Public Health Association
AUSTRALIA

Public Health Association of Australia submission on Role and Functions of an Australian Centre for Disease Control

Contact for recipient:
Professor Paul Kelly – Chief Medical Officer
A: Department of Health and Aged Care
E: CDC.Consultation@health.gov.au
T: (02) 6289 1555

Contact for PHAA:
Terry Slevin – Chief Executive Officer
A: 20 Napier Close, Deakin ACT 2600
E: phaa@phaa.net.au **T:** (02) 6285 2373

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The **Public Health Association of Australia** (PHAA) is Australia's peak body on public health. We advocate for the health and well-being of all individuals in Australia.

We believe that health is a human right, a vital resource for everyday life, and a key factor in sustainability. The health status of all people is impacted by the social, commercial, cultural, political, environmental, and economic determinants of health. Specific focus on these determinants is necessary to reduce the root causes of poor health and disease. These determinants underpin the strategic direction of PHAA. Our focus is not just on Australian residents and citizens but extends to our regional neighbours. We see our well-being as connected to the global community, including those people fleeing violence and poverty, and seeking refuge and asylum in Australia.

Our mission is to promote better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.

Our vision is for a healthy population, a healthy nation, and a healthy world, with all people living in an equitable society, underpinned by a well-functioning ecosystem and a healthy environment.

Traditional custodians - we acknowledge the traditional custodians of the lands on which we live and work. We pay respect to Aboriginal and Torres Strait Islander elders past, present, and emerging and extend that respect to all other Aboriginal and Torres Strait Islander people.

Introduction and Executive Summary

PHAA welcomes the opportunity to provide input to the consultation process on the *Roles and Functions of an Australian CDC*.

In this submission, we:

- Comment on the vital future role of the CDC as a lead actor in detecting and managing infections disease pandemics;
- Emphasise the need for a coordinated, agreed, and amicable set of relationships between the Commonwealth and state and territory governments; and
- Articulate a list of functions for the CDC, which – crucially – includes functions related to chronic, non-communicable diseases in Australia.

Key features that would bring about a successful Australian CDC are as follows:

- The need for the CDC to have an appropriate level of independence from the political considerations of the government of the day;
- The need for the CDC to build and maintain strong functional relationships with many other elements of government, particularly with states and territories;
- The need for the CDC to be properly resourced. This will be a genuine test of the commitment of the Government to the new agency. A simple truth of government is that the level of financial commitment is a tangible reflection of the priority given to any issue. The CDC annual budget MUST be in the hundreds, not tens of millions, of dollars;
- Health taxes, in the form of modifications to current tobacco and alcohol tax regimes, as well as a sugary drinks tax, both advance chronic disease prevention efforts as well as providing much needed revenue to finance the broad range of public health work necessary to operate the CDC, both at national and jurisdictional level.
- The CDC MUST commence with an active plan and appropriate resourcing for Chronic Disease Prevention. The National Preventive Health Strategy is the obvious framework through which this can occur;
- The imperative to establish the CDC has come out of an infectious disease pandemic, and communicable disease control must be a priority. However, work to prevent chronic disease cannot be relegated to being a poor cousin;
- The CDC MUST give focus to the 'causes of the causes', through prioritisation of sections of the community most in need of assistance and support, and a focus on equity as an essential underpinning of public health;
- The CDC MUST prioritise efforts to advance the health of Aboriginal and Torres Strait Islander people;
- The CDC MUST build public health workforce capacity in Australia. It needs to do so by leading and investing in advancement of the workforce through a range of national initiatives and programs, including an Australian Public Health Officer Training Program;
- The CDC MUST be expert, trusted and trustworthy, and transparent, and must communicate openly, clearly, and frequently with all its stakeholders, and the people of Australia;

- The CDC can establish a network of engaged and expert research groups by the putting in place a network of "CDC Collaborating Research Centres" which can drive and provide policy international quality, timely and policy relevant research; and
- The CDC MUST seek to establish itself as a long-term cornerstone agency, an ongoing part of the public health system in Australia with a 50- or 100-year outlook.

The PHAA is strongly committed to support the successful establishment of and future growth of the CDC. This submission seeks to contribute constructively to thinking about the CDC, in the expectation that the resulting institution will be effective, responsive, and above all will contribute to the health of people in Australia for generations to come.

PHAA Response to the Consultation Paper's Guiding Questions

Functions of the CDC

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

As outlined in the consultation paper, the recent pandemic highlighted the lack of a single and coordinated mechanism to allow Australia to respond effectively.

To improve our national capability into the future, the CDC should have decision-making responsibility for responses to broad-reaching public health issues and emerging threats of national importance including responses to cross-sectoral, cross-border or international emergencies, and programs that enhance and support state and territory functions particularly where there have been evident gaps, such as emergency responses in long-term care facilities. As already indicated in the draft functions, this would include responsibility for areas such as the National Incident Centre, Biosecurity Act, and National Medical Stockpile.

Without legislated decision-making responsibilities, inconsistent or delayed jurisdictional responses, as seen during the present COVID-19 pandemic, are still possible.

A suggestion has been made that the Australian Medical Assistance Teams (AUSMAT) service, which is managed by the National Critical Care and Trauma Response Centre (NCCTRC) in Darwin, become deployable to domestic as well as international emergencies. The NCCTRC is one of many current centres with roles in health protection with which the new CDC should have a coordinating relationship. But it is not necessary to take over this function, as it is by nature a clinical service.

We also acknowledge that it would be unlikely that states and territories would relinquish their substantial and legislated powers under jurisdictional Public Health Acts. Any attempt to see these powers relinquished, modified, or ceded to the Commonwealth would be likely to cause barriers and delays to the establishment of the CDC, and as such are not recommended. Over time, should there be agreement by Commonwealth and states and territories to revise the distribution of those powers, such options might be considered and negotiated.

Food Standards Australia New Zealand (FSANZ) has produced a model Food Act that jurisdictions use to frame their food legislation. This may provide a model for creating consistency between state and territory Public Health Acts, which should be a longer-term objective.

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

As outlined in the consultation paper, the CDC should not replicate functions effectively delivered by other government and non-government sectors and networks, but rather coordinate and leverage existing capabilities to strengthen responses and address gaps. The summary of scope and budgets of international counterparts in Appendix B is particularly useful in considering what should be in and out of scope for the Australian CDC.

Functions that should be in scope include:

- Biosafety and radiation emergencies
- Collaborating with research institutions and laboratories
- Design and implement national public health programs
- Disease prevention and control (including infectious and chronic disease)

- Disease surveillance, evaluation, and data analysis
- Emergency preparedness and response
- Expert advice and guidance
- Health promotion
- Health workforce education and development
- International collaboration on public health
- Manage national medical stockpile

Notably, 'radiation protection' as outlined in Appendix B is currently a function of Australian Radiation Protection and Nuclear Safety Agency (ARPANSA). It would be a mistake to have CDC pick up the regulatory functions, along with guidance associated with this. Rather, response to disease arising from state or national emergencies, such as 'radiation emergencies', communicable diseases, environmental health disasters, etc. should be in scope.

Functions that should be *out of scope*, because mechanisms pre-exist, and/or the activities would require significant budget allocations, include:

- Operate research institutions and labs
- Provide preventive health and other specific research grants
- Regulation of medical and health professionals
- Regulation on the use of chemicals and medicines

The CDC does not need to operate a laboratory per se, but it does need genomic epidemiologists and bioinformaticians to coordinate and analyse data that state and territory reference laboratories generate. The CDC needs to prioritise and fund reference functions to complement that of the states and territories. There is a large component of this work that is coordinating and collaborating in nature. The CDC Discussion Paper is almost silent on laboratories, which appears to be an omission.

One of the things that does get lost in many national health responses to non-communicable disease emergencies, is 'who will collect data on persons affected and monitor the impact of the event'. There have been numerous events, such as breast implant associated cancers, skin rashes associated with certain batches of methadone, needles in strawberries and more recently, poppy seeds causing illness. All of these had regulatory processes in place, but no one was charged with collecting data on affected persons and monitoring the effect of the event.

We note that inclusions in the CDC functions need to be influenced by feasibility and timeframes and suggest that a phased approach to defining its scope is sensible. As referred to in Question 27, we recommend a legislated review period be established for the CDC to explore both the performance of the CDC and the consideration of modifications, most likely expansion, of the CDC scope. This will allow for the possibility of a progressive expansion of CDC scope and responsibilities into the future.

We also note that it is suggested that food regulation policy remain outside the remit of the CDC. Whilst we agree that this should be the case in the first instance, during its establishment and initial growth, this is an area we would like to see revisited in the medium term as the scope of the CDC expands in the future, especially given the issues with food security experienced during the current pandemic.

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

Currently in Australia there is no national One Health framework to prevent and respond to emerging and re-emerging infectious diseases and non-communicable diseases. The management of zoonotic disease outbreaks is often dependent on both formal and informal working relationships and protocols between federal and state or territory human and animal health departments, the strength of which varies across jurisdictions. (1) The establishment of the CDC provides an opportunity to embed a One Health approach into its operational platform, providing a truly integrated and holistic approach to complex health

challenges. This would be facilitated by establishing a trans-disciplinary team with structures and relationships that enable coordinated planning and preparedness for pandemics.

The discussion paper recognises human health as the dominant concern of policymakers. However, because a One Health approach recognises the interlinkages between human, animal, and ecosystem health, to successfully operationalise One Health within the CDC and across all national agencies, there is a need to draw on broader expertise with equal standing of all players to bring a diverse range of perspectives to complex problems, such as disease emergence and antimicrobial resistance (AMR). This requires involvement from the CDC's inception of a range of disciplines – human health, animal health, eco-health, social science, engineering, and economics.

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

Essentially, the CDC needs to be able and confident to independently provide trusted, authoritative, and evidence-based advice, and be both acknowledged and sustainable, irrespective of the reluctance of any Government to hear such advice.

We welcome that the agency is being established by a government that has shown a commitment to improvement and expansion of public health capacity. This commitment may not exist in future governments. As a result, the governance structure must be created in a manner that best improves the chance of the agency remaining in place and effective through the normal cycle of changes in government into the future. It must be given the best chance to weather the storm of any future government that might be indifferent - or even hostile - to the value and importance of public health advice and expertise.

This strongly suggests that the CDC should be established as a new statutory body, similar in governance arrangements to the Australian Commission on Quality and Safety in Healthcare. It has an independent, expert governance board rather than an advisory board, with clear independence mechanisms. The Board membership should come from a diversity of disciplines and segments of Australian society and have unassailable public health credentials and expertise. It should be supported by a cross-jurisdictional committee consisting of representatives from the federal, state and territory health departments, and various subcommittees made up of subject experts relevant to its functions. This would create the balance between the need for independence from government, whilst achieving accountability and jurisdictional buy-in across our federated government system.

The new institution's structure should reflect a hub-and-spoke model, with a properly resourced administrative centre, to coordinate its activities and functions, and enable international collaborations. The hubs should include jurisdictional offices for regional coordination and engagement, in much the same way as the Public Health Agency of Canada is structured, staffed with funded positions to capacitate national functions. This could be done in a similar fashion to OzFoodNet, which is funded under a national agreement to place 1-2 epidemiologists in each jurisdiction. The OzFoodNet network is strongly coordinated nationally. A key consideration is that there is a need to minimize the potential for cost-shifting with funding.

The CDC would also draw on other partnering entities such as universities and research institutes, public health units, laboratory networks, non-government agencies, advocacy, and professional bodies and so on, to draw on our existing national expertise. There are many different organisations and actors that need to be partners in the new CDC that have big roles in health protection, such as NCCTRC, National Centre for Immunisation Research and Surveillance (NCIRS), Kirby Institute, the Peter Doherty Institute for Infection and Immunity, and many more. Regulatory bodies such as the Therapeutic Goods Administration (TGA), FSANZ and ARPANSA and others would also need to be factored in as key collaborators.

Why do we need a CDC?

A coordinated and national approach to public health

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

As aforementioned, given the federated system in Australia, the CDC will play a critical coordination and leadership role. The PHAA proposes that this should take the form of a network of centres and collaborating agencies. Lessons can be learnt from the European CDC, which is made up not just of jurisdictional states, but of national member states, providing support to its country member's activities and networks and ensuring effective partnerships through cross-representation at a governance level via its coordinating competent bodies.

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

Prior to the pandemic, and as outlined in response to Question 18, the most recent Joint External Evaluation of International Health Regulations Implementation identified areas Australia could improve in its preparation for the next public health emergency.

Most recently, the National Contact Tracing Review was tasked with evaluating the contact tracing and outbreak management systems across the nation and identified a range of lessons learned from the pandemic response. Most importantly, there is a need for all jurisdictions to undertake continuous improvement, and to evaluate, and communicate their performance. Other integral areas for improvement included constant preparation, end-to-end contact tracing, outbreak investigation and management, data exchange, technology, community communication, and community confidence.

However, we also know that linkages between public health and primary care were strengthened through the pandemic response, for the purposes of communication with patients, distribution of vaccines and prescription of antivirals, telemedicine, hospital in the home models of care, amongst other things.(2) There was also strengthened relationships between the Commonwealth and the Aboriginal Community Controlled Health Organisations sector, which performed very well through COVID.(3). A specific review of that response would be helpful for lessons learnt. We also saw a new dedicated Deputy CMO position used to very good effect.

These institutional links should be structured into the new CDC, with primary care representation on any governance board, and/or representation on a dedicated primary care advisory subcommittee, and joint work with primary care organisations on pandemic planning and future vaccine rollouts.

A full review of Australia's response has yet to be conducted to comprehensively this answer this question, which begs the question: 'What are the plans for a national COVID-19 health/public health review, and how will that feed into the CDC deliberations?' A thorough and arm's length piece of work answering this big question clearly should be undertaken.

The CDC can also ensure linkages with other sectors by embedding a One Health approach within its platform. Firstly, this will allow development of an integrated and collaborative platform enabling more effective preparedness and response. This will in turn enable establishment of formal communication pathways between a One Health platform and sectors external to the CDC. With respect to environmental health, the expertise of that sector was under-utilised in the first year or so of the current pandemic. It had a lot more to contribute to risk management and communication, based on its 'business as usual' approach to managing risk across a range of issues.

The animal health sector workforce provided significant surge capacity to the public health response during the COVID-19 pandemic, with the Elizabeth McCarthy Agriculture Institute in NSW providing COVID testing as an example. Many veterinary epidemiologists provided surge capacity working in public health departments and the Department of Health and Aged Care across Australia and also provided modelling expertise given significant experience in modelling. (4) In the case of zoonotic disease, it is paramount that risk mitigation operates at all parts of the human/animal/ecosystem interface.

Tools and processes that drive intersectoral cooperation and planning will be vital. If they are supported by scenario and response testing (simulations) then there is the added benefit of developing workforces that can work across the cultures of the different sectors to respond to outbreaks and future pandemics. There could be an agreed set of priority diseases based on their impacts on one or both sectors or based on shared problems such as Japanese Encephalitis Virus, Hendra virus or rabies.

A data revolution

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

The greatest barrier is the lack of, and/or inconsistent, legislation to enable data sharing and linkages across the nation including Commonwealth as well as states and territory governments. Even with the new Federal Data Availability and Transparency Act 2022, this is likely to be an ongoing issue as, while it enables data sharing, it does not compel any jurisdiction to do so, and the existing federated system means it is often difficult (or requires long wait times, often in the order of years) to access national or multi-jurisdictional data.

Even when legislation permits it, entrenched risk aversion in government agencies to sharing of data hinders essential data exchange. Additionally, there is often inconsistent coverage of data capture, or standards of data quality, in the various systems across jurisdictions. Sufficient resourcing and infrastructure to enable timely access to data for policy decision making and research will be essential to the future operation of the CDC.

Existing systems of data capture and analytics also need strengthening. Had they been working better, we may well have seen better capacity, intelligence, and public communications during the pandemic. The National Notifiable Diseases Surveillance System data needs to be bolstered.

Question 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?

The lack of national (or even at a state-level) general practitioner data is a major gap in Australia's health data landscape. While hospital-based and other secondary health care is generally well covered, the lack of primary care (i.e., general practitioner desktop or clinical registry) data is a major issue. This gap is also not sufficiently covered by available Medicare or PBS data, and it often takes too long for access decisions to be made.

There are also serious shortfalls in the environmental health space. One critical example is human biomonitoring for chemicals. Other simple environmental health measures (e.g., safe water, safe food etc) should form a central part of the data and analytics approach going forward. The establishment of the CDC provides a great opportunity to address this.

Another useful proposal is to develop a 'national surveillance plan' for diseases with epidemic potential, including those of unknown aetiology. Surveillance is collection of health-related or hazard-based data for the purposes of public health action.

To ensure that Australia can identify emerging risks to public health in a timely way, a fully functional national data linkage capacity supported by routinely updated data repositories to improve efficiency of data access is thus needed.

The development of a national data plan with an agreed scope and an evidence-based health monitoring framework would be useful. There have been several previous attempts to achieve this, all of which have either failed completely or not improved the situation. Such a plan would need to be supported at the highest levels (politically and bureaucratically) of state and territory as well as Commonwealth governments. Such a plan should also include legislative underpinnings to give it durability. Otherwise, the plan will likely not lead to the required level of change, nor data access for national monitoring or responsive evidence-generation using data.

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

A coordinated approach is needed as most jurisdictions have their own government requirements, many of which vary considerably. This could be included in the above-mentioned development of a national data plan, with accepted standards and agreed principles and practices of governance included in such a plan.

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

The CDC needs to be adequately resourced to ensure it has the appropriate technical and analytical infrastructure and personnel. Evidence-based training programs, such as the Australian Field Epidemiology Training Program (FETP), which is the Master of Applied Epidemiology (MAE) program that the Australian National University (ANU) delivers, are vital. This program is part of a global network of similar training programs that teaches people to conduct surveillance and investigate outbreaks. Every other CDC around the globe has a FETP. In the US, it is the Epidemic Intelligence Service, which is the foundational workforce program of the agency.

Training programs should also be adopted, adapted or developed in specific data analysis skill areas where there is a current shortage. These can then be used for capacity building of CDC staff as well as others around the country. Such training programs would also improve the consistency and level of standards across the sector in these areas.

In addition, some evaluation could be outsourced to accredited agencies (universities or research institutes) with expertise in particular fields to undertake the work commissioned by the CDC, potentially as a CDC Collaborative Centre (see Question 27).

Question 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?

The new CDC should have Aboriginal and Torres Strait Islander identified positions within the organisation to ensure appropriate engagement with the sector. Currently, there are too few Aboriginal and Torres Strait Islander people working in health protection, which leads to burn-out in those who do. This should also apply to the training programs provided by the CDC – so there are identified positions in all training programs that the Centre runs.

Effective collaboration with Aboriginal and Torres Strait Islander communities must support a more holistic concept of health that acknowledges the close connection between physical, mental, cultural, environmental, and spiritual health of Aboriginal and Torres Strait Islander peoples and communities. To

ensure respectful, culturally informed policy and practice that reflects community priorities, Aboriginal and Torres Strait Islander leadership and decision making must be embedded into all aspects of data collection, analysis, use and interpretation.

The CDC should work to maximize community benefit from research and data by developing and expanding partnerships across existing Aboriginal and Torres Strait Islander organisations, networks and fora, including the National Health Leadership Forum, the University of Melbourne's Indigenous Data Network, the NHMRC National Network for Aboriginal and Torres Strait Islander Health Researchers, community controlled research organisations such as the Lowitja Institute**,** and the Aboriginal Community Controlled Health Organisations sector.

While it is well-established that high quality health data is required to implement effective place-based health interventions, the collection and use of Aboriginal and Torres Strait Islander data should respect and operationalise the principles of Indigenous Data Sovereignty (5), and ensure alignment with the principles outlined in the National Agreement on Closing The Gap, the Maiam nayri Wingara Indigenous Data Governance protocols and principles, and Mayi Kuwayu**,** the National Study of Aboriginal and Torres Strait Islander Wellbeing.

Aboriginal and Torres Strait Islander communities must retain ownership, access, and control over their data, with a focus on building local capacity and facilitating self-determination to empower and support communities to utilize data to effectively address community priorities and make informed decisions on programs and policies that address local need. Also, the aforementioned training programs could include aspects of data sovereignty to build capacity across the workforce.

National, consistent, and comprehensive guidelines and communications

Question 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?

The answer to this question is reflected in our thinking in questions 15 and 16 on workforce development, question 3 on governance and independence, and question 27 on the links with research.

The CDC must have a clear charter focused on advancing the public health of people in Australia and must have a governance structure that allows independent advice to be provided to the governments of the day and the Australian people. This independence will add to the agency's credibility.

The CDC must be staffed with some of Australia's best and brightest public health minds who should come from a diversity of disciplines and a diversity of sections of the Australian community. The CDC should be a place where people aspire to work and should aim to be considered our leading public health organisation. Our position on the issue of developing the public health workforce is central to this aspiration.

However, authoritative evidence-based advice relies on more than just good training. The new CDC needs to build a strong architecture for generating, categorising and synthesising evidence. It is vitally important that this function works in concert with state and territory health departments that operate separately. This guideline development function needs specific funding and allocation of effort and should use a standardized framework that is nationally agreed. Since the results will be very much in the public view, the CDC will be judged on how well it achieves such coordination.

The CDC should develop strong relationships with agencies which have impacts on public health through upstream determinants. For some areas this will mean a seat at the table in decision-making, and in other situations the CDC could provide binding or non-binding policies and guidelines. This reflects the current

function of the US CDC in providing guidelines for Environmental Health and the Built Environment for example.

This is related to the need for the CDC to have strong underlying principles of equity, justice, and human rights. When providing policy determination and advice, it will be essential that the CDC meets the high bar of considering the unintended consequences of policy, particularly with respect to health protection. In other words, the policy that the CDC recommends should be based in evidence and meet the broader aims of public health as a holistic discipline.

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

The PHAA argues that the CDC should have carriage of the National Preventive Health Strategy, and that reinforces the conclusion that health promotion should be a key function of the CDC. The CDC needs to provide the leadership to ensure the policy goal of this strategy achieved: "Preventive health and health promotion activities in Australia are sustainably funded through an ongoing, long-term prevention fund – rebalancing health action." For this to happen there is a need for genuine health promotion expertise on the board and at senior staff levels.

Communications must therefore be at the core of the work of the CDC. There is no point in developing a world class agency with credible and reliable public health evidence, advice, and policy capacity unless that expertise if effectively communicated, in a timely, consistent, accessible, and sensitive manner. The agency should have capacity and infrastructure to communicate to all audiences in Australia, through as many channels as is necessary to achieve its purpose.

It is important that communication is health-literate, uses a variety of channels and reaches the consumers/communities who need the information and/or advice. Communication is key to achieving all the major functions of the CDC, and we note that the CDC in the US produces some of the most prominent health literacy resources available (such as their plain English word database, for example).

Therefore, the CDC should have high quality internal technical expertise on communications, social sciences, and health promotion, to be capable of reaching a diverse range of audiences and communities.

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

There are many. As an example, and already outlined, if the CDC is going to operate within a One Health framework and tackle the wider determinants of health, it will need to engage stakeholders outside the health system. It can engage with these experts through specialised advisory committees at a governance level, and through the relationships it builds with other organisations and professional associations through its networks.

National Medical Stockpile

Question 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?

As the PHAA is a peak advocacy body and not a service provider, we have no need to access supplies as such. However, we agree that the CDC could play a key role in leadership and national coordination of a National Medical Stockpile.

World-class workforce

As a general response to the content in this section of the discussion paper, PHAA argues that the establishment of temporary pandemic registers for a surge workforce was required to respond to the COVID-19 pandemic, because practitioners of most public health disciplines are either unregulated or not specifically regulated for public health practice in Australia. Recruiting from the general health workforce and drawing on departmental staffing or defence force personnel was therefore necessary as it was impossible to identify those workers trained and qualified in public health – a major flaw in our national response to the pandemic.

Australia therefore urgently needs to professionalize and enumerate its public health workforce through accreditation of core public health education programs, including bachelor and masters' degrees in public health provided by the various schools of public health, enabling graduates to become registered as public health practitioners under a yet to be determined registration scheme. In turn, the requirement to maintain continuing professional development can be enforced through an associated credentialing program for regular re-registration. Only then will we be able to draw on those with appropriate training and qualifications for emergency preparedness and response via a permanent register of public health practitioners.

The WHO has recently embarked on an international exercise to professionalize the public health workforce, which includes a focus on emergency preparedness and response. PHAA has representatives on both the Steering Committee and Technical Working Groups responsible for implementing this roadmap through WHO member states, including Australia. The roadmap provides a timely opportunity to consolidate evidence and build on existing resources, collaborate with global partners, inform, and guide the development of a national public health workforce policy or plan that will strengthen public health and emergency capability in Australia under the remit of the CDC, whilst setting up systems that allow us to make international comparisons and linkages across the public health sector.

Meanwhile, a national Public Health Officer Training Program (PHOTP) can be immediately implemented by the Australian and state and territory governments. The existing NSW PHOTP should be appropriately adapted to the jurisdictional circumstances, to create a pipeline of highly trained public health professionals. A detailed proposal on how an Australian Public Health Officer Training Program can be established, including costing estimates, is found in Appendix 1. Acting on this proposal would assist with Australia's urgent public health workforce needs, as well as create an important source of future expert senior officers in public health leadership positions, for all Australian jurisdictions.

This would be in addition to, and not substitute for, the specialist training program provided through the Australasian Faculty of Public Health Medicine for medical practitioners.

Consideration also needs to be given to approaches to build public health workforce capacity that do not require full-time commitment for long periods from students, to increase access to workforce entry and diversity of the workforce.

Additionally, a continuing professional development program for both public health and general health practitioners can be developed and provided by the CDC in partnership with members of the Council of Public Health Institutions of Australasia, similar to the model provided by the European CDC. In addition to the specialised programs focused on emergency preparedness and response outlined below, these courses should focus on specific areas of critical and emerging areas of practice (6) such as One Health, the wider determinants of health, advocacy and political engagement, systems thinking, ethical and culturally safe public health practice, to name but a few.

More specific responses to the guiding questions in this section are set out below.

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

Workforce planning undertaken by the CDC should recognize the importance of disciplinary diversity rather than focusing only on medico-centric public health. Enhancing the available public health workforce with a wide skillset and experience is necessary to prepare for future emergencies.

The CDC should be responsible for specialty fellowship training, as well as traineeship and mentorship exchange programs in areas related to emergency preparedness and response, such as Public Health Leadership and Public Health Informatics programs.

The Department already has an MoU with ANU acknowledging them as the Australian FETP, which is provided elsewhere by other CDC. FETP is a key workforce strengthening activity for all countries globally, and they are a requirement of the Joint External Evaluation. Importantly, they are a key part of the capacities outlined in the global public health workforce roadmap. FETP are usually conducted in three levels – Advanced (2 years), Intermediate (6-9 months) and Frontline (3 months) – and are specific epidemic response strengthening programs. In neighbouring countries, such as PNG, they have all three levels running. In Australia, we have had an advanced program since 1991, which is accredited by TEPHINET – the global network for FETP. Expanding the FETP is critically needed.

The environmental health workforce area is also sorely in need of a national focus. The risks in this area were exposed with contamination of waterways, with Per- and Polyfluoroalkyl Substances (PFAS) from firefighting foam, and air quality from bushfires incidents. Australia has limited toxicology training and limited career pathways, and there are not enough Environmental Health Officers – who are critical to addressing many of the public health challenges locally – on the ground.

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

The National Preventive Health Strategy is one of our keynote national health strategic statements, and implementing it will be vital both to achieving sustained reductions in chronic disease among Australians.

At the heart of the Strategy is the target that by 2030 at least 5% of total health spending will be dedicated to investments in preventive health. The achievement of the NPHS goals is logically tied up with the creation and mission of the CDC - playing a role of coordination, standard-setting, and outcome monitoring. The CDC should have a mandate to drive and oversee the directions in the NPHS, including the need to help create an Australian preventive and public health workforce capable of reducing the burden of non-communicable disease within all jurisdictions.

We note that the Department of Health and Aged Care's project (contracted to Ernst and Young) to define the public health workforce has commenced, but has already fallen behind its original timeline, and appears to have overlooked the work happening at the international level, which is by contrast progressing rapidly. We strongly recommend that action is not delayed because of the CDC establishment process.

Rapid response to health threats

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

With an established One Health approach, the CDC will be aligned with overseas bodies with this capacity e.g., Quadripartite, and other CDC and public health agencies overseas. Taking the opportunity to develop an independent, transdisciplinary approach for One Health in the CDC will enable us to be a leader in this

area, particularly in the Indo-Pacific region. One Health is seen as central to the work of current organisations such as the Indo-Pacific Centre for Health Security, Asia Pacific Consortium Of Veterinary Epidemiology, Food and Agriculture Organization and World Organisation for Animal Health.

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

In the most recent WHO evaluation of Australia's capabilities under the International Health Regulations (2005), which require countries to develop capabilities to respond to and manage acute public health threats and events, several areas for improvement were observed. Notably, this evaluation was completed prior to the pandemic, yet these areas proved to be those which could have strengthened our response had they been addressed, namely the need to:

- Develop the public health workforce both generally and for surge capacity, but particularly in areas with limited specialists (including radiation and toxicology specialists and clinical virologists).
- Harness the use of genome data in disease surveillance.
- Conduct training and exercises across Australian Government agencies and jurisdictions to identify areas requiring improvement, sharing and implementation of lessons.
- Greater coordination between the human and animal health sectors, including integration of laboratory networks across sectors.

There is an opportunity for the CDC to take on this coordination role to support public health responses and cross sector coordination, with real-time sharing of information, better planning and building relationships.

A national public health emergency exercise program to regularly test Australia's capacity to respond at both a national and regional level should also be developed and implemented by the CDC in collaboration with our international partners.

Question 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?

Issues such as climate change, natural disasters, emerging diseases, migration, food supply chains, commercial influence and national security will affect Australians irrespective of our administrative borders. The CDC therefore needs to function as a global agency, both nationally and when requested internationally, to strengthen public health systems and deploy public health experts, prevent, and protect against the spread of infectious disease, reduce the burden of non-communicable diseases, and respond to public health threats, be they natural or man-made. In so doing, we need to work respectfully in partnership with other nations and their agencies.

In so doing the CDC can set up networks and capacity that will also serve to enhance our capacity to respond at home and improve ability to capture intelligence and evidence that will serve our own interests as well as the international community. We also need to be prepared to train not just our own workforce, but that of our closest and most vulnerable neighbours, including provision of exchange programs that will further enact to strengthen relationships and connectivity between our respective public health systems. In doing these things we would also be playing a role in soft diplomacy by improving our relationships with near neighbours.

The CDC will, however, need to differentiate itself from the role played by other partners, especially the Department of Foreign Affairs and Trade which is responsible for foreign policy, trade and AusAid administration, instead collaborating and building on the areas they do not currently engage. The US CDC model will be a useful comparison given its delineation from their similar US AID agency.

International partnerships

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

Threats from emerging and re-emerging disease and the development of antimicrobial resistance extend beyond Australia's national borders. Effective management of these risks requires a collaborative, transdisciplinary approach that works at the local, state and territory, national and global level to understand, prevent, detect, and respond to both Australian and global health threats.

Having a global reach will require working in partnership with other national governments, multi-lateral agencies such as the World Bank, WHO and APEC, as well as international non-government agencies such as Red Cross, International Federation for Human Rights, Vets without Borders, and Médecins Sans Frontières.

Given the work currently underway in the WHO to professionalise the public health workforce, mentioned in relation to Questions 15-16, the CDC will need to partner closely with the associated organisations to ensure its workforce development initiatives are both consistent with international standard setting, but localised for the Australian context for both national and jurisdictional implementation.

Leadership on preventive health

Question 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?

This can be achieved by commencing from the outset to undertake programs to employ all these public health domains. From the outset the CDC should take on functions that require a holistic approach. To achieve this the CDC needs to put in place strong relationships with a broad range of agencies and organisations across government academia and civil society. Staffing the CDC with professionals from a diversity of disciplines will also enhance the organisation's capacity to implement this approach. A means of developing this capacity is addressed in our contributions to questions 15 and 16 on workforce.

The scope of the CDC will be a continually discussed and debated issue. An interpretation of the aspiration for the CDC to foster "a holistic approach across public health…." certainty raises the question of what range of public health issues the CDC seeks to actively contribute to or lead. The scope of the agency is much discussed in the discussion paper and is being widely debated in the public health community.

Pragmatism vs Aspiration

We recognise that the CDC must have a clearly defined scope to give the organisation the hope of achieving measurable and worthwhile outcomes in its first period of operation. The agency needs to build identifiable successes early if it hopes to survive the contested environment of attracting public resources. To do so it should seek to avoid trying to achieve too much, which may risk it achieving little, or nothing. The CDC will need to "climb a mountain one step at a time".

Nonetheless the organisation should aspire to provide leadership across a wide range of important spheres of public health. We recommend that the CDC is established in a manner that expansion of its areas of focus will occur over time.

We expect that the CDC will grow and evolve as Australia's leading public health agency. The initial focus, as stated by the Government, and consistent with the pre-election commitment, is on infectious disease preparedness, management, and prevention, as well as chronic disease prevention. However, a range of other spheres of public health might legitimately be undertaken by the CDC, as is done so by similar

agencies in other countries. Areas such as injury prevention, occupational health and safety, sexual health and many more are relevant and important spheres of activity in which the CDC might become active.

By establishing a routine review process about the performance and future scope of the CDC, a mechanism is built-in that allows such expansion to be managed in a rational manner and allows consideration of resources and capacity necessary to meaningfully prosecute any additional areas of responsibility or activity.

In this way the CDC can plan a process by which it genuinely develops to pursue health protection and promotion, and disease prevention and control, for many generations of people in Australia in the decades ahead.

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

In the legislation that creates the CDC, a provision should be included to replace the legislation that created the Australian National Preventive Health Agency (ANPHA). The CDC should absorb the previously legislated responsibility and purposes of ANPHA, and the replacement should also bring into the CDC the remnant resources of ANPHA (approximately $12million).

An appropriate approach to absorbing the previous ANPHA responsibilities is to take responsibility for leading the implementation of the National Preventive Health Strategy (NPHS). This would serve as a means of addressing the chronic disease prevention component of the CDC scope, as articulated by the ALP in its platform policy commitment to establish the CDC.

So, in effect the CDC could and should have the role of leading the implementation of the NPHS. It would need, as in all areas of its scope, to work with States and Territories, public health and related not-for-profit sector organisations, and the research sector, to determine priorities and seek to attract resources to put in place evidence-based programs and promote evidence driven policies to advance chronic disease prevention through the NPHS. This should be a substantial and well-resourced component of the CDC work that is built into the opening scope and responsibilities of the CDC.

Spheres of activity – such as programs and policy on major chronic disease risk factors such as tobacco and vaping, alcohol, unhealthy eating, physical activity and more – could be effectively led by the CDC in concert with existing work by States and Territories.

The CDC should lead proposals for investment in national initiatives under the NPHS, as well as actively promoting and supporting co-ordination and consistency of approach 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. Many examples exist in the fields of tobacco, alcohol, healthy eating and more.

The CDC can also promote and lead endeavours to work in sectors outside the health portfolio that play an important role in chronic disease. An example is in physical activity, where many portfolio areas play a role in facilitating environments which can enhance physical activity. Similar examples exist in nutrition and other areas.

Question 23: Should the CDC have a role in assessing the efficacy of preventive health measures?

Assessing the efficacy through proper and rigorous evaluation is a key underpinning of high-quality preventive health measures. Evaluations of this kind should be structurally built into any respectable preventive health measure, whether conducted at local, state, or national level.

Evidence-based, best practice, and 'best buys' work has been undertaken around the world relating to the assessment of interventions and policies in preventive health. The CDC could certainly add to that body of work, with a focus on areas of highest priority in Australia.

Further, an extremely important and largely under-resourced area of work is the economic assessment of preventive health measures. There is only a modest supply of relevantly specialised health economists. And of those specialists, an extremely small number focus their efforts in assessing the economic impacts (for the benefit or disbenefit) or preventive health measures. Data that captures, assesses, and reports metrics of this kind may potentially be very important in influencing resource investment in preventive health.

This might be an important option to establish as an internal economic capacity of the CDC, or it may be a function that is best outsourced to groups or agencies with the necessary technical expertise.

Wider determinants of health

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

As the discussion paper outlines, addressing the wider determinants of health calls for integrated solutions that tackle inequity for Australia's most priority populations, including First Nations peoples, people with a disability, and older Australians. This requires genuine stakeholder engagement that empowers public participation both early, and at every stage of the policy development process, to foster community-developed solutions tailored to meet their needs. The CDC should therefore commit to the principles of 'nothing about us - without us', and ensure representatives of priority population groups and associated sectors are at the table, whilst being mindful that diversity and inclusion strategies should also be considerate of intersectionality. The CDC will need to ensure policies are flexible enough to consider context and nuance, and disease prevention and control activities do not increase inequity.

For First Nations peoples, this is especially important given the unique context of inequities resulting from colonisation. Principles of self-determination are critical to ensuring that solutions are community-controlled and led, holistic, strengths-based, place-based, culturally safe, and responsive.

As mentioned above, lessons learned from the successes of the Aboriginal Community Controlled Health Sector during the COVID-19 pandemic, and the instrumental role played by the Aboriginal and Torres Strait Islander Advisory Group on COVID-19, should be considered in the design of the CDC. While Aboriginal Community Controlled Organisations and representative peak bodies and are well-established for the human health care field, similar representation is not well-established for other One Health disciplines, including animal health, environmental health, ecosystem health.

The CDC should also focus on building relationships with community-based organisations such as Indigenous ranger groups, animal health and environmental health workers to improve Aboriginal and Torres Strait Islander representation.

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

Particularly in rural and remote environments, social and cultural determinants of health, including poverty, overcrowding, barriers to accessing healthcare and education, have contributed significantly to the disadvantage and health inequalities experienced by Aboriginal and Torres Strait Islander peoples, particularly for chronic disease conditions which are a substantial contributor to gap in disease burden between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians (AIHW, 2018). Furthermore, there is both contemporary and historical evidence that Aboriginal and Torres Strait Islander peoples are disproportionately affected by pandemics. (7, 8)

Effectively closing the gap in health inequity requires a framework that allows the CDC and its partners to be responsive to the needs of Aboriginal and Torres Strait Islander people and their communities, focusing on a holistic view of health, building local capacity and infrastructure, and strengthening the role of Aboriginal Community Controlled Organisations and community-based organisations in other health sectors to delivery and coordinate culturally safe and responsive programs.

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

The National Preventive Health Strategy acknowledges that priority population groups may not be measured nor represented equally in data sets and sets a target for improved collection of demographic information in national datasets for priority populations to ensure differences in health and wellbeing outcomes can be measured. In order to understand the populations the CDC needs to engage with, there is a priority need to ensure there is adequate investment in the collection of data where there is currently insufficient data to allow for appropriate disaggregation.

One of the priority populations that was largely misunderstood – and whose vulnerabilities were particularly exposed during the pandemic – was Australia's culturally, ethnically, and linguistically diverse (CALD) communities, providing valuable insights into how planning for future public health crises can be improved. The PHAA supports the recommendations contained in this policy brief and associated communication guide for engagement with CALD communities to ensure the CDC can best deliver timely, appropriate, and evidence-based health information to culturally diverse and/or priority populations.

Question 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)?

Clearly, the CDC should adopt a model of intersectoral collaboration as a core feature of its design, whereby the CDC can build networks and partnerships with government departments, community organisations, public health actors and the research community. Intersectoral collaboration is key to addressing the determinants of health and addressing inequities as responsibility for most determinants fall outside of the health sector. Working with other sectors to collect and link data on the determinants of health will facilitate our understanding of inequities in health and social outcomes.

Research prioritisation

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

The discussion paper has made clear that current thinking on the connection with the research community and the CDC is largely as follows:

- To ensure the highest possible quality of advice and policy recommendations across its sphere or responsibility, it is essential that the CDC establishes and maintains a close relationship with leading

public health research organisations and the research sector. This evidence driven policy advice and practice will be a fundamental building block for the credibility of the agency.

- However, the CDC should NOT itself be a research funding agency, other than perhaps for emergency situations where specific research questions of immediate and high priority may promote the leadership of the CDC to commission urgent and policy relevant research.
- Finally, an important potential role of the CDC is to communicate and influence research funding priorities for Australia's key health and medical research agencies such as (but not restricted to) NHMRC and MRFF. In this way publicly funded research investment can be steered in the direction of research questions of highest priority to the public health issues as identified by the CDC. In addition, the CDC might be well placed to ensure that research that is classified as public health might in fact be closer to the relevance and priorities in public health than might be the case currently relating to research funding labelled in this way. For some time, many in the public health community have been concerned about the boundaries drawn around research that has been classified as public health related.

The PHAA supports each of these approaches. We presume that various research funding arrangements with existing research organisations around Australia, receiving block or other core grants from the Australian Government, will also seek to determine their relevance to the work of the CDC and where appropriate establish specific agreements with the CDC with respect to the nature of the relationships between the CDC and the research organisation.

In addition, we would like to propose a notion of establishing CDC Collaborating Centres, akin to the WHO Collaborating Centres (see Appendix 2).

The CDC Project

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

The PHAA recommends that high quality, fair and objective assessments are made of its progress, to guide its development. With that in mind we recommend that the legislation that initiates the CDC, builds in required review periods.

A review should happen after the first three years of operation (therefore report by early 2027) and subsequently every five years. Those reviews should address three fundamental questions:

- What has the CDC done well?
- What could the CDC have done better? and
- What additional roles and responsibilities should the CDC take up?

However, its development will take time, so the three-year review should mainly be about whether it's been properly set up and is fit for purpose – it's then for the next five-year review to look at evaluation.

Funding the CDC

The PHAA would also suggest there are creative ways in which the CDC activities can be funded.

Firstly, we suggest the $12 million still allocated to the Australian National Preventive Health Agency revealed in the recent October Budget statement should be reinvested in non-communicable disease prevention by transferring these funds to the new CDC. This would be a good starting point specifically for

the chronic disease prevention and National Preventive Health Strategy oversight role that the CDC should have, thereby emphasising that non-communicable disease is in its remit from inception.

Various taxes could also be collected to contribute to the CDC operations, including introduction of a travel levy, where every domestic and international flight has a $5 levy for biosecurity measures.

There are other potential tax changes, such as sales of alcohol, sugary drinks, and tobacco. In our July 2022 PHAA Budget submission, we outlined several significant revenue measures available to the Government, that could potentially be used to support the CDC, as well as the activities of the states and territories to support the work of the CDC, conduct chronic disease prevention programs and support infectious disease related initiatives. Our estimate of revenue that could be generated is illustrated by the table below. As is clear, their scale is far from minor.

Table: Summary of revenue measures

Revenue ($m)	**2023-24**	**2024-25**	**2025-26**	**2026-27**	**Total**
Equalisation of excise and customs duties on 'roll your own' tobacco products	160.0	250.0	350.0	440.0	1,200.0
Volumetric equalisation of alcohol excises	2,900.0	2,987.0	3,076.0	3,168.0	12,133.0
Sugar-sweetened beverages tax	738.0	723.0	696.0	677.0	2,835.0
TOTAL	**3,798.0**	**3,960.0**	**4,122.0**	**4,285.0**	**16,168.0**

Conclusion

PHAA believes the establishment of the CDC is the largest single institutional enhancement to our health system in decades. It holds out the prospect of substantial reductions in risks of both communicable and non-communicable diseases for all Australians. Done well, it will be celebrated by future generations of Australians. It will also be a significant addition to the international community's network of health-promoting institutions.

The PHAA appreciates the opportunity to make this submission and the opportunity work with the Government and the Department in this historic moment. We are all committed to getting the establishment of the CDC right for the benefit of all Australians long into the future. The Government and the Department can be assured of our close collaboration and support for this undertaking.

Terry Slevin
Chief Executive Officer
Public Health Association of Australia

9 December 2022

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Appendix 1:

Public Health Officer Training Program for Australia

An outline of options

Introduction

COVID-19 has highlighted the state of public health infrastructure and the need to bolster the public health workforce capacity and systems in Australia, both nationally and at the state and territory level.

With the advent of the establishment of the Australian Centre for Disease Control (CDC) the following proposal should be seen as a core and central program to be led and implemented by the CDC in concert with state and territory departments of health as an essential piece of capacity building, while also serving as being the "glue" that can bring together national and jurisdictional governments with a view to improving co-operation and co-ordination of public health efforts in Australia.

This is a broad outline for a possible Public Health Officer Training Program (PHOTP) that can be immediately considered by the Australian and state and territory governments. What follows is broadly based in the NSW PHOTP and should be appropriately adapted to the jurisdictional circumstances.

There is existing machinery in place in some state and territory governments, providing an opportunity for the Australian Government to play a co-ordinating and facilitating role. This may be via the Australian Health Protection Principal Committee (AHPPC) or other mechanisms. Building of the public health workforce is a clear and vital priority that must be urgently addressed in Australia.

What is needed?

A program must be established to assess, recruit, train, retain and place both medically and non-medically trained staff to undertake a three-year training program (which might be run over four years – allowing a year for an unpaid sabbatical) to create a pipeline of highly trained public health professionals who will assist with Australia's urgent needs, as well as become in future an important source of expert senior officers in public health leadership positions for all Australian jurisdictions.

Entrants to the program are likely to be already trained at the postgraduate level, with both medical and non-medical backgrounds, in a position to undergo further academic and on the job training in the broad aspects of public health work. The program would take a competency-based approach, working in real policy and service delivery settings. This might include, but not be restricted to, working on:

- public health data design, capture and reporting functions
- Infectious disease outbreak surveillance and management
- sexually transmitted disease tracing and management
- chronic disease prevention and control
- immunisation
- screening
- health promotion
- public health regulatory functions
- sexual and reproductive health
- disaster management
- environmental health

- cross government liaison on social issues of relevance to public health including housing, transport, working with high needs population
- and many other roles.

A combination of placements in various agencies undertaking specific outcome related projects and an ongoing professional development program including recognised academic training is at the core of this initiative.

How might it operate?

Core Administrative Infrastructure

To run a program of this kind there is a need for a core unit of ongoing staff, probably at a national level and potentially at the CDC, who have the responsibility to establish and administer the program. That might include one FTE program manager, two senior project staff and some admin support function. A core staff plus funds for OGS (travel, communication, conference participation etc) of approx. $700 – 800Kpa might be allocated.

Their role is to design, document, and oversee the program, facilitate national co-operation and a process for policy and decision making that guides the national program. Its purpose is to maximise consistency while allowing for flexibility based on needs of S&T governments.

States and Territories Co-ordination role

Staff would be required at a state and territory level to recruit participants. They would establish and manage all HR related to the program as it applies to the jurisdictional employer. They would arrange and quality control the placements across the system, trouble shoot, manage financial aspects of the program and support the officers within the program. The number of staff would be determined by individual states and territories according to the number of participants in the program. It might range between one FTE in smaller states and territories to 2-3 FTE in larger states and territories.

Funding trainee positions

The program should aim to recruit a minimum of fifty high quality trainees per year nation-wide who have a minimum entry requirement which might include an undergraduate program, a Master of Public Health, and a minimum of 3-5 years in the health sector.

For the purposes of projecting some costs, some estimated unit costs for salary, on-costs and necessary infrastructure are stated below. These might be more precisely calculated by Departmental staff in the various jurisdictions staff using current costings, salary scales and related costs and allowances.

- Medical Trainee - $200Kpa
- Non-Medical Trainee - $150Kpa

We assume that the annual cohort would be split as 30% medical trained and 70% non-medically trained recruits. This however may vary from year to year based on the necessary merit-based assessment process.

Number of positions to be recruited and estimated costs are reflected in Table One. The program would take three years to build up to full roll out and would be cheaper in years one and two.

Aboriginal and Torres Strait Islander Workforce development

In addition to the recruitment of positions by jurisdictions, it is proposed that an additional 20% of the recommended total be recruited to increase training opportunities for Aboriginal and Torres Strait Islander people or people working in the field of Indigenous health. These may be people who have advanced training as Aboriginal Health Workers or may come from other disciplines. It is anticipated that most people recruited under this category would be Indigenous.

Total program costs

This estimate should be CPI indexed and the core administrative cost bring the peak annual cost in **2021 dollars to $37.46Mpa**.

Table One: Estimated number of PHOTP trainees to be recruited and estimated cost

State/Territory	Population (Millions) (ABS 2021)	PHOTP Positions no. pa*	When Fully rolled out	Cost when fully operational** ($M pa)
NSW	8.18	14	42	6.93
Victoria	6.65	10	30	4.95
Queensland	5.21	9	27	4.46
Western Aust	2.68	5	15	2.98
South Aust	1.77	3	9	1.49
Tasmania	0.54	1	3	0.5
ACT	0.43	1	3	0.5
Northern Territory	0.25	1	3	0.5
Australia (AG DoHAC)	NA	10	30	4.95
Staff to administer the program#	NA		15	2.251.8
Additional roles focus on Aboriginal Health##	NA	11	33	5.45
TOTAL	***25.7***	***65***	***195***	***37.46***

* Number based on one recruit pa per 600,000 population

** Assuming total three years of program, $200Kpa for medical and $150Kpa non-medical recruits

Staff spread across CDC/ ADoHAC (x 3 national program co-ordination) and S&T (x9 Local recruitment HR etc)

Estimate 20% additional recruits to focus on Aboriginal health, recruits predominantly Indigenous people.

Additional considerations

Establishing senior Public Health roles

For the program to be sustainable there is a need to maximise the prospect of relevant employment beyond the period of the training program. The greatest benefit of establishing such a training initiative would occur in the health system in Australia if pathways were in place to find relevant mid to senior PH roles for graduates of the program. This has been achieved in NSW, where such a program has operated for 30 years and 50% of all Trainees from the program remain to this day employed by NSW Health, many in very senior PH roles.

However, in the absence of a clearly established pathway, there remains substantial benefits in such a program in that the talent pool to fill the normal run of vacancies in public health roles will be a stronger better trained and skilled to fill many of the key positions in the health sector.

Regional and other structures

The establishment or reinvigoration of Public Health Units, metropolitan and regional are under consideration in various jurisdictions around Australia. This system has served NSW well during the current and in previous outbreaks, and in terms of serving a variety of important ongoing public health functions within NSW.

Should such structures be developed, the PHOTP could engage via offering placement during training and providing strong candidates for senior roles in Public Health units post training program.

A National System

The benefits of establishing a national system are many, and include, but are not limited to:

- Consistent high-quality pipeline of public health expertise to serve the Australian population long into the future
- Infrastructure to establish clear consistent national standards of training and expertise
- Capacity to allow for movement between jurisdictions to provide a wider range of experience and to retain people in the system if they are required to move jurisdictions due to family or other circumstances
- Ensuring all trainees are exposed to and trained in issues of importance to Aboriginal and Torres Strait Islander health

Surge Workforce

During the Covid19 pandemic in Australia there was wide concern about the absence of a clear and well-trained surge workforce that could be brought to service to respond to the public health emergency. Many groups were drawn upon, most with little or no public health training.

The challenge of putting together an appropriately managed, collated, and curated public health emergency surge workforce is a more detailed piece of work to which PHAA might happily contribute.

However, as relevant to this proposal, it is recommended that All graduates of the PHOTP should automatically be recruited to a formalised surge workforce capacity under the banner of the Australian CDC.

Conclusion

There are a wide range of initiatives and efforts required to rebuild and improve the public health infrastructure in Australia to make the system more robust and effective in protecting the health of Australians into the future. There are many other issues to address, issues around accreditation of training programs, registration of public health professional, carer progression and much more. This paper does not seek to address these in detail but recognises their importance.

This proposal may be one piece of that puzzle. It is offered as a constructive step towards building a stronger, sustainable, and long-term public health capacity for Australia, to ensure preparedness for the future anticipated and unanticipated public health assaults that will no doubt have to be faced.

Appendix 2:

Recommendation on Engagement with Research

A "CDC Collaborating Centre" model

In the first instance the CDC might set up a fundamental structure, beginning with research organizations currently funded by the Australian government, of offering the formal title and status of "CDC Collaborating Centre". This title signifies a close affiliation to the CDC and affords prestige to the research group carrying the name. The CDC might set out a range of expectations, requirements and opportunities that might go with the title.

Any research organization carrying the title CDC Collaborating Centre must be able to demonstrate:

- They are publishing high quality internationally recognized research
- Has close and ongoing relationships and programs of research with equally high impact high performing research groups internationally
- They are preforming policy relevant research addressing questions of high relevance to public health problems and outcomes and their research is influencing public policy
- There are high standards of governance and quality control in the way the research agency is operating and
- The research organization is conducting research of relevance to high needs population groups and groups experiencing disproportionate burdens of disease.
- The research group has high quality and successful collaborations with relevant partners and has demonstrated a commitment to broad engagement and consultation with policy leaders, high needs population groups and researchers across a variety of discipline and organizations.

Other criteria might be considered and developed. These arrangements might be put in place in the immediate term with research centres with current Australian Government Contracts. A second stage might be developed where the CDC might call for expressions of interest for research groups to attain the CDC Collaborating Centre title.

In this arrangement, no financial incentive is offered. Rather, by meeting the CDC Collaborating Centre status research groups might then look to leverage the title to improve their prospect of attracting competitive research groups, establish a wider array of collaborations with other research groups and attract stronger resource support from within their own universities or other hosting institutions. It may also provide the incentive for smaller research groups/centres/institutes/ agencies to seek to build partnerships with others to make stronger case to become CDC Collaborating Centres. Clearly, groups conducting research in areas of high priority to the CDC will be preferred early collaborating centre candidates.

It is anticipated that the "CDC Collaborating Centre" model will evolve and grow over time as the CDC evolves. Establishing a mechanism to appoint CDC Collaborating Centres of public health research excellence has the potential to better connect the CDC with relevant groups with relevant expertise in a very cost-efficient manner. It should further enhance the expertise quickly available to the CDC which should contribute to the quality of advice provided by the agency.