AUSTRALIAN DENTAL ASSOCIATION

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Prof Paul Kelly, Chief Medical Officer
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Chief Medical Officer Group
Department of Health and Aged Care
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By email: cdc.consultation@health.gov.au

Re: Role and functions of an Australian Centre for Disease Control Consultation paper – November 2022

Dear Prof Kelly,

The Australian Dental Association (ADA) recently became aware of the *Australian Government Department of Health and Aged Care consultation paper: Role and Functions of an Australian Centre for Disease Control (November 2022).*

The ADA is the peak representative body for dentists in Australia and an active member of the World Dental Federation (FDI). Our 17,000 members operate more than 7,500 small businesses across Australia and include dentists who work across both the public and private sectors, across 14 specialty areas of practice, in education and research roles, and dentistry students currently completing their entry-to-practice qualification.

In dentistry, microorganisms may be inhaled, implanted, ingested, injected or splashed onto the skin or mucosa as well as through airborne transmission. Dental practitioners are well versed in the minimisation of these risks and practice in a way to ensure that the spread of infectious diseases is prevented or minimised. They are one of only a few health professionals who are required to declare they have complied with infection prevention and control measures in their registration renewal process. We were therefore disappointed to see that the consultation seems limited to the medical professions, particularly given the 'all-hazards' approach, and look forward to being included in the next stage of consultations.

The importance of dentistry is recognised in our representation and expert advice to a number of bodies with a role in disease prevention and control including the National Health and Medical Research Council, Communicable Diseases Network Australia, Standards Australia and the Australian Commission on Safety and Quality. The ADA develops and maintains the highly valued Guidelines for Infection Prevention and Control that is a reference document for dentists, dental therapists, dental hygienists, dental prosthetists, oral health therapists and dental assistants. The Guidelines are also used by regulators, training institutions and industry suppliers as the standards for dentistry.

The ADA provided guidance to and liaised with the Infection Control Expert Group on the risks and management of COVID-19 as it related to dental practices and shared that expertise across the sector to ensure that patients could continue to be confident in the safety of receiving dental care. Our input was sought by international dental organisations throughout the Covid-19 pandemic. The profession continues to work under the guidance of our 'Risk Management Principles for Covid-19' under current infection prevention and control regulatory / guidance arrangements.

Context

The Australian government is establishing the Centre for Disease Control (CDC). It will take an 'all hazards approach' to strengthen Australia's ability to respond to various public health threats – both natural and those created by humankind. The Australian CDC will ensure ongoing pandemic preparedness, lead the federal response to future infectious disease outbreaks and work to prevent non-communicable (chronic) and communicable (infectious) diseases.

The ADA welcomes the initiative to create a unified national organisation to meet the current and emerging public health challenges.

ADA's comments

Below are some comments to address the specific guidance questions in this initial consultation.

Functions of the CDC

1. **What decision-making responsibilities, if any, should the CDC have?**
    - The ADA is supportive of the CDC having decision-making responsibilities if it is adequately resourced to do so (in terms of evidence appraisal and consultations) and where this does not duplicate processes already in place. There must be a clear indication of where the CDC fits in terms of the hierarchy between existing structures such as AHPPC, ICEG, CDNA and NHMRC. As far as possible, there should be 'one voice' of consistent advice with absolute clarity around decision-making & delegation authority, to avoid conflicting advice or confusion about applications for health practitioners and the public.

    - In a health emergency, it may be necessary for the CDC to delegate some responsibilities to trusted advisory groups within individual professions to ensure broader advice is being applied in specific settings (such as dental settings) to provide national rapidly evolving guidance remains fit for purpose and appropriate risk mitigation measures can be applied.

2. **What functions should be in and out of the scope of the CDC?**
    - The ADA is supportive of the In-Scope roles and functions proposed. In addition, we are supportive of Immunisation and Preventative Health falling under the remit of the CDC (for instance, publication of the Australian Immunisation Handbook).

3. **What governance arrangements should be implemented to ensure public confidence in the CDC?**
    - Representation from relevant specialist areas of practice will be critical.
    - States and Territory representation on the CDC, and reciprocal arrangements for State and Territory health groups to ensure direct collaboration on an ongoing basis.
    - Use of recognised (nominated, qualified) experts and publication of levels of confidence in recommendations (such as in the NHMRC Guidelines) based on the evidence available.

- Defer to individual professions for expert guidance on how broader agreed outcomes/evidence-based principles can be achieved in specific professional contexts.
- Ensure the CDC is active in health promotion beyond times of national emergencies, and that it builds public confidence through demonstrated efficacy in population health outcomes beyond Covid-19 mitigation.

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?

- Identification of key stakeholders and implementation of an engagement strategy recognising the importance of the private sector.

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

- The need for a working list of 'approved collaborators' in terms of expert groups with appropriate governance to rapidly develop guidance for consideration of the CDC as an interim measure to optimise public safety. To formally implement this, the structure for when this 'delegated authority' is implemented, the scope, and clear overarching CDC Guidance to underpin recommendations to individual professions/work settings will be required.
- Clarity on pandemic level classification and what this means for authority, allocation of resources and approval of published guidance relating to public health measures, including ongoing expectations for risk assessment and mitigation.

A data revolution

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

- Poor uptake of eHealth records and universal systems for health reporting across all health professions.

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?

- There is not a strong culture of reporting and no incentivisation to do so in some professions. There are disparate patient record systems with no connectivity. Consideration should be given to how reporting can be encouraged, supported, and, if needed, incentivised.

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

- Storage in Australia, de-identification wherever possible and protection of patient records with best-practice security protocols, particularly given the current mistrust of the public.

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

- Appropriate resourcing.
- Ensuring collaboration with all health representatives to test data efficacy, frictionless yet secure exchange and risk implications.

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?

- Foundational engagement of Indigenous working groups within the CDC.

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 ADA would support proactive CDC engagement with the media so that it becomes the recognised leading authority in public health intervention. This is consistent with the 'one voice' recommendation previously discussed to avoid confusing mixed messages to the public from various organisations with confusing interrelationships.
- Public support for Universities and institutions publishing information relevant to CDC outcomes and initiatives.
- Whilst involvement in innovations such as health literacy are enticing, the CDC may be better to remain focused on being perceived as, first and foremost, a trusted source of evidence-based guidance and entrusting other organisations with disseminating this information in a way that accommodates and builds health literacy.

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

- The ADA believes that the CDC should be involved in the leadership of health promotion, communication and outreach activities in Australia.

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

- It is important to recognise the role of the private sector. For example, 85% of all dental care in Australia is delivered through private practice.
- Community groups
- Education sector including schools, universities, and training institutions
- Standing committees that involve these groups may serve to ensure broader consultation with these sorts of groups occurs before the implementation of decisions.

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 the CDC could expand or improve?

- During the Covid-19 pandemic, there was limited access to the National Medical Stockpile. There was no information readily available to the profession on the current status of the stockpile or the triage for use that was driving prioritisation. The ADA was initially advised that dentistry was not able to access the stockpile reserves so we had to develop our own approach to securing critical personal protective equipment such as masks and distribute them to the profession to ensure the continuation of services to the community. As mentioned earlier, private practices provide 85% of dental services in Australia; without PPE, patients would not have been able to receive treatment even for the most urgent conditions resulting in burdening an already stretched public sector. Late in the pandemic, the dental profession was granted access to the stockpile, reversing earlier guidance and creating confusion. Clarity around the professions able to utilise the National Medical Stockpile, even if in staged tranches based on risk of exposure, is necessary.

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?

- Work with universities and accreditation organisations to embed readiness to assist in emergencies in the education and training of all health professionals.

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

- Support for further research in this area. Understanding what the current burden is and what are the barriers to retention. Providing public health oriented policy advice on the clarity and accountability of funding of the public health workforce between the Federal Government and states, which is severely lacking, particularly in the dental sector.

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?

- Support for research that seeks to understand similarities and differences in the threats faced in Australia versus overseas from a One Health perspective.

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

- The proposal to undertake mapping to understand skills gaps, regulations in each state and territory around scope, and modelling of what skills would be needed in different incident scenarios are supported to answer this 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?

- Transparency and publication of findings regarding surveillance, health emergencies and public health threats is an adequate first priority in establishing enhanced international preparedness.

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. CDC should include additional objectives like leadership, deep technical expertise in implementing and evaluating public health programs and using data for emergency preparedness and response.

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?

- Involve representatives from across health professions whenever possible.

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

- The ADA believes the CDC should have a central role in implementing the goals of the National Preventive Health Strategy.

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

- Yes

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?

- Developing a reconciliation action plan as a foundational piece of work.
- Ensuring consultation with Aboriginal and Torres Strait Islander people on significant policy decisions.

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

- Engage community groups already disseminating health information to these at-risk populations. Use existing trusted networks.

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)?

- Being clear about the scope of the CDC and publication of a transparent stakeholder engagement policy.

Research prioritisation

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

- The CDC should be involved with identifying priority areas for public health and medical research funding in a transparent way. In particular, the crucial link between adequate workforce numbers to maximise the use of available funding for the provision of services to eligible Australians should be scrutinised through the lens of public health benefit.

The CDC Project

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

- Life expectancy international comparisons
- Quality of life metrics
- Measure public trust
- Measure professional trust (from health professionals)
- International comparison across further health indicators

The ADA is happy to discuss any or all of the comments provided and looks forward to ongoing involvement in forming a functional, robust, consultative CDC. Should you have any questions, please do not hesitate to contact Mr Damian Mitsch, ADA Chief Executive Officer, at +61 2 8815 3333.

Yours sincerely,

Dr Stephen Liew
President