Guiding Questions

Functions of the CDC

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

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

For the CDC to fulfil its role it would likely be necessary to take over some existing responsibilities, particularly where related to the already defined core scope, early and urgent priorities. Otherwise, it should consider leverage and partnerships and not duplicate existing structures or functions. CDC should also establish shared leadership with existing initiatives, which will allow for continuity of existing functions, as well as limiting the scope and responsibilities of the CDC from becoming too broad.

The CDC will need adequate imprimatur to overcome jurisdictional issues such as politicisation of the response in pandemics. It should have sufficient responsibility over national data governance, standards, and policies - including regulatory change - to facilitate activities such as data (microbial and human) sharing between jurisdictions. With the right authority, there is also opportunity for CDC to embark upon collective bargaining for supplies for jurisdictional public health response efforts. Public communications/media interactions should be harmonised through CDC to avoid mixed messaging.

The consultation document would benefit from a map or list of existing government and non-government stakeholder organisations and their existing activities relating to CDC scope and their key related roles and policies. This would help consultation responders to better understand the current landscape and proposed scope. During the consultation workshop participants commonly questioned "who does that now?", demonstrating a collective lack of understanding of how much a CDC would assume existing responsibilities and how much would be new.

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

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

The proposed scope of the CDC is very broad, which was a commonly agreed theme among participants in the workshop we attended. It also alludes to many policy frameworks (e.g. National Preventative Health Strategy (NPHS); National Aboriginal and Torres Strait Islander Health Plan; Australian Disability Strategy). How the CDC affectively encompasses all these areas is challenging to consider. However, the concept of national coordinated responses to health is a great value proposition - and one we've often championed in health genomics - with Australian Genomics.

Incorporating the One Health approach by CDC will be increasingly necessary. It will require broader consultation than previous health policy, working with CSIRO / environment / EPA: human health networks; and public health infrastructure. It should also consider and incorporate Aboriginal and Torres Strait Islander involvement, given One Health is an intrinsic element of First Nations culture. Likewise, the CDC should seek to contribute to policymaking in all other sectors of government as per the "health in all policies" approach promoted by the US CDC and others.

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

• How can the CDC balance the need for the CDC to be responsive and accountable to governments, while also providing trusted, authoritative, and evidence-based advice?

The goals of the CDC: responsiveness, authority, and professional and public trust, mean that governance and organisational models should be carefully considered. CDC would ideally be seen as providing independent evidence-based advice, and in the absence of having its own research program, should be well-connected with centres of research excellence. It could function as an Agency, Company Ltd Guarantee, or structure akin to Australian Commission for Safety and Quality in Healthcare, with Federal and jurisdictional governance/funding. It will need to have stable funding to achieve its goals.

The design of the planned Genomics Australia considers similar factors. Genomics Australia will support the integration of genomic medicine as a standard element of healthcare in Australia, with its coordination role sharing many similarities with the proposed CDC. Australian Genomics has recommended a model for a national genomics body whereby it is established as an independent body, potentially a company limited by guarantee, which would allow flexibility to attract philanthropic funding and partnerships with industry bodies. Establishment as a GBE/Commonwealth company under s8 of the PGPA Act could also be considered: representing less flexibility, but heightened accountability. Authorisation and support from Commonwealth Government is essential, along with partnerships across state and territory jurisdictions. Therefore, the organisation should consider a reporting line to the Secretary of the Australian Government Department of Health and the HCEF. Australian Genomics' current advisory structure provides an exemplar for large research entities. Broad consultation through advisory and reference groups ensure voices from across Australia are elevated and heard. The advisory structure is key in the coordination of a national, multidisciplinary genomics network in Australia and globally.

The OECD recently did a survey of the public to find out what makes government organisations trusted. The results showed that the top characteristics were that: they should listen to and act on citizens' concerns; seek community input in decision- making and policy development; respond to feedback; act with integrity, and continually improve (don't 'rest on laurels'). They should also work harder to gain trust of groups who distrust (OECD Survey of Public Trust in Governments, https://www.oecd.org/governance/trust-in-government/). These data could be reviewed in greater depth in designing any government organisation that needs to build public trust.

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

CDC needs adequate independence to be nimble and responsive, but at the same time have sufficient powers to promote response and action amongst state and territory governments nationally and private/public health providers. As discussed in relation to the question above, consideration of the tension between independence and authority should be given specific attention when deciding upon an organisational model for the CDC.

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

A hub and spoke model, with Commonwealth and jurisdictional nodes, would be the best model for national participation and for states and territories to have 'on the ground' representation. It would also provide opportunity for jurisdictions to define priorities to be addressed nationally, for shared leadership, and potentially to maintain local data and registries connected to a federated data infrastructure. The CDC should have its own decision-making responsibility with respect to distribution of funding, allowing it flexibility to redirect funding in an emergency, or to ensure equitable share in CDCs benefits by the different jurisdictions. The CDC may also need to be a structure whereby it can mandate data sharing from states, particularly in emergency situations.

It has been noted that the US CDC "agency traditionally acts in an advisory role and can only take control from local authorities under two circumstances: if local authorities invite them to do so or under the authority outlined in the Insurrection Act in the event of a total breakdown of law and order". It should be considered whether the Australian CDC should have a more consistent arrangement for authority.

Why do we need a CDC?

A coordinated and national approach to public health

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

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

Effective collaboration and exchange of information can be facilitated by the establishment of representative advisory groups / committees in the governance structure (including jurisdictional representation on all advisory committees and including community representatives). If CDC is established under HCEF this will ensure jurisdictional guidance. It would be easier to mandate data

collection from states with this jurisdictional collaboration, and CDC should provide the jurisdictions with frameworks for data collection.

CDC should aspire to manage/coordinate/disseminate information and data to be the source of truth for Federal and jurisdictional governments. It should be a resource reservoir and the central communicating entity to the Australian public about health responses and issues. In this role it should also develop policies / guidelines to inform jurisdictional health practice. It should also coordinate research efforts.

Consumer involvement in CDC consultation document and design is notably absent – the need for such involvement is evident in the challenges associated with implementation of COVID restrictions and vaccination mandates during the pandemic.

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

• How can the CDC best ensure linkages with all sectors relevant for preparedness and response – including primary care and the animal and environmental health sectors?

National preparedness for an emergency response, such as a pandemic response, will require sustained proactive engagement, including the development of national action plans with clear designation of roles and responsibilities. In this context, the CDCs coordination role would be expected to bring people together at short notice in the event of an emergency. This level of engagement and preparedness with existing sectors requires appropriate levels of funding. Mapping the extent to which platforms / systems can integrate with existing infrastructure to provide real-time information and advice via APIs to GPs, laboratories, hospitals, ACCHOs etc should be an immediate priority (e.g. Telstra Health bowel cancer screening infrastructure). As discussed in relation to an earlier consultation question, the consultation document is missing any mapping of stakeholder organisations and so it is hard to conceptualise the extent of this engagement task.

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

From the consultation document it seems that a desktop international review has been thorough. However, an international consultation may help define/limit scope, to find out what has and hasn't worked for equivalent organisations, and to gain further insight into the progress of the restructure of the US CDC. Consultation with Singapore and New Zealand as they establish their centres would also be highly valuable. Further discussion of the potential governance structure could be facilitated by identification of additional exemplars and key informants.

A data revolution

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

Australian Genomics has been tasked by Australian Government with developing recommendations for a National Approach to Genomic Information Management (NAGIM). A significant consideration is the sharing of genomic and health data across jurisdictions, which necessitates interoperability. The recommendations are currently in their final stage of consultation, and reports developed under the project identify many barriers associated with sharing personal, sensitive health data that would be applicable to data sharing in the context of the CDC as well. Barriers to achieving nationally useful data relate to legislative/regulatory requirements, differences in privacy laws (or interpretation of privacy laws) and risk aversion of data custodians – which increases the importance of consent of the individual/data donor. Australian Genomics would be pleased to share the set of reports associated with the NAGIM project as soon as they are finalised.

A relevant example is the US CDC, which receives data from 50 states and 3000+ local jurisdictions and territories. Each jurisdiction has its own data sharing agreement with CDC and with each other. Mostly, it is up to each city, county, and state to decide what information is collected, as well as how and when it can be shared with CDC. This leads to inconsistencies in the data the US CDC receives. The design of the Australian CDC should strive to avoid this situation by developing standardised data collection frameworks and an organisational model that gives it appropriate authority to request data.

The consultation document discusses the sharing of identifiable data in at least two different contexts. In the context of sharing data for contact tracing, data must of course be identifiable. Perhaps therefore it would be best for contact tracing activities to be led by the states and territories (the 'spokes'), with a nationally coordinated approach, rather than sharing identified data to the 'hub' for these purposes. On the other hand, the need for sharing identifiable data in the context of the data linkage to "result in a greater understanding of Australia's health and wellbeing" should be reconsidered. Is identifiable data necessary for this purpose, or would data with identifiers removed suffice? This seems to be a risk in terms of both operationalising data sharing and to public trust.

7. What existing data sources are important for informing the work of the CDC, and how could existing data bodies (national, state and territory) be utilised and/or influenced by the CDC?
• Is there data currently not collected in Australia which should be considered?

We have not identified any examples of data that is not collected but should be. The issue may instead be that there is so much data collected but the public don't get to see the results from it. For example, governments undertook extensive data collection in relation to COVID testing, COVID disease symptoms, reactions to COVID-19 vaccines etc, but has that data been useful?

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

Aside from good quality data and real time sharing of data, productive relationships and established pathways for information sharing between Australia and its immediate neighbours and more broadly internationally.

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

A national data plan and disease surveillance and monitoring action plan would be an ideal initial action for the CDC. This should draw upon and harmonise with existing efforts to share health data more efficiently – such as the National Approach to Genomic Information Management being developed by Australian Genomics. The incorporation of self-reported information and individual consent into such a data plan would be important.

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

Communities, particularly vulnerable populations, should be appropriately represented in the governance arrangements for collection and management of data. This includes CALD, Indigenous and LGBTQI+ communities, as well as others. Consent and education for data donors; independent auditing, monitoring, and cybersecurity evaluation; access mechanisms to enable tiered access dependent upon data sensitivity, and minimisation of access to identifiable data should all be strong considerations. The governance needs should be informed by the ADHA and all relevant international policy.

CDC should engage relevant expertise to manage the development of data infrastructure, rather than tackle the design itself. This is growing increasingly important across the health sector, and individual efforts risk fragmentation and reduced potential for interoperability.

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

Technical and analytical capability can be ensured through multidisciplinary data expertise; collaboration with ADHA and other government agencies, public health workforce development, and partnerships with research centres. CDC should benchmark data collection, management, quality and analysis frameworks against international standards, with additional input from relevant stakeholders (e.g. HHS health information system leads; academic researchers; medical research institutes).

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?

Engagement with First Nations people will be essential to the design, governance, goals and scope of the CDC. Starting conversations early, engaging regularly, and expecting that it will take time to build relationships that engender trust. CDC should engage with local community-controlled health organisations through its consultation and respect the principles of Indigenous data sovereignty.

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?

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

Like the US CDC, an Australian CDC should engage in public health messaging and health communications. Public health advice may be well-received from an independent organisation. In terms of communications, it should leverage and share messaging with other Commonwealth and state and territory government organisations but take leadership in being a single source of communication with the public. This will require all communications channels, especially the media for fast messaging. This would ensure consistent messaging, which is difficult to attain given the different circumstances of the different jurisdictions. The current messaging is very uni directional and considering involvement of and consultation with communities to shape priorities and direction of CDC communications would be beneficial.

COVID19 vaccine hesitancy is a tangible and recent example of the critical importance of timely and appropriate public comms/media strategies.

Another equally important question that is not specifically asked here is how CDC establishes leadership and trustworthiness for jurisdictional and international governments. Strong collaboration and communication will be fundamental in establishing this.

• What could the CDCs broader role be in increasing health literacy to support sustained improvements in health outcomes?

The CDC should be involved in and support the priorities of the health literacy plan currently being developed as a priority of the NPHS. CDC should also develop communications materials with the levels of health literacy of different parts of the community in mind. However, it should not take on a leadership role in increasing community health literacy. This would be, in our view, an example of scope creep. As reiterated throughout our response, defining realistic scope will be very important for the success of the CDC.

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

There is a critically important coordination role for CDC in ensuring alignment with and between jurisdictional and other agency/government messaging. Communication and outreach should be in scope, but it is difficult to determine to what extent CDC should lead health promotion activities. Partnership with organisations already involved in this area would be a good model. CDC could provide support and endorsement and amplify messaging.

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

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

The importance of consultation and governance with Indigenous communities and other priority communities has already been touched on in relation to other questions. Other non-health stakeholders may include experts in data, communications, media etc.

Involve Australia (https://www.australiangenomics.org.au/projects/involve-australia-public-involvement-in-genomic-research/) is an initiative of Australian Genomics that is developing tools and frameworks for the involvement of the community in research and genomics, initially engaging with the public to develop consumer involvement guidelines for genomic researchers. This model and the developed resources could be adapted to involve community stakeholders in the design and ongoing functions of the CDC.

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?

Australian Genomics is not involved in accessing supplies of the National Medical Stockpile but does administer research projects where the acquisition and distribution of medical diagnostic laboratory-related supplies in bulk has been required, including during the COVID pandemic. This included saliva collection kits for genomic sequencing tests. As part of the Mackenzie's Mission Australian Reproductive Carrier Screening study the kits were posted to research participants in urban, rural, and remote areas and were returned by post to that laboratory. There were three sequencing laboratories and nearly 20,000 research participants involved. This research program was run alongside normal laboratory activities during the pandemic, and there was a degree of stockpiling of laboratory products since in most cases products are sourced from overseas suppliers.

It is very difficult to navigate continuity of service delivery in such circumstances, and one potential solution is increasing sovereign manufacturing capability. The MTPConnect / Pathology Technology Australia National Action Plan for establishing end-to-end sovereign manufacturing capability for diagnostic tests in Australia is analysing supply chain resilience for the pathology technologies. The action plan will likely be highly aligned and address issues related to the National Medical Stockpile. Australian Genomics participated in consultations on the development of the Action Plan, and an interim report is now available (https://www.mtpconnect.org.au/reports/Diagnosticreport).
National coordination of the stockpile would have benefits including equity of access by the different jurisdictions and increased purchasing power.

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?

It should be within the CDC's scope to take on the management of temporary pandemic registers and to undertake the comprehensive mapping of the public health workforce. Australian Genomics has previously undertaken extensive mapping of the genomics and health workforce in Australia, which has been valuable in identifying gaps, workforce planning and in the design of educational opportunities according to the preferences and needs of the health workforce.

Beyond this, CDC should lead emergency planning (and communication of the plan) and co-ordinate skilling a temporary workforce with emergency response training. The ability to call upon a large temporary workforce has been critical in the COVID pandemic and expanding this capability could be done through training medical and allied health university students, the recently retired workforce and workers in other industries that are likely to be shut down during an emergency response.

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

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?

This is another area where the coordination role of CDC will be critical. CDC can work to identify, establish partnerships with, and connect, experts from different disciplines both within Australia and internationally to tackle threats from a One Health perspective. Then, CDC can coordinate and lead cohesive, collective communications rather than fragmentation across states/territories; provide scientific and technical assistance and distil research evidence into policy and guidelines. CDC can also be the platform stakeholders use to engage with experts and policy makers.

As a comparison, Australian Genomics participates in and has a leadership role in the Global Alliance for Genomics and Health, the international standards setting organisation in genomics. Locally we have established partnerships with more than 100 organisations and engaged a network of more than 450 individual researchers, clinicians, diagnosticians, and community advocates. Building these networks of experts has tangibly accelerated progress in genomics, including piloting pathways for international genomic data sharing to collaborate on increasing diagnoses for patients, and translation of research into health policy. CDC can accelerate progress by investing in developing multi-disciplinary networks.

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

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

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

Data infrastructure improvements will be required to share and receive data securely and rapidly. A media engagement plan will also be important. CDC will also need to establish or have access to reliable digital channels to deliver consistent communications and messaging – e.g. internet and mobile Apps.

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

•What could our contribution to global preparedness look like?

Australia could focus on supporting our Indo-Pacific neighbours by sharing information and knowledge in response to threats. More stable relationships with other regional neighbours would also give confidence in timely and accurate information sharing. Australia should participate in all global public health forums. The CDC can develop a pandemic response plan that is communicated with the Australian public and if appropriate, shared across borders so that neighbouring countries respond to health emergencies in a harmonised way.

International partnerships

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

• International engagement, coordination and intelligence sharing are central to the role of all international CDCs. What additional objectives should the CDC include? (for example, leadership, technical engagement and capacity building, or other issues?)

The CDC should focus on leadership and capacity building both domestically and in the Indo-Pacific region, by knowledge sharing, contributing to development and strengthening of public health agencies in those countries. Communication with other countries in relation to importance of First Nations healthcare (e.g. NZ, Canada) would be beneficial.

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

The Australian CDC should support our regional neighbours, especially in the Indo-Pacific region, to support their own surveillance and response activities.

There may be instances where sharing data globally about the incidence, spread, burden or other aspects of communicable (or non-communicable) disease from an island nation such as Australia could be highly valuable. Also, the impact of pandemic on our diverse, multi-cultural population and First Nations people could provide insights internationally. Australia should therefore be prepared for opportunities to share information to benefit other countries and have developed technical capability to do so.

There needs to be improved reference in the consultation document about public / community engagement and involvement in co-design – the document remains largely silent on this (beyond providing public health education).

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?

The CDCs role should be centred on the coordination of consistent information. It should be a platform to engage with experts and policy makers. It should leverage AIHW for data collection, surveillance, and monitoring expertise since it effectively leads the burden of disease study. Assessment of effectiveness of preventative health measures is an important issue discussed in response to question 23.

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

The CDC should prioritise taking an active role in implementing several of the goals of the NPHS. Although emergency health situations such as the COVID-19 pandemic may have prompted the introduction of the CDC, preventive health is a critical component of disease control (reflected in the fact that the US CDC is the Centers for Disease Control ***and Prevention****).*

The consultation document notes that "screening" is out of scope for CDC. However, screening is a core function in implementing preventive health strategies, with increasing cancer screening in particular being one of the focus areas identified in the NPHS. While a portion of the scope described in the consultation document is about communicable diseases, non-communicable diseases are also featured as being within scope. For non-communicable diseases, especially those that are heritable/due to genetic causes, screening is key element in disease prevention. DNA screening for predisposition to conditions that are medically actionable (able to be prevented or caught and treated early), such as certain cancers and heart disease, makes a significant impact on disease prevention and future health system cost savings.

The US CDC has identified 3 conditions that are currently appropriate for population-level DNA screening (hereditary breast and ovarian cancer, Lynch syndrome, and familial hypercholesterolaemia (FH)). These genetic predispositions are chronically under-diagnosed in Australia, with estimates that up to 90% of people with DNA variants predisposing them to these conditions are not aware and cannot take preventive steps. The Australian CDC should consider the role of screening in preventive health and the potential for DNA screening in the near future and reconsider its categorisation of screening as out of scope. It may be useful to consider the distinction between areas that are out of scope and areas that do not need urgent attention. Screening may be an example of an area that should be considered in scope and an essential aspect of implementing the NPHS, but not an area of immediate urgent focus.

Along with screening, there are other specific roles that CDC could take responsibility for in the NPHS. These may include:

- *Priority setting for health promotion programs and activities*
- *Preparedness*
- *The national strategic plan addressing the impacts of environmental health, including horizon scanning to identify and understand future threats*
- *Public health workforce future proofing "through the enhancement of the availability, distribution, capacity and skills of the workforce".*

- *A framework addressing the impacts of emergencies and disasters on mental health and wellbeing.*
- *A national framework for real-time, nationally consistent air quality information*

Specific actions of the NPHS CDC could take responsibility for:
- *A national platform providing credible and reliable health information*
- *Enhanced public health workforce planning*
- *A national prevention and monitoring framework*

Specific boosting action in focus areas CDC could take responsibility for:
- *Increasing cancer screening and prevention*
- *Improving immunisation coverage*

General roles for CDC in implementing other public health related strategies:
- *Translating research into guidelines and policy*
- *Coordinating data access*
- *Utilising its data resource for identifying the priority populations in relation to public health issues*
- *Ensuring all public health policies are developed through the lens of Closing the Gap*
- *Interconnected health policies with shared commitment and responsibilities*
- *Participating in cross-sector collaboration*

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

Alternatively, government could consider establishing a separate centre for health policy evaluation to impartially monitor all health policy, including those related to preventive health, by applying appropriate and reproducible evaluation frameworks. This could also be established as an academic centre.

Wider determinants of health

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

By developing all policy through the lens of the goals of Closing the Gap, and by ensuring Indigenous involvement and leadership/governance and continued engagement with communities, not just in the design of the CDC. Establishing links with community-controlled health services and their associated peak bodies is essential.

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

GPs, community leaders and groups, and social programs and events are good ways of reaching communities that may not watch mainstream television or interact with social media. The use of interpreters and an understanding of the culture and practices of minority groups is also important. An excellent list of prevention partners in the NPHS on p71 could be considered and expanded upon for the CDC.

GPs remain of incredible importance to reaching people with health information, but issues with shortages of appointments and having to pay gap fees will keep people from seeing a regular GP. A large multi-country social research study collecting the opinions thousands of participants on genomic data ('Your DNA Your Say') has shown that people overwhelmingly trust their doctor with their genomic information, and this is likely translatable to other health information. GPs should therefore be specifically engaged in delivering CDC's health messages as well as promoting the benefits of sharing of health information.

We have noted that there are other at-risk populations not mentioned in the CDC consultation paper, such as the LGBTQI+ community. The list of priority populations in NPHS on p21 could be considered in the scope of CDC.

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)?

Previously noted as missing from the consultation document is an identification of sectors, organisations and their policies that will be the CDCs stakeholders. Early identification of stakeholders will be essential, as will be the clear delineation of roles and responsibilities of CDC. CDC should consider inclusion of sectors outside its immediate remit when establishing its advisory committees and consult widely on design and ongoing operations. There should be dedicated and sustained commitment to work in partnership with Indigenous, culturally diverse, and at-risk members of the community in delivery of core CDC functions. The importance of having a user-friendly website, inclusive approach and regular communications with stakeholders cannot be underestimated.

Research prioritisation

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

CDC should provide expert guidance to NHMRC/MRFF on the prioritisation of research funding opportunities but have no formal powers or involvement in administration. It should not directly administer grants; this should be coordinated by the respective granting bodies so that CDC can remain impartial and focus on its own remit. Synthesising research outcomes into policy and guidelines should, however, be a key role for the CDC and so relationships with research centres and maintaining current knowledge of research being undertaken in Australia will be important.

The CDC Project

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

During the consultation workshop, several of the groups came up with the suggestion that evidence of 'public health wins' would be a measure of success. Examples of this would be ideal for communication of the CDCs work with the public as well.

Being able to evaluate and measure success will be achieved through development of transparent, granular goals and the development of specific policy targets. Evaluation could be managed by an external organisation or department within Department of Health.

The most important thing is that the budget is proportional to the scope and organisational model/structure, and so it is appropriately resourced.

Final General Comments:

Themes of our response:

- *Scope is very broad*
- *Consultation and active, ongoing involvement and co-design with communities, including Indigenous, CALD and other priority populations*
- *Partnerships with organisations rather than taking on all responsibilities*
- *Strengthening emergency responses within Australia and the Indo-Pacific region*