



**Australian Federation of
Disability Organisations**

Submission on

**Role and Functions of an
Australian Centre for Disease Control
Consultation Paper**

Department of Health & Aged Care

December, 2022

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About AFDO

Since 2003, the Australian Federation of Disability Organisations (AFDO), a Disabled Peoples Organisation (DPO) and Disability Representative Organisation (DRO), has been the recognised national peak organisation in the disability sector, along with its disability specific members, representing people with disability. AFDO's mission is to champion the rights of people with disability in Australia and support them to participate fully in Australian life.

Our member organisations represent disability specific communities with a total reach of over 3.8 million Australians.

AFDO continues to provide a strong, trusted, independent voice for the disability sector on national policy, inquiries, submissions, systemic advocacy and advisory on government initiatives with the Federal and State/Territory governments.

We work to develop a community where people with disability can participate in all aspects of social, economic, political and cultural life. This includes genuine participation in mainstream community life, the development of respectful and valued relationships, social and economic participation, and the opportunity to contribute as valued citizens.

Our vision

That all people with disabilities must be involved equally in all aspects of social, economic, political and cultural life.

Our mission

Using the strength of our membership-based organisations to harness the collective power of uniting people with disability to change society into a community where everyone is equal.

Our strategic objectives

To represent the united voice of our members and people with disability in national initiatives and policy debate.

To enhance the profile, respect and reputation for AFDO through our members.

To build the capacity and sustainability of AFDO and our members.

To foster strong collaboration and engagement between our members and stakeholders.

To enhance AFDO's connection and influence in international disability initiatives, particularly in the Asia Pacific region, through policy, advocacy and engagement.

Our members

Full members:

- Arts Access Australia
- Autism Aspergers Advocacy Australia
- Blind Citizens Australia
- Brain Injury Australia
- Deaf Australia
- Deafblind Australia
- Deafness Forum of Australia
- Down Syndrome Australia
- Disability Advocacy Network Australia
- Disability Justice Australia
- Disability Resources Centre
- Enhanced Lifestyles
- National Mental Health Consumer and Carer Forum
- People with Disability WA
- People with Disabilities ACT
- Polio Australia
- Physical Disability Australia
- Women with Disabilities Victoria
- Women with Disabilities ACT

Associate members:

- AED Legal Centre
- All Means All
- Aspergers Victoria
- Disability Advocacy and Complaints Service of South Australia
- Disability Law Queensland
- Leadership Plus
- National Organisation for Fetal Alcohol Spectrum Disorder
- National Union of Students – Disability Sector
- Star Victoria
- TASC National Limited
- YDAS – Youth Disability Advocacy Service



Acknowledgements

AFDO acknowledges people with disability living in institutional settings and in the community across Australia, who have suffered or are suffering from violence, abuse, neglect and exploitation and hold them in all of our work.

AFDO also proudly acknowledges Australia's Aboriginal and Torres Strait Islander community and their rich culture and pays respect to their Elders past, present and emerging. We acknowledge Aboriginal and Torres Strait Islander peoples as Australia's first peoples and as the Traditional Owners and custodians of the land and water on which we rely.

Introduction

AFDO welcomes this opportunity by the Department to provide comments and feedback on the proposed Australian Centre for Disease Control Consultation Paper.

The continuing COVID pandemic has focused our attention on what is missing and needed to appropriately respond to a national or world-wide health emergency. It has shown glaring issues of: a lack of preparedness across all levels and areas, faults within numerous systems, problems operating with a federated government model, issues with a lack of supply or sovereign capability for health goods with basics such as PPE and inclusive of vaccine manufacture and deployment.

It has also demonstrated the initiative, capacity and common purpose that can arise and be responded to from the intense pressure of a major health emergency across governments both on a national basis and across international jurisdictions, health providers public or private, emergency services, military services, community responses and compliance to health mandates.

Looking forward, there is a need to evaluate and ensure that appropriate responses, necessary structures and levels of resources including budgets, are put in place to respond, coordinate our responses to any other health emergency whether a pandemic, epidemic, biosecurity, etc. as they occur.

The community must be paramount in the planning, design and review of any response systems or initiatives such as the ACDC and not merely an afterthought or piecemeal consulted. It is in fact community that holds the ownership and are the very ones who experience the impacts directly, either positive or negative, of any health systems or structures in response to daily or emergency health issues.

AFDO requires people with disability, who represent 18% (4.5 million) of the total Australian population, to be included front and centre in a true codesign process on all health services and emergency responses, planning or operations. The total reach of people with disability along with their families and supporters is at least 13.5 million Australians, who demand the right to be listened to by all levels of government.

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Responses to Guiding Questions

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

The CDC scope outlined in Appendix A covers a very broad set of areas in which it may definitively operate along with quite a number of additional areas it may potentially cover. We would caution danger in attempting to take on such a large scale of areas with many currently handled both by other Federal entities or at a State / Territory jurisdictional level.

This may compromise the effective development of the operations of the CDC in the implementation stage which we would advance is more likely to be required for at least three years rather than one year as outlined in the paper.

The establishment of a new national entity is a significant undertaking and requires sufficient time and resources to ensure it is undertaken in a focused approach with this further complicated by the need to establish solid working relationships with multiple entities at a national, state, territory and local levels.

• 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 CDC in its development should focus on the identified first phase areas in the paper and should not attempt to take on existing responsibilities currently held and administered by other entities at a Federal, State, or Territory level.

As outlined in the paper:

“The CDC could provide national leadership and coordination in identified areas, but it would not replace or undermine the existing responsibilities for public health in the states and territories.”

We would prefer to see the CDC role as exactly that, national leadership and coordination rather than taking on or replicating what is already there and working, albeit in some instances, requiring improvement.

The leadership role would be about assisting all levels of government operations to improve and more efficiently undertake their role through greater connection with demonstrated improvements, best practice and improved health outcomes from an international perspective with this also being reinforced via national or jurisdictional examples.

That said there is an obvious tension between what a CDC and State / Territories can work on together, as demonstrated through the, at times, fraught multi government relationships over the responses and course of the COVID pandemic. This was no more aptly demonstrated to our sector than by the constant need for AFDO, our members and sector colleagues to constantly reiterate the need to consider people

with disability and their families in the multi layered responses over most of the main pandemic period with all levels of Government.

In responding to emergencies the CDC would have a coordinating role and would need strong ties and arrangements with existing bodies responsible for differing elements depending upon the nature of the emergency. This should be complimented by its main work outside of an emergency response in providing national leadership and coordination.

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

The outline of the functions contained in Appendix A of the paper, at just the proposed in scope areas, are broad and very significant with requisite challenges. We would recommend stepping these out over a realistic phase in period for three years or more as the CDC is developed.

Key areas already identified from the multiple reviews on the pandemic response should be given the first level of priority for the CDC.

The potential in scope areas should be carefully reviewed and prioritised with some to come on line longer term in the years following the start up phase. We would recommend that a number of the potential areas should be left for other agencies that already hold responsibility for their completion at Federal, State or Territory levels, due our concern that the CDC will be too broad that it loses its focus on achieving national leadership and coordination.

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

The role of CDC in this regard should be again in leadership and coordination of a One Health model. As a conduit of data, information on best practice and health outcome improvement with examples from international, national or other jurisdictions.

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

Governance arrangements recommended would be to have the CDC as an independent agency of government with a skills based Board of qualified health experts along with qualified and experienced consumer representatives/advocates for particular communities impacted the most by emergencies (disability, aged, First Nations, Cald, Women, mental health, etc) and/or multiple advisory groups established for this purpose.

Public confidence in the CDC will only be built based on how it starts up, promotes, interacts and engages with not only health professionals and relevant organisations but with the wider community and the specific cohorts. Outcomes for the CDC need to

take these factors into account as part of its monitoring, reporting and evaluation of its outcomes.

• 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?

We advanced that the CDC needs to be an independent agency of government which still requires relevant government accountability but promotes in reality, a more trusted source for non government organisations and the wider community.

• What aspects of independence do you believe are important to the successful function of the Australian CDC?

The true independence of the CDC from direct government control or perceived government agenda setting is critical to ensure the CDC not only provides a trusted , authoritative, and evidence-based source but is unfettered and allowed to “walk the talk” in this regard, which may, at times, be at issue with governments views

• How should the CDC be organisationally structured to best meet the needs of Australia’s federated society?

Whilst not providing a structure chart, the CDC would need to ensure that it has sufficient resources and staff to focus on the key part of relationship building and maintenance with relevant departments within the federated structure along with other key organisations in the health sphere, primary health, community health, public health, and mental health with a strong connection established with relevant sector advocacy and consumer representative bodies.

It would need to consider whether it needs office footprints in each jurisdiction or may utilise office sharing with other agencies as required. It should also undertake greater utilisation of assistive technology like video conferencing (a rapid change in uptake over the pandemic) for connection in main capitals and/or for regional, rural, remote and very remote areas. Working with communities such as CALD and First Nations will require specialist skills and training in cultural understanding and safety and are best met via face to face engagements. Training should also be provided in disability awareness to all CDC staff which must have been developed by and then delivered by people with disability who comprise 18% of Australia’s total population and are significant consumers within health systems.

The federated model presents challenges for any national CDC roll out and is complicated requiring significant attention to ensure full engagement across each jurisdiction with population spread, distances, etc. creating the need for a specific approach to be developed for every jurisdiction as a “one size model” will not work and has been proven in recent years as with lessons from the NDIS roll out. We would encourage the Department to consult with relevant staff at the NDIA in order to gather lessons learned in undertaking a national roll out.

A coordinated and national approach to public health

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

It is in the current pre-establishment and then implementation phase of a CDC that will set the scene for its ability to provide and be given the authority for the requisite coordination role across the health sector. Failure to bring States, Territories, local governments, health sector stakeholders and consumers along this journey will result in an entity seen as beaurecratic with significant powers that may be legislated but it will not have its authority recognised.

The CDC consultations are a good example of allowing others input into its format, scope and function but only if this is seen by those consulted as truly reflecting and taking on board main themes, feedback and suggestions on its shape, scope and implementation.

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

Not our area of expertise, we would be guided by others more qualified and experienced

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

There are many lessons that should have been learned from our responses;

- Issues with national cocordination of responses, communication and information across a fractured federated model which became more evident as the pandemic progressed
- Providing information and announcements in accessible, understandable and preferred mediums for differing communities inclusive of people with disability and their families
- Ensuring that health systems responded with ethical considerations for emergency treatment and post hospital treatment for people with disability
- Significant delays in signing up adequate vaccine agreements affecting delays in supplies and mass vaccination results
- Lack of action and delays by Federal Government in recognition of health implications/impacts despite the international advance warnings, no doubt causing additional fatalities, distress and confusion amongst the community
- Mixed messaging on health, infection control and vaccine key information federally and across State, Territory Jurisdictions

- Inadequate response and to the provision of PPE for people most at risk inclusive of primary health care (our first line of defence), aged care facilities staff and residents, disability care facilities staff and residents, people with disability as NDIS participants or out of Scheme, immunocompromised individuals, support workers for people with disability, families or carers of people with disability
- Several false starts with Federal Government and other governments forgetting about the priority of including people with disability or their representative bodies in pandemic response, not just initially but over the first twelve to eighteen months
- Health Department making a decision to leave People with Disability off the Vaccine planned roll-out, despite this originally being developed and including them in Stage A as a priority cohort. It included aged care and people with disability but the Department decided without consultation to only tackle aged care and deprioritise PwD until their representative bodies discovered this shift following ongoing questioning of government. A disgraceful event and should not occur with a national coordinated approach.
- Inadequate and delayed response for vaccination program for people with disability in Special Disability Accommodation residential facilities (17,500 People in sites across Australia, not counting aged care) Many could not get out to obtain (as per aged care) and required to be provided into the facility.
- No legislation undertaken by Federal Government as a national/international pandemic emergency to prevent, shut down and/or prosecute those perpetuating misinformation on the pandemic, vaccines, ppe, health response, government control conspiracies, etc.
- NDIS Scheme with delays and about face on whether people with disability could claim PPE via their participant plan (their pre-approved allocated money, or not)
- NDIS Scheme, allowed by NDIA for service providers to charge additional fees to participants for their support staff PPE provision with NDIA making this a requirement for Providers to advise participants of the additional costs not the Agency in the first instance. Added to confusion, concern and delays for participants.
- Impact of primary industry or specialist industry undersupport and research underfunding resulting in a lack of sovereign control in production of vaccines, PPE, other equipment (ventilators) in Australia
- Lack of planning or rapid establishment of potential and fit for purpose quarantine centres across all states & territories
- Ineffective use and supervision of hotel quarantine facilities with many inappropriate and not fit for purpose
- Engagement of totally untrained and/or unqualified staff to monitor and secure quarantine facilities

- Use of “lockdowns” creating significant emotional and mental health issues for individuals affected in various states, along with politics played across governments about this process
- Allowance by governments of mass release of potential infected individuals from cruise liners and airports without sufficient checks and follow up
- An apparent “changing the rules as we go along” approach between Federal, state and territory governments with a lack of consistent, uniform messaging or positioning
- Disregard by Federal and all governments on the current risks of the pandemic and down play of the number of individual affected and those still dying. 16,651 Australians have died from COVID related issues this year up until 15th December, reporting is there if you like to find it but not truly publicised anymore.

The pandemic is still a significant issue for many people with disability and for those immunocompromised with those choosing to continue to remain in a self-imposed isolation for their own safety, who knew and who supports?

- Down play of data requirements and reporting across Australia. E.g. Four week delay in NSW (plus delays elsewhere) providing relevant timely data to Federal Government or reporting for transparency. 16,651 Australians have died from COVID related issues this year up until 15th December, reporting is there if you would like to find it, but not truly publicised anymore

• 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?

Not our area of expertise, we would be guided by others more qualified and experienced

• Are there any national, state and territory or international reviews that would be of assistance in designing the CDC?

Not our area of expertise, we would be guided by others more qualified and experienced

A data revolution

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

Experience across multiple sectors highlights that there is no area that does not have a data issue in Australia. Barriers include collection of relevant data, lack of focus on critical data required for planning and response, lack of understanding of necessary data needed rather than just collect all.

There are many good data research programs being advanced across governments at present but we currently do not have sufficient or synthesised data to truly understand the varied disability types, disability cohorts and their communities.

The Census has higher level data and will not vary the questions much/if at all to obtain further clarification on PwD across Australia. The AIHW provides more in-depth data for PwD but it is still not collecting sufficient information on different disability types, multiple disabilities, or in-depth economic and health statistics on these, etc.

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

In looking at those for people with disability, there are the current usual sources, Census, AIHW, NDIS (for NDIS participants) and some smaller University Research Data collections. The proposed Disability Data Asset Program has been building a framework for a more comprehensive data set on people with disability nationally, which would be available to all for strategic and comprehensive planning of any activities, programs, policies or interventions. The Program has still to be started and data captured for this purpose.

• Is there data currently not collected in Australia which should be considered?

Further disability data is urgently required covering national, state, territory and local government area breakdowns.

• What else is needed to ensure that Australia is able to identify emerging risks to public health in a timely way?

Clearly, primary health care, hospital, specific health issue providers and research is needed to round out potential or developing risks along with data and trends from internationally acquired results.

A coordination of all of this to a CDC with the capacity and resources to examine and review would provide a greater identification in advance of potential or likely trends.

• Would the development of a national data plan with an agreed scope and/or an evidence-based health monitoring framework be useful?

Absolutely, the current state has not seen an appropriate level of planning with a national plan being essential to provide clear evidence and enable a more rapid response required for any identified issues

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

Not our area of expertise, we would be guided by others more qualified and experienced

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

An appropriately resourced and staffed CDC will be critical in any analysis and provision of guidance. We would not hold the expertise to detail what this would entail but support ensuring that appropriate funding for start up and ongoing implementation is provided by the Government as data oversight and capability will be critical for a rapid, considered response for further emergency situations.

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

We would agree that there needs to be a strong connection by the CDC with key populations such as, people with disability, First Nations and CALD communities, along with their families and representative organisations. We are looking for better data and reporting to assist us in representing people with disability their families.

National, consistent and comprehensive guidelines and communications

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

We refer to our previous responses in terms of building this by being a statutory authority of government suitably legislated to have separation and true independence from any undue or perceived influences from any government of the day

- **To what extent should the CDC engage with the media, public messaging and health communications directly or via other existing structures such as Australian Government and state and territory health departments?**

The CDC should only engage in terms of its role as providing National Leadership and Coordination

- **What could the CDC's broader role be in increasing health literacy to support sustained improvements in health outcomes?**

We don't support a role for the CDC in health literacy outside of recommending appropriate campaigns to governments based on data and evidence collected

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

We don't support a role for the CDC in health promotion, communication or outreach activities outside of recommending appropriate issues to governments based on data and evidence collected

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

People with disability, their families and their representative bodies must be included to assist in formulating advice that takes into account their experience and understanding of their interactions with the health systems and structures. People with disability are 18% of the total Australian population and combined with their families and supporters make up a reach of at least 13.5 million Australians.

This area priority cohort along with experience of health systems by their families, supporters and representative bodies on their behalf. They must be included as key stakeholders to provide advice and input on what works or requires changing from a consumer perspective. We experienced a failure of governments initially to ensure that this significant cohort were left out and forgotten in the first months of the pandemic response and again with the responses to the vaccine roll out. To maintain any

credibility with these Australians, people with disability must be included front and centre in the CDC formation, scope of works and ongoing consultation and input as it is rolled out nationally.

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

As advanced, people with disability, their families and their representative organisations have a deep knowledge of what is working or not working across the health systems in particular and also form an emergency response situation.

In order to engage effectively with our members and communities, there needs to be an allowance at the outset, for sufficient and adequate time to consult. As an example, for AFDO to adequately consult with its 34 members organisation of various disability specific communities or population based communities we need a minimum of eight weeks (2 months).

This is because a number of our members have accessibility / communication needs such as Auslan, captioning, braille, tactile interpreting, large print, Plain English, Easy English, support staff both pre, during and post any consultation to ensure the PwD understands what is being requested of them, etc. Booking in a number of these areas takes time due to high demands and a lack of available resources such as Auslan or captioning, etc.

Whilst the pandemic has improved the governments understanding we still receive request with inappropriate time line demands for appropriate consideration. A current example being DSS only requesting feedback on Tuesday 13th December with a deadline of the 6th January 2023! This means that we have been given 24 days to respond but it fails to take into consideration the time of the year, staff leave and the level of current submissions from all departments including DSS, that we are already completing, let alone the fact that our organisations close over the Christmas new year period and wont be back until 3rd January 2023.

The point we are making is that any consultation must provide sufficient time for completion, PwD can have significant accessibility / communication requirements, PwD, their families and their representative organisations need to be treated with respect as part of any consultation, in order for them to provide their relevant expertise and knowledge. Best practice consultation must take into account all factors for the cohort being engaged and not be pushed along by internal or external timelines just for the sake of completion.

National Medical Stockpile

14. 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 on which the CDC could expand or improve?

There have been significant issues with accessing the NMS before and during the latest pandemic.

The NMS proved to be inadequate in providing stock at the start of the pandemic, with the excuse being that a significant volume of masks, etc. had been used over the bushfire emergency which occurred pre the pandemic. Not good enough, as what is the point of an NMS if it can't rapidly respond to stock usage issues in real time? This resulted in lengthy delays for medical practitioners, service providers, aged care service providers, disability service providers, people with disability and their families being able to access stocks to prevent the spread and containing the rate of infection or cross infection. Our lack of sovereignty of production of PPE also added to significant delays due to the impact of an international pandemic and all countries seeking supplies or holding their own manufactured products.

Apparent confusion, in terms of the NMS policy concerning supplying PwD and their support workers, even though they are recognised as a most at risk group. Confusion by the NDIS as to whether PwD can access stock and whether this could be claimed in the participants support plan.

The need for primary health care and disability support providers having immediate access to a sufficient level of PPE in line with the numbers of persons likely to approach for assistance.

Many disability service providers had to seek their own PPE supplier outside of the NMS, due to the lack of available supply or because of insufficient access to any supplies in the first instance.

We lack the sovereign capability to provide for our own production of PPE and/mask preparation or agreed ability for an onshore company to retool (as needed) to take up the provision of PPE.

Other issues were the confiscation by government for the NMS of RAT's purchase directly by service support providers and then the delays in issuing these to the same providers through the NMS

Insufficient quantities on PPE being provided to primary health care and service support providers in aged care and disability support, in terms of actual quantities required for a requisite period of time for each practice/organisation based on their advice. It was like the NMS just sent out whatever they thought and that was all they could do until next time. As an example, basic maths would tell you that a general practice with ten doctors on duty plus thirty allied and practice staff, seeing an average of five patients each per hour over an eight hour shift, allowing for mask changes (not

damage) at the required interval equals a minimum of at least 1760 masks per day and a total of 12,320 masks for seven days of operation. They would receive 2,000 for the week and had to make their own purchase for the real amount required to protect the safety of the staff and patients and be able to function.

World-class workforce

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

There needs to be significant resources provided into health workforce planning but we must also recognise existing Australian blockages, barriers and the allowance of significant time lags despite identified shortfalls, which has been ongoing for decades.

A simple example being a reducing number of available General Practitioners, our first line of public health defence, not only in Metropolitan areas but occurring across the range of working environments. Solutions have varied but this has been a continuing issue ongoing for at least the last fifteen years and has speed up with female and male GP's now not wanting to undertake full time practice and preferring to have a better work life balance impacting further on numbers required.

Insufficient numbers of medical students wishing to take on the GP role, forcing overseas trained doctors into guaranteed times practicing in regional/rural settings (not appealing for many) and movement of these around areas over short time frames. This does not provide sufficient continuity of patient treatment and understanding of their health needs. It is of significant concern for people with disability who require continuity of health support especially for those with multiple chronic health conditions.

Difficulty in overseas trained doctors to acquire RACGP certification to practice here, predominantly and harshly linked to where they did their training and placements.

This is just one area of workforce where the CDC would need to focus and be able to implement some rapid changes to ensure that our health workforce is built up in numbers to cater for existing health needs let alone those demands in an emergency, especially one which extends for a significant time such as a pandemic, epidemic or bio security issue.

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

Not our area of expertise, we would be guided by others more qualified and experienced

Rapid response to health threats

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

The CDC would be best placed to engage on a national footing as long as its focus is on National Leadership and coordination in identified areas. It must not replace or undermine the existing responsibilities for public health in the states and territories but assist in providing evidence and best practice guidelines for improvement.

18. What are the gaps in Australia's preparedness and response capabilities?

We identified a number of issues with the learnings that are required from the current pandemic highlighting significant gaps, but would propose that this is not our area of expertise and we would be guided by others more qualified and experienced

• Could the role of the National Incident Centre be modified or enhanced?

Not our area of expertise, we would be guided by others more qualified and experienced

• What functions should a national public health emergency operations centre deliver to strengthen Australia's coordination of health emergencies?

Not our area of expertise, we would be guided by others more qualified and experienced

19. How can the CDC position Australia, mindful of global, regional and local expertise, to be better prepared for future pandemics, health emergencies, and other public health threats?

Not our area of expertise, we would be guided by others more qualified and experienced

• What could our contribution to global preparedness look like?

Not our area of expertise, we would be guided by others more qualified and experienced

International partnerships

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

Not our area of expertise, we would be guided by others more qualified and experienced

• 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)?

In keeping with our view of the principle role of the CDC being National Leadership and Coordination we don't see additional objectives being required for this element

• How can the CDC be utilised to strengthen pandemic preparedness internationally?

Contributing to international data, case studies and providing the sharing of best practice results from Australia to other participating countries.

Ensuring regular engagement with the international community to build respectful robust and solid relationships that encourage the continuation of trust, goodwill and openness of shared learnings.

Leadership on preventive health

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

Not our area of expertise, we would be guided by others more qualified and experienced

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

Not our area of expertise, we would be guided by others more qualified and experienced

- 23. Should the CDC have a role in assessing the efficacy of preventive health measures?**

Not our area of expertise, we would be guided by others more qualified and experienced

Wider determinants of health

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

Please refer to responses provided earlier detailing the importance of involving front and centre” all people with disability, those from First Nations, Cald communities in the implementation, planning, development and ongoing feedback on the CDC . This needs to be in genuine co-design and collaborative process respecting the individual and communities accessibility, communication needs, culture requirements and ensure that CDC staff have been trained to undertake appropriate, culturally safe, disability safe consultation and communication. This must recognise that one size fits all is a complete misnomer and out of step with individual and community expectations

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

Not our area of expertise, we would be guided by others more qualified and experienced

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

Please refer to responses provided earlier detailing the importance of involving front and centre” all people with disability, those from First Nations, Cald communities in the implementation, planning, development and ongoing feedback on the CDC. This is inclusive of the means and methods in providing information that maintain disability, cultural, safe practices allowing for accessibility needs and communications designed for particular target groups or individuals.

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

Not our area of expertise, we would be guided by others more qualified and experienced

Research prioritisation

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

We would advise that the CDC should have a role strictly National Leadership role in advising on priorities for public health and medical research. It should not hold or directly administer funding for the required work

The CDC Project

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

Not our area of expertise, we would be guided by others more qualified and experienced