RACGP

RACGP response to the Department of Health and Aged Care's consultation on the establishment of a Centre for Disease Control

December 2022

Functions of the CDC

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

The nature of Australia's structure of federal and state and territory governments and subsequent power structures would limit a future Centre for Disease Control's (CDC) capacity to act as a future decision maker and enforcer. However, the CDC would be well positioned to provide national leadership and coordination to federal and state and territory governments in an advisory capacity and in reducing duplication of efforts and resources between these and other entities.

No one entity is sufficient in responding to health emergencies, however providing clear guidance and a coordinating role will support collaboration, consultation, implementation, and enforcement.

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

The RACGP recognises the statement in the discussion paper that "the CDC's focus will be on ensuring Australia is prepared for future pandemics" and that "it will lead the national response to future infectious disease outbreaks and work to prevent both communicable (infectious) and non-communicable(chronic) diseases". We reiterate that whilst the COVID-19 response is currently at the forefront of challenges facing our healthcare systems and has been an impetus in establishing the CDC, it's spotlight must not overshadow the importance of the inclusion of chronic disease prevention and management in this country.

Whilst recognising that states and territories have unique differences that may require different policy settings, the COVID-19 pandemic highlighted extraordinary duplicity of efforts as well as confusion when navigating a health system that straddles federal and state/territory decision making and authority.

The CDC could play a role in developing and implementing nationally consistent criteria for disease definitions, testing and treatment to minimise confusion for both clinicians and patients.

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

The COVID-19 pandemic has highlighted that Australians simultaneously hold great trust and scepticism towards government.

Independent advisory bodies previously unknown to most of the public, such as the Australian Technical Advisory Group on Immunisation (ATAGI) and the Australian Health Protection Principal Committee (AHPPC) provided a trustworthy source to clinicians and the public on evidence-based health information, independent of government.

The CDC should be developed with a similar model of independence, with representatives from a broad spectrum across all states and territories and medical and social disciplines that reflect the needs of Australia's diverse communities.

Governance and management of the CDC should include organisations representing health professionals who are not representatives or employees of federal or state and territory governments jurisdictions so they have an equal role in the decisions and actions. This includes GPs, other specialists, and Allied Health professionals. Extensive consultation with these critical healthcare professionals is essential in shaping future responses to meet the needs of current, ongoing and future disease response.

GP representation:

The RACGP believes there should be formal and permanent GP representation in future CDC governance arrangements, that is appropriately recognised and remunerated. It is essential health policy effectively addresses issues experienced by GPs and recognises the critical role GPs play in Australia's healthcare system. GPs are often a person's first contact with the healthcare system and GPs must be supported to adapt quickly to challenging situations, strengthening their capacity to provide optimal care.

GPs play a critical role in a patient's journey through the healthcare system, often acting as the central point of contact, coordination, education, and trust, providing high-quality best-practice care for their patients. GPs are experts in providing patient-centered, continuous, and coordinated care. GPs know their patients, their medical history, backgrounds, social and mental health circumstances.

While the RACGP strongly advocates that the CDC is a centre for ALL disease control, not just infectious-disease control, the COVID-19 pandemic has highlighted the leading role general practice plays in responding to infectious disease outbreak and put a spotlight on their role at the forefront of the pandemic response - from providing continuity of care for Australians through uncertain times, providing primary care for COVID positive patients, administering over 50% of the nation's COVID-19 vaccines and more recently responding to the longer terms effects of the pandemic such as long-COVID, repeated COVID-19 infections and the impact on Australia's healthcare system.

GP's have proudly represented their profession and the health needs of the community on numerous advisory boards throughout the pandemic at a federal, state/territory and local level, including the National COVID-19 Clinical Evidence Taskforce and ATAGI. As key stakeholders in this space, it is important that general practice is represented at all levels of policy and decision making.

While the pandemic has increased the public profile of GP advocacy and representation, GPs have – since the inception of their profession – shared their significant insights on advisory panels and expert working groups and are well placed to support the CDC in an advisory capacity.

Participation from GPs and similar representatives requires funding, as representatives are not salaried employees and time away from clinical practice equates to lost income, which acts as a disincentive to active participation.

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?

The establishment of an Australian CDC should ensure that timely, reliable, quality, evidence-based, and nationally consistent information is available to both the public and healthcare clinicians to ensure provision of evidence-based health information and best-practice healthcare.

The RACGP recognises that different levels of government and agencies have different roles and responsibilities relating to managing health responses. However, cross-jurisdictional, and inter-agency roles must be better coordinated and streamlined, which could be supported through the establishment of the CDC.

The COVID-19 pandemic and the initial vacuum of information relating to a new disease provided fertile ground for the dissemination of misinformation, non-evidence-based health claims and vaccine scepticism. Having a central body such as a CDC may go some way to removing these vacuums by providing trusted information from a high profile and trusted authority.

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

There are significant lessons learnt – and many lessons which remain to be learnt – from the COVID-19 pandemic, some of which are outlined in the final report of the Senate Select Committee's inquiry into COVID-19, to which the RACGP made a submission.

While the federal government led the response to the pandemic, much of the public health policy and implementation was driven and enacted by the states and territories. GPs and their teams, primarily work within the federal Medicare system while simultaneously expected to meet other local requirements. This left GPs battling inconsistencies between the policy positions of different levels of government, particularly around vaccine eligibility. A CDC could play a key role in guiding and communicating a consistent federated approach to health information dissemination and policy.

A data revolution

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

Key to timely, consistent and accurate national data is interoperability. The foundation for interoperability is based on data being entered into a single source of truth to be utilised over multiple platforms and by multiple healthcare providers to reduce inefficiencies in data collection and reduce transcription and relay error. While a significant amount of valuable health data is captured in Australia, there is currently a lack of interoperability of health care systems to best utilise such data.

Interoperability would allow all parts of the healthcare sector to easily access the most current and correct information, enabling high quality care to be delivered to patients across the nation. Systems should be so

well-designed that users, particularly those in overburdened sectors such as general practice do not require high levels of digital literacy. Technologies need to be user friendly to minimise the need for extensive training and education.

The RACGP believes establishing Standards should be prioritised for delivery. The key role of standards is to create consistency and compatibility. The current healthcare IT systems use different coding and terminology across fragmented systems making it difficult to transfer, compare and analyse data, a key barrier to effective data exchange and consistent and accurate national data.

See the *RACGP response to the National Healthcare Interoperability Plan consultation* in December 2021.

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?

Data has the potential to support GPs in providing comprehensive, whole person, and coordinated care.

The collection and use of appropriate data can support the delivery of high quality, accessible care for those who need it most and improve coordination and collaboration with patients and their carers to reduce fragmentation of care. By improving system efficiencies there will be better accessibility and utilisation of beneficial data. It is essential end users (healthcare workers) are involved in the design of any data collection solutions from the outset.

Disease surveillance often relies on hospital data because it has historically been easier to collect. However, primary care date is a richer, more immediate source of information about epidemiology of emerging communicable and non-communicable conditions and should be prioritised for appropriate and effective interpretation and utilisation.

Currently, less than 1% of National Health and Medical Research Council (NHMRC) competitive funding is awarded to primary health care projects, and less than 1% of funding in the Medical Research Future Fund (MRFF) 10-year plan is specifically allocated to primary care.

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

When utilising general practice data, the RACGP's *guiding principles for managing requests for the secondary use of de-identified general practice data* should be followed.

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

The CDC should leverage expertise currently available in the field from which the data is collected. For example, it is essential that GP researchers are engaged in the interpretation of data sourced from general practice.

There needs to be a renewed focus on supporting and funding research in general practice. General practice research must be a priority because it is the cornerstone of the health system that provides care to the

majority of the population. Funding must be prioritised to embed outcomes from research findings into best-practice care, so benefits are realised for both patients and clinicians.

Australia needs a data driven plan to manage communicable and non-communicable diseases, now and into the future. Data allows us to set targets and measure outcomes.

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 RACGP supports the re-introduction of funding for high-quality longitudinal data collection and studies in general practice. One of the key challenges facing general practice is the lack of evidence generated through these long-term studies, such as the now discontinued Bettering the Evaluation and Care of Health (BEACH) and Medicine in Australia: Balancing Employment and Life (MABEL) studies.

Data that concerns or that might affect First Nations people, either individually or collectively, should be given specific consideration by third parties, including the CDC. First Nations data sovereignty ensures that data on or about Aboriginal and Torres Strait Islander people is used in ways that are consistent with their values, culture, and diversity, and meets their current and future needs.

Enhanced data sets can assist to design tailored preventative health strategies to those with the poorest health outcomes. Identification and analysis of key demographic data collected is critical, particularly that which reflects groups with the poorest health outcomes. This would include socio-economic status, age, disability, First Nations background, culturally and linguistically diverse background.

GPs must lead primary care research and the interpretation of primary care data.

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?

The CDC could assist GPs and other healthcare providers by acting as a single source of truth during future pandemics. COVID-19 led to GPs being inundated with uncoordinated and sometimes contradictory information via the federal Department of Health, state-base health authorities, Primary Health Networks and Local Hospital Districts.

Living guidelines that keep abreast of changing evidence-base have been fundamental for the management of COVID-19. The establishment of the National Clinical Evidence Taskforce (formerly the National COVID-19 Clinical Evidence Taskforce) with representation from 34 peak bodies (including the RACGP) and trusted independent evidence-analysis from Cochrane Australia, was one of the successes that emerged from the pandemic that could be maintained and supported by a CDC.

Clinical practice guidelines are an essential mechanism to define 'best practice' . To be trusted and fit for purpose they need strong input from generalists, need to be informed by people with expertise in coal-face delivery of healthcare and need to be continuously reviewed and updated.

Funding must be prioritised to embed outcomes from research findings into best-practice care, so benefits are realised for both patients and clinicians. The National Institute for Health and Care Excellence (UK), Scottish Intercollegiate Guidelines Network (SIGN) (Scotland) and United States Preventative Services Taskforce (United Sates of America) are all examples of government-funded independent guideline groups.

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

The COVID-19 pandemic saw an increase in the spread of harmful misinformation via social media platforms such as Facebook, Twitter and Instagram. There were also instances where a lack of restraint and critical and objective reflection in more traditional media generated and circulated misinformation and invited reactions against necessary public health measures.

The RACGP believes a role of the CDC would be responding swiftly to limit the distribution of misleading information on all media platforms, striking an appropriate balance between removing harmful information and ensuring people's right to freedom of speech is maintained, but most importantly filling a vacuum of information with evidence based, targeted and culturally appropriate health information across communities and platforms.

Public awareness campaigns are required to educate Australians about the importance of heeding the advice of medical experts rather than celebrities who promote views contrary to scientific evidence, to support the best health outcomes for all Australians.

Support – via a CDC – for developing, collating and disseminating high quality accredited translated patient information would assist in expediting health messaging to culturally and linguistically diverse communities, particularly in emergency situations.

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

Stakeholder engagement across Australia's diverse communities, including those with the poorest health outcomes, is essential to developing, delivering and embedding appropriate, relevant and inclusive advice and health information. It must address the needs of culturally and linguistically diverse people (e.g. translations available in multiple languages), be culturally safe for First Nations people (e.g. consultation with communities) to understand their needs and ensure these are met), and be physically accessible.

Peak bodies and organisations representing minority Australians (including First Nations, culturally and linguistically diverse, LGBTIQA+ and socio-economically disadvantaged communities) must be engaged, ensuring that voices "on the ground" are heard.

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?

Planning for future pandemics should include the establishment of efficient distribution channels for PPE and other supplies from the National Medical Stockpile that are able to be tailored to local requirements.

During COVID-19, initial timely access of goods from the National Medical Stockpile to general practices was hindered by distribution of goods via the PHNs. While PHNs coordinated orders of goods, they were ill equipped to mobilise the goods to practices, particularly where a PHN covered a large geographical area. Later implementation of supplies being delivered direct to practices from the stockpile (while still being ordered via the PHN) remedied some of these issues.

Digitising the ordering of supplies would also aid efficiencies, as during COVID-19 the use of Excel spreadsheets and email for ordering added a layer of complexity, particularly around version control.

During COVID-19 supplies from the stockpile were strictly limited and general practices struggled to access adequate PPE from private suppliers due to worldwide shortages from both clinical and public demand. Where the National Medical Stockpile is unable to meet the requirements of general practices and other healthcare providers, they must be supported in accessing supplies via other channels and prioritised under commercial arrangements.

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?

The RACGP will not be providing comment in response to this question.

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

The RACGP will not be providing comment in response to this question.

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?

Please refer to response to question 20.

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

In 2020 the RACGP submitted a response to the Royal Commission into National Natural Disaster Arrangements. Our response advocated for greater support and inclusion of GPs in national natural disaster arrangements across planning, mitigation, response, and recovery. This includes formal general practice representation on national and state/territory-based planning groups and committees and greater coordination and inclusion of GPs involved in frontline responses – not only in response to natural disasters but any event that has the potential to cause significant impacts on the health and wellbeing of Australians, including those that would fall under the remit of an Australian CDC.

The RACGP strongly supports the Primary Health Care 10 Year Plan inclusion that "*primary health care needs to be better integrated into emergency preparedness and response at local, jurisdictional and national level to prepare for future droughts, floods, bushfires, communicable disease outbreaks and other emergencies*".

Efficient utilisation of GP services in areas effected by disasters and emergencies is crucial to the health and welfare of the community. Developing clear roles and responsibilities for GPs participating in disaster and emergency planning and response will support greater confidence and willingness of GPs to participate.

General practice is not currently represented formally, permanently, or consistently in federal, state/territory or local disaster/emergency management planning, resulting in inconsistent utilisation of GP skill sets, and poor communication with general practice in times of disaster/emergency.

The development and implementation of a framework for the inclusion off general practice in disaster/emergency planning and response at federal, state/territory and local levels is needed to address these issues, protecting community health and wellbeing.

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?

The RACGP will not be providing comment in response to this question.

International partnerships

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

Australia – while small in population by global standards – is a trusted leader in the Indo-Pacific and is well positioned to facilitate a One Health approach with our neighbours through relationship building, information sharing and international support and aid in preparing for or responding to health emergencies or crisis.

The CDC could provide advice in such contexts to support decision making.

Australia is oft viewed as less at risk from external threats due to our island state and distance from many of the world's population hub. However we have unique risks in our region, which can be mitigated through collaboration and cooperation across the region, with the CDC playing a key advisory role on health related matters.

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 establishment of an Australian CDC provides an opportunity for a national public health agency that incorporates both communicable and non-communicable disease prevention and control strategies.

The CDC could provide similar function to the former Australian National Preventative Health Agency (Promoting a Healthy Australia), whilst also incorporating coordination of communicable diseases and disaster responses.

This is achievable, as evidenced by similar agencies in other countries, and would allow for better visibility, stability and continuity of preventative health programs. The CDC could undertake the role of coordinating public health activities at all levels of government – especially coordinating with state/territory government and independent agencies.

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

The CDC could incorporate governance for the main preventive programs identified as focus areas of the National Preventive Health Strategy, being:

- reducing tobacco use and nicotine addiction
- improving access to and the consumption of a healthy diet
- increasing physical activity
- increasing cancer screening and prevention
- improving immunisation coverage
- reducing alcohol and other drug harm
- promoting and protecting mental health.

Having these programs under one agency may go some way to reducing fragmentation among programs, while increasing efficiencies.

The CDC could play a role in collaborating with PHNs and primary care to support the implementation of these programs.

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

Any activities to support preventative health measures should be evaluated to ensure that they are meeting the expectations of the broader population and achieving their goals.

Some of the individual programs under the National Preventive Health Strategy already incorporate routine monitoring and evaluation and this should continue.

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?

The health needs of Australians are as varied as the wonderful diaspora of our community. Health literacy and health equity are as diverse. There must be a clear focus on improving the health outcomes of groups who already experience poorer health outcomes to reduce health inequities over time. Identifying populations with high needs, critical gaps in health care and poorer health outcomes is the first step.

The CDC must represent **ALL** Australians and not be exclusive to any population group/s. This involves a fair and equal representation from all health-related and community stakeholders.

There should be a particular focus on addressing social determinants of health and delivering culturally appropriate preventive health activities to ensure community preparedness for future pandemics and emerging health crisis.

While many determinants lie outside the health system – such as income, unemployment and working conditions, social security access, housing, experiences of racism and discrimination – there is no current cross government framework to ensure that the health impacts of policies in these areas are incorporated into the policy making process. The CDC presents a significant opportunity to drive cross government collaboration and action on the wider determinants of health.

Equity of access to health care must be considered, with supportive measures such as patient education to ensure all Australians can receive high quality care. This includes services that are inclusive of culturally and linguistically diverse people (e.g., translations available in multiple languages), and are culturally safe for Aboriginal and Torres Strait Islander people (e.g., consultation with communities to understand their needs and ensure these are met).

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

Improving the collection, integration and quality of data describing culturally diverse and/or at-risk populations is essential and can be achieved through the use of standardised data fields in primary, secondary and tertiary care settings.

The RACGP supports data capture which includes a patients social history if this might increase their risk of health issues. These may include country of birth, year of arrival, cultural background, need for an interpreter and preferred language/s. Additional fields that relate to other at-risk populations may include drug or alcohol use, disability, smoking, nutrition, physical activity, gender identity and other social determinants of health.

There is often a risk of 'unintended consequences' where policies are implemented rapidly, particularly for population groups that may have unique or specific requirements. As evidenced during COVID-19, where communities continue to be engaged in designing and delivering public health messaging, there is a significant improvement in understanding and uptake.

Health promotion activities should focus on community engagement, resilience and improving health literacy. This may be achieved through access to quality language services, employment of multicultural workers and engagement of community groups, ensuring health information is appropriate to the setting, including format, audience, age, and health literacy.

Please see also response to question 24

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)?

The Australian CDC could engage in regular dialogue with health services and practitioners in specific areas focusing on the broad determinants of health, including language barriers, socioeconomic barriers and geographical and physical access to healthcare.

The RACGP has a significant network of clinicians with specific interests who can be utilised to provide advice and guidance on the above.

Research prioritisation

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

There are a number of existing models responsible for public health and medical research and any future role of the CDC should not be duplicative.

At the heart of any research will be primary care data and there needs to be active involvement of clinician researchers from the primary care setting.

The focus of healthcare research must extend to prevention and any data supporting this must be available in real time and extracted directly from the systems where it is collected.

The RACGP recommends there is further investment in data analytics and artificial intelligence to allow the interrogation of datasets more quickly and at scale.

Please also refer to responses to questions 9 and 10.

The CDC Project

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

The establishment of any new entity is likely to bring both successes and learnings and the CDC will need to be transparent with these.

We need to see meaningful outcomes achieved through a consistent national approach, reflected in data demonstrating a decrease in disease burden, faster response to emerging health threats and better health outcomes for **ALL** Australians.

General comments

The RACGP is the voice of GPs in our growing cities and throughout rural and remote Australia. For more than 60 years, we have supported the backbone of Australia's health system by setting the standards for education and practice and advocating for better health and wellbeing for all Australians.

As a national peak body representing over 46,000 members working in or towards a career in general practice, our core commitment is to support GPs from across the entirety of general practice, address the primary healthcare needs of the Australian population.

We cultivate a stronger profession by helping the GPs of today and tomorrow continue their professional development throughout their careers, from medical students and GPs in training to experienced GPs. We develop resources and guidelines to support GPs in providing their patients with world-class healthcare and help with the unique issues that affect their practices. We are a point of connection for GPs serving communities in every corner of the country.

Australia's GPs see more than two million patients each week, and support Australians through every stage of life. The scope of general practice is unmatched among medical professionals.

Patient-centred care is at the heart of every Australian general practice, and at the heart of everything we do.

To that end, the RACGP is keen to work productively and collaboratively to support the development of a CDC and to ensure GPs are appropriately and consistently represented.