informed community messaging is key not only for education but for building long term trust in the CDC as a source of reputable and practicable information.

- Several stakeholders also noted the importance of embedding specialist health and infectious disease social science and communication science expertise in public health decision-making to enable better integration of social and behavioural data with existing epidemiological and programme data. For example, qualitative and quantitative studies of attitudes of key population groups can determine the types of information that people need from government about new vaccines. It can also guide as to where, how, and from whom these groups want to hear this information. Policymakers can then respond more effectively to specific issues and improve the acceptability of interventions within wide-ranging communities.

- Views were mixed on whether increasing health literacy should be within scope for the CDC – some noted this is a core function of the U.S. CDC and should be considered in scope, while others suggested CDC take advice from health literacy experts and community leaders in crafting any communications.

5.2 Health promotion

- While most stakeholders agreed that the CDC needs to provide the evidence base to actively shape and influence health promotion, the majority view was that the CDC shouldn’t own programs/program delivery. The CDC would provide robust evidence, whilst states and territories – along with community health organisations and NGOs – would craft programs at the state & community level that leverages this robust knowledge base. The CDC providing national, evidence-based advice that can be adjusted to the local context was seen as appropriate and beneficial.

5.3 Stakeholders outside of health structures

- Stakeholders commonly reflected on the desire for the CDC to adopt a 'One Health' perspective when responding to this question. To this end, most agreed there would be strong need to engage stakeholders outside of health structures.

- From a communicable disease perspective, the aforementioned need to engage with animal health and environmental health stakeholders is needed. This cross-sector engagement will ensure surveillance and detection capabilities are appropriately robust and ensure emerging threats can be detected in a timely manner across the ecosystem.

- From a non-communicable disease perspective, stakeholders commonly reflected on broader determinants of health in framing their response. To this end, there were many stakeholders outside of health structures that can and do have a material impact on health. Examples given included taxation on foods/drinks known to contribute to poor health outcomes, agriculture and food security policy, and the development of active transport policies to encourage human movement. There is an expectation that the CDC would take a wide lens and consider contributing to these policy domains as needed.

6. National medical stockpile

6.1 Access of supplies from National Medical Stockpile

- There was relatively limited input from stakeholders on the topic of the National Medical Stockpile.

- The minority that did comment tended to call for broader visibility of the stockpile and its operations, to engender trust and collaboration. Ideally, this would include clear information on what items are in stock, what items have been ordered, what items are confirmed en route to the facility (by air, ship or road), and what items are due to leave the facility.

- Additional information required should include the months of stock on hand at the current usage rates, and the projected position of the facility in 7 and 14 days (accounting for inflows and outflows).

- Some stakeholders suggested a dashboard displaying this information should be broadly visible to the states and territories to foster collaboration over competition.

- Some also called for equitable access to private sector health practitioners who commonly face the same health risks as their public sector counterparts.

- It was noted and appreciated that there had been priority allocation of materials (especially vaccines) to high-risk sub-groups during COVID-19, and it was envisaged this would continue under the guidance of the CDC.

7. World-class workforce

7.1 Prepared workforce

- To be effective, stakeholders commonly argued that the CDC must have access to diverse relevant scientific and data analytic expertise, drawn from diverse disciplines and backgrounds, across the biomedical, psychological, social, environmental and data sciences, for example in health economics, health systems and services including primary care; emerging and endemic infectious diseases; mental health, gender and diversity; environmental health, climate change and chronic disease.

- It was strongly argued that it would be insufficient for the CDC to merely contact such capacities. To be a trusted and authoritative voice, the CDC requires the in-house expertise spanning all functions to ensure it can appropriately coordinate and consolidate scientific outputs to ensure all directions or guidance is fully robust and defensible. To this end, a number of stakeholders anticipated that senior leaders across the CDC would come from a senior academic background and that CDC staff themselves may be routinely placed into academic roles to ensure the organisation is always connected to and leveraging global best practice.

- A number of stakeholders noted much of this specialist capacity either already exists or has strong foundations across a number of academic education and training institutions. Rather than duplicate these capacities within the CDC itself, it was suggested the CDC could partner with these institutions to access:
    - Comprehensive expertise and leadership in public health and health security across all relevant aspects of prevention, surveillance and response;
    - Analytic and modelling capabilities, particularly for large and complex data; and
    - Regional and global links in the non-government sector.

- Several stakeholders noted the Australian CDC has a key role to play in workforce development, surge capacity and refresher training across key disciplines. This should include a specific role in training future public health leaders in a range of relevant disciplines, including in applied epidemiology with a focus on practical field experience.

- A number of stakeholders noted that all CDCs globally include a Field Epidemiology Training Program (FETP) as a key workforce development activity, and argued that this should potentially be a key requirement for some Australian CDC staff too. This echoed comments from other stakeholders who commonly noted the proposed CDC needs to have ready access to all essential technical capacity in house rather than on a sub-contracted basis.

- It was noted that one of the key weaknesses of Australia's response to COVID-19 was the limited resourcing consideration, and response to social determinants of disease spread and control. Many localised (that later became generalised) outbreaks were seeded and accelerated by social, behavioural, and economic factors (e.g., casualised workforces, cultural practices interacting with household composition/size). A CDC must invest in strong capacity to support social and behavioural epidemiology, and local community-driven responses, and have senior management and advisory structure that include these skills and experience.

- To ensure appropriate engagement with First Nations People, a number of stakeholders noted It will be critical to ensure that Aboriginal and Torres Strait

Islander people are represented cross all levels of the CDC governance structure. This was seen as ensuring Indigenous input and oversight on all matters that effect the health and wellbeing of Aboriginal and Torres Strait Islander people – aligning with priority reform three in the National Agreement on Closing the Gap that speaks to the importance of ensuring government organisations are adequately equipped to respond to the needs of Aboriginal and Torres Strait Islander people.

- To support this, the CDC will require a skilled, multidisciplinary, and culturally safe workforce. This workforce will need to include a broad range of Aboriginal and Torres Strait Islander public health experts including Medical Officers, Registered Nurses, epidemiologists, and data analysts. This will enable a culturally safe approach to the work done and ensure that an equity lens is applied in all processes undertaken by the CDC.

- To create a workforce that includes a broad range of Aboriginal and Torres Strait Islander public health experts, it will be integral to design national public health training programs, that are identifiable and accessible for Aboriginal and Torres Strait Islander people.

- Stakeholders noted the CDC should have responsibility for any surge workforce response required in times of health emergency. Ideally, this workforce will be appropriately trained and available to be stood up at short notice. At times of emergency, the CDC would adopt a direct command and control approach to ensure this surge workforce is directed and coordinated to achieve the CDC's stated directions.

- A number of stakeholders noted that there needs to be greater coordination of public health expertise. During COVID it was noted there was insufficient mapping of public health expertise which limited or delayed appropriate responses. Ideally, stakeholders suggested the CDC would encompass a national public health accreditation program that would serve both as a national register of public health capacity and expertise, and also facilitate ongoing professional development and training for this cohort to ensure they can be ready to respond to any future pandemic.

8. Rapid response to health threats

8.1 Collaboration on One Health issues

- Many stakeholders, particularly from animal and environmental health organisations, highlighted that animal and environmental health is often sidelined and not as much of a priority as human health. The CDC should build stronger links with these stakeholders to ensure an equitable, One Health approach that has true representation of animal and environmental health stakeholders.

- Stakeholders believe a good starting point is to have national surveillance programs that link with international surveillance programs and include all aspects of One Health (human, animal and environmental health). This is anticipated to promote collaboration on One Health issues both nationally and internationally.

- Climate change was marked by some stakeholders as the biggest health threat and evidence that a global One Health approach is essential in this current context. As with disease, climate change knows no borders. Thus, the CDC should play a leading role in the establishment of a national One Health agenda to public health, that be coordinated, collaborates with and is complementary to international One Health implementations.

- Locally, First Nations stakeholders highlighted the experience and expertise held by First Nations peoples that promote One Health resilience, such as cultural burning practices, caring for Country and ACCHO led initiatives. The CDC can be strengthened by working with First Nations stakeholders to build a strong One Health capacity.

8.2 Current gaps in preparedness and response capabilities

- Many stakeholders saw inadequate data sharing, mixed communications and fragmented response between jurisdictions as the biggest gaps in the COVID-19 response.

- Access to national, rapid, real-time data and surveillance is currently inadequate, leading to some decision-making being made on limited evidence or decisions being delayed while evidence is gathered. The balance of gathering high quality data, evidence and research, with the balance of needing advice and guidance rapidly, was a challenge Australia faced during COVID-19. For example, occupational stakeholders mentioned guidance around workplace PPE, ventilation etc needed to be provided earlier. The CDC can provide large value in this space. A linked data network, with high-quality, real-time surveillance and analysis, can ensure that decision making, guidance and advice can quickly be generated based on high quality evidence.

- The lack of communicable disease horizon scanning is a known gap in Australia's preparedness and response capabilities. Some stakeholders mentioned the need for AI to be utilised for instant notification of ‘red flags’ or unusual data that should be investigated.

- One stakeholder mentioned that as waves and new variants of an outbreak occur, testing and monitoring strategies need to be revised, or created, and that these strategies have lasting implications on diagnosis, treatment, prevention and future policies. The CDC should be well positioned to monitor new waves and variants of outbreaks and be positioned to recommend testing and monitoring strategies that ensure reach, equity, accuracy and cost-effectiveness are achieved.

- Establishing a clear ‘chain of command’ during health threats can be beneficial to public clarity, trust and uptake of health protection behaviours. The CDC could potentially take more of a command-and-control role during times of crisis, rather than an advisory role.

- Stakeholders mentioned the value CDC could bring by scenario planning and mapping of potential future health threats. There is a need to model and measure the impact of different health threat interventions. Particular attention must be paid to the impact on priority populations, who are disproportionately affected by health threats and interventions. Only after this modelling and measurement of impact has been assessed, should drastic interventions be recommended to be implemented.

- As mentioned above, the CDC must ensure the public health workforce has capacity and capability to adequately respond in times of emergency.

- Some of the responses to COVID-19 in Australia that were created on-the-go worked well. For example, education stakeholders mentioned quickly developing educational material to distribute among health services and clinicians. However, these often felt like last minute, chaotic responses. The CDC has potential to establish partnerships

and structures in peace time, that can be activated and utilised during times of crisis. These partnerships and structures will enable Australia to have a proactive rather than reactive response to health threats.

- The National Incident Centre (NIC) was not mentioned in much depth, however those that did mention it, believed it was appropriate to sit within the CDC. Some First Nations stakeholders emphasised the importance of the NIC operating in a culturally safe manner.

- The current research infrastructure in Australia is not rapid enough during times of crisis. The CDC must ensure that there is a fast track to enable research during these times, such as more rapid ethics approval and funding. Research prioritisation is explored further in the section 12.

8.3 Future pandemic, health emergency and public health threats

- Stakeholders acknowledged that public health threats do not exist in a bubble in Australia, or even jurisdictions within Australia. Therefore, the CDC must be in constant communication and collaboration with the international community, particularly our neighbouring countries. Many stakeholders mentioned that geographically, building strength in response capability and capacity around Australia, also makes Australia's response stronger. A strong, resilient region enables a strong, resilient Australia.

- Furthermore, the CDC is uniquely positioned to take a strong leadership role in the Asia Pacific, especially the western pacific. Australia has a wealth of knowledge and public health capability that the CDC can utilise to build its leadership in the region, including driving a 'One Health' approach. Although this was the majority view held by stakeholders, those based in the Northern Territory and Queensland expressed particular importance in the CDC playing this vital role in our region.

- Some stakeholders mentioned the need for a surge capacity that can quickly be activated in times of crisis, including a rapid assessment and response unit that can be deployed both nationally and internationally when a crisis occurs.

- Most stakeholders encouraged global collaboration, particularly around intelligence of disease and health threats. Some mentioned the epidemic intelligence systems that are used in the WHO, US CDC and Gulf States CDC as world leading and recommended the Australian CDC has great opportunity to learn from, collaborate and share with these intelligence systems.

- One stakeholder mentioned that the World Health Organisation Framework for Public Health Emergency Operations Centre (WHO PHEOC) needs to be revised and the CDC would be well positioned to be involved in this process.

9. International partnerships

9.1 International engagement

- Stakeholders consistently noted that the Australian CDC would become a valuable entry point for technical advice and engagement in bilateral, regional and global forums, coordinated across the range of Australian Government entities.

- Several stakeholders noted the establishment of the CDC represents an opportunity to improve and increase Australia's international development efforts to bolster healthcare and health responses to our Indo-Pacific and regional partners, particularly as the region is vulnerable to the health impacts of climate change, natural disasters and disease outcomes.

- Many stakeholders anticipated that the CDC will play an important role in supporting and enhancing epidemiological research in the Pacific Island Countries and Territories (PICTs). It was noted that the CDC's engagement in capacity building in the Western Pacific region will be important for fostering close collaborating with our Pacific neighbours, particularly in relation to climate change challenges.

- The CDC will need to undertake extensive international engagement, in particular throughout the Asia-Pacific region, and develop partnerships with relevant international bodies, including the World Health Organisation (WHO), the Pacific Community (SPC), Asia Pacific Consortium of Veterinary Epidemiology, Food and Agriculture Organisation and World Organisation for Animal Health.

- Engagement with other CDCs across the world should not be limited to infectious diseases, but also include environmental and climate change impacts on health in the Asia-Pacific region and more widely.

- The Australian CDC should be seen as a good training ground for high-quality staff who can deploy, if needed, and may take up roles in international organisations, such as WHO, or other regional or local CDC.

10. Leadership on preventive health

10.1 Holistic approach to public health

- Most called for the CDC to include preventative health and to make determinations on which non-communicable diseases should be the focus of investment to return the greatest improvements in public health. To ensure transparency, stakeholders argued that such decisions need to be made against some agreed, objective criteria and be led by the latest data available.

- Several stakeholders also noted that the burden of non-communicable disease and communicable disease are linked. COVID has clearly demonstrated that those who live with preventable diseases like diabetes and heart disease are less able to withstand the significant biological and societal stressors of a viral pandemic. As such, it was argued that the best preparation for a future pandemic is to lift the baseline health of our population through proactively addressing the growing and significant burden of chronic disease among Australians.

10.2 *National Preventive Health Strategy 2021-2030* goals

- Many stakeholders suggested that the CDC should guide proposals for investment in national initiatives under the National Preventive Health Strategy 2021-2030 (NPHS) (leveraging its strong, data-driven evidence base), as well as actively promoting and supporting co-ordination and consistency of approaches by states and territories. It should also seek to bring together policy initiatives and recommendations pertaining to chronic disease prevention.

- The CDC should also provide best practice policy proposals that might be taken up by jurisdictional levels of government, including recommending model legislation for the various areas of policy reform, while also seeking to harmonise state and national legislation and regulation. Stakeholders commonly linked this to wider determinants of health including tobacco, alcohol, healthy eating and more.

- Several stakeholders noted that the CDC should investigate ways to integrate preventive medicine into Medicare as a clear signal that preventative health interventions are just as important as treatment of disease and related conditions.

10.3 Assessing efficacy of preventative health measures

- While the CDC was not expected to deliver preventative health programs, there is a strong expectation among stakeholders that it would play a central role in ensuring there are rigorous evaluation frameworks in place to assess the efficacy and efficiency of these programs. The CDC would act as the central clearing house of evaluations to ensure it continues to build on existing knowledge of what works and what doesn't.

- Several stakeholders noted that the CDC should have a role in guiding the establishment (and potentially the operation) of systems to measure key preventive health indicators within health and community settings. CDC advice regarding measurement systems should inform analytical strategies that provide greatest utility in guiding responses (e.g., measurement systems that allow for the determination of association between health states and policy, practice, and interventions).

- Technical resources within the CDC should be available to undertake these analyses and provide the regular and ad hoc (upon request) reporting to inform iterative responses to programs. To do this, it is important that the CDC is not part of the implementation of the NPHS.

- Stakeholders noted that underpinning the NPHS is surveillance, a key function of the CDC. Robust national surveillance is required for non-communicable diseases and the risk factors that cause them. The descriptive epidemiology, projections and health economic assessments that surveillance data inform underpins all good health policy and decision making. Surveillance data are also central to assessing the efficacy of public health interventions, and for benchmarking the success of the National Preventive Health Strategy.

11. Wider determinants of health

11.1 Partnership with at-risk populations to inform policy development

- These stakeholders need a voice at the table from the outset – including specific appointments within CDC to reflect the diversity of Australians that the CDC needs to serve.

- First Nations people are served across many jurisdictions and have many agencies already involved in their community and challenges, however most submissions called out the need for this cohort to be specifically included in a culturally sensitive way. For example, currently in many locations there are well established and strong local Aboriginal Health Networks and Services that are trusted by their local communities. CDC's task is to engage and leverage them appropriately.

- Beyond specific populations, and at a macro level, including in the CDC's remit, the social determinants of health is imperative to delivering on reducing burden of disease, better health equity and improved outcomes for at-risk populations, including:
    - Safe and affordable housing,
    - Employment,
    - Meaningful social connection,
    - Time, resources and access to healthy choices, and
    - Safe environments free from violence, abuse or neglect.

- An investment in social and behavioural epidemiology is warranted in this context.

11.2 The CDC and Closing the Gap

- Two key themes emerged across stakeholder submissions:
    - The need for Closing the Gap to be a priority objective of the CDC (a disproportionate and prioritised focus), and
    - The need to understand the broad and culturally specific definition of health for First Nations peoples. This definition of health goes beyond just physical wellbeing to also include the social, emotional and cultural wellbeing of the whole community. This holistic understanding of health is essential to the success of the CDC in this context.

11.3 Delivery of evidence-based health information to CALD and/or at-risk populations

- Two themes are evident from the submissions:
    - Representation within the CDC (by design or through the CDC's own staffing strategy) or partnerships with engaged stakeholder groups, and
    - Using a co-designed approach, such as that which was deployed during COVID-19 to reflect unique contexts and address the needs of special populations.

11.4 Engagement across sectors

- All submissions mention the need for engagement and well-intentioned connection with peak bodies and community representative groups in principle.

- Many stakeholders also advocated for the use of advisory groups or committees that are established to give the CDC guidance where appropriate and are representative of the population that the CDC will serve.

12. Research prioritisation

12.1 The role of the CDC in research prioritisation and funding

- The majority view was that the CDC should have a role in the prioritisation of research for both communicable and non-communicable diseases. The proposed data, analysis and modelling capacity of the CDC would have it positioned to objectively identify gaps, emerging concerns and flag the need for research in these areas.

- Again, some stakeholders expressed that research must be wide and include all aspects that can affect health, implementing a true 'One Health' approach. Animal and environmental health research must also be prioritised when needed.

- Most agreed that the CDC does not need to directly administer funding and should instead work closely with the National Health and Medical Research Council (NHMRC), Medical Research Future Fund (MRFF) and other funding bodies to direct research to the gaps and priorities identified. Some believed CDC representation on funding body's advisory boards or a formal agreement between the CDC and the funding bodies would ensure that priority research identified would actually receive funding from these bodies.

- Whilst most noted that these funding bodies are sufficient in peace times, many stakeholders also identified that this process can be too slow and inadequate during times of crisis. To ensure rapid research during emergencies, the CDC should have the capacity to fund and commission research, when required. It is recommended that an established, fast-tracked route to applied research must be pre-established, including approval for ethics and discretionary funding, and able to be activated instantly in times of crisis.

- Beyond funding, the CDC should also build strong partnerships with key research and academic institutions that hold a wealth of research expertise in their fields, to create a network of highly skilled and capable researchers across the country.

- Community and preventative health stakeholders welcomed the CDC as an objective, independent agency to prioritise research. Some community and preventative health stakeholders noted that research in their areas of work were already underfunded and believed this would be reiterated when the CDC analyses priority/gap areas.

13. The CDC Project

13.1 Measurement and evaluation of CDC success

- The majority believe it is imperative to measure and evaluate the success of the CDC to build trust and demonstrate to government, stakeholders and the public, the additional value of the CDC. However, many also found it challenging to determine what these specific measurements should be.

- As mentioned earlier, many stakeholders believe that burden of disease should be used to determine the success and justify future priorities for the CDC. One stakeholder mentioned the 'Health Burden Monitoring Framework' for both communicable and non-communicable disease. This framework monitors the burden of disease (both currently and projected burden) and also monitors interventions actual and potential impact and cost-effectiveness. By tracking the impact of disease and return on investment, the CDC has an opportunity to demonstrate expertise and value in the Australian public health landscape.

- Measurements of success should be co-created with stakeholders to ensure common goals and 'buy in' is achieved. For example, First Nations stakeholders advocated for culturally appropriate evaluation frameworks, that are co designed with First Nations peoples and representative organisations to ensure Indigenous methodologies and measurement of outcomes are meaningful, culturally safe and do not cause unintended harm.

- Stakeholders acknowledged the need for short-, medium- and long-term goals to be established, so the CDC can demonstrate early and sustained additional value to Australians. Some suggested that the CDC should just focus on operational measurements of success to begin and evaluate public and professional perceptions after the CDC is operational for a period. Some suggested operational, public perception and health measurements are listed below.

- Potential operational measurements identified by stakeholders included:
    - Timeliness and quality of CDC resources, including guidelines and communications (in both emergency and non-emergency times)
    - Cost effectiveness (e.g., of transitioning to an efficient national data linkage system)
    - Timeliness of surveillance and response
    - Representativeness and completeness of data, particularly with priority population groups
    - Capacity building, including workforce size and skills
    - Stakeholder feedback on collaboration with the CDC

- Potential public perception measurements identified by stakeholders included:
    - Awareness of the CDC
    - Trust and confidence in the CDC
    - Understanding of the CDC generally and also specific CDC communications
    - Awareness of health emergencies and recommended actions

- Potential health measurements identified by stakeholders included:
    - Quality of life
    - Life expectancy
    - Burden of disease
    - Mortality and morbidity
    - Successful implementation of the NPHS

- Further, an annual report/review to evaluate productivity (including reports published, national and international committee participation etc) is seen as appropriate and a useful resource to establish priorities and resource allocation for the following year.

- The final scope, function and governance of the CDC will determine final measurement and evaluation frameworks. However, as the CDC builds its reputation as leader of the data revolution in Australian public health, measurement of the success of the CDC should be built on high quality data, evidence and analysis, whilst ensuring a ‘One Health’ and equity lens is embedded in the CDC’s success.

BASTION INSIGHTS

www.bastioninsights.com