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Submission on behalf of the Royal Australasian College of Surgeons (RACS)

Critique of the Australian Centre for Disease Control Bill 2025 and the Australian Centre for Disease Control (Consequential Amendments and Transitional Provisions) Bill 2025, and their impact on surgery in Australia

Dear Committee Secretary,

Introduction

The Royal Australasian College of Surgeons (RACS) is supportive of the Australian Government's commitment to establishing a national Centre for Disease Control (CDC). The COVID-19 pandemic highlighted structural and information distribution issues that had a direct impact on surgical care; most significantly, opaque and rapidly changing restrictions meant elective procedures were paused, anaesthesia and peri-operative pathways disrupted, and screening backlogs increased. RACS therefore supports the proposed legislation that permits real- time, high-quality data collection and transparent, evidence-based public health advice that actively protects time-critical surgery (and other urgent surgical conditions, particularly cancer) during health emergencies and other shocks to the system.

At the same time, RACS has significant concerns about aspects of the legislative package. Particularly secrecy and Freedom of Information (FOI) carve-outs which could inadvertently erode transparency around decisions that restrict operating theatre capacity, limit anaesthesia staffing and intensive care unit (ICU) recovery, and extend time-to-treatment. We encourage changes to ensure CDC's new powers lead to peri-operative protection and transparency, not just centralisation.

RACS duly requests Parliament and the Department to adopt the rule-based measures outlined in our submission, and suitably narrow the FOI carve-out, to ensure the new Australian CDC provides the surgical community and our patients with the intelligence they need most: transparent, real-time, de-identified, peri-operative intelligence that provides safe and accessible surgery, even in a crisis.

Background

The Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards,

professionalism, and education in Australia and Aotearoa New Zealand. It represents close to 8,000 surgeons and 1,300 surgical trainees and Specialist International Medical Graduates (SIMGs). As a not-for-profit organization, RACS funds surgical research, advocating for members and patients, supports healthcare, as well as provide surgical education in the Indo-Pacific. The College trains surgeons in nine main specialties: Cardiothoracic, General, Neurosurgery, Orthopaedic, Otolaryngology Head and Neck, Paediatric, Plastic and Reconstructive, Urology, and Vascular surgery.

Basis for this submission

From a surgical perspective, there is value in ensuring that the CDC collects and applies data to protect anaesthesia and surgery. During COVID, lockdowns resulted in an unintended consequence of ceasing elective surgery, in turn, eroding the skills of the workforce, and forcing many to leave the workforce. Concurrently, screening activities and preventive procedures were diminished, resulting in greater risk of avoidable morbidity and mortality. This was an area of public health planning that was neglected, so by not prioritising surgical services contributed to negative consequences. If surgical need were established as a facet of this centre, we could intentionally develop evidence-based processes that protect surgical capacity when there are dangers or crises, avoiding the mistakes made during COVID.

As such, the position of RACS rests on three pillars:

(i) peri-operative data collection and application
(ii) continuity of time-critical surgery and screening in crises; and
(iii) transparency of modelling and advice that inhibit surgical services.

The differences between the Bills

Bills	***Australian Centre for Disease Control Bill 2025 (CDC Bill)***	***Consequential Amendments & Transitional Provisions Bill 2025 (C&T Bill)***
Core purpose	Establishes the Australian CDC as a non-corporate Commonwealth body; sets powers, responsibilities, governance, data and publication obligations.	Modernise the CDC in relation to current legislation; transfers responsibilities/powers from Chief Medical Officer (CMO)/Department to CDC Director-General (DG); adds FOI carveout; creates and oversight transitional rule-making.
Key levers	Information directions with limited ability to override other laws; civil penalties; publication requirements; secrecy/offence framework.	Amends *Biosecurity Act*, *National Health Security Act* (NHS Act), *National Occupational Respiratory Disease Registry Act* (NORDR Act); transfers National Focal Point under the International Health Regulations (HR); adds FOI Schedule 3 exemption for CDC "protected information"; repeals Australian National Preventive Health Agency (ANPHA); 12-month window for transitional rules

Legislative differences that impact surgery in Australia

Information-gathering power (CDC Bill) vs. cross-Act re-wiring (C&T Bill)

The CDC Bill provides a strong new direction power to obtain information needed for advice (with limited overrides), civil penalties for non-compliance, and a public register of directions with reasons. Examples required for highlighting from the CDC Bill are as follows-

- **Clause 48**: makes an entity liable to a civil penalty if the entity fails to comply with a direction under Clause 45(1)
- **Clause 71:** offences relating to the protection of information and record disclosures
    - Subclause 71(1) offence up to 2 years' imprisonment or 120 penalty units
    - Subclause 71(4) a defendant bears an evidential burden
    - Subclause 71(5) exception to imprisonment is acted in good faith, with the defendant bearing the evidential burden.
- **Clause 74:** The maximum civil penalty for persons failing to comply with a direction at clause 48 is 60 penalty units… penalty set with the policy aim of deterrence.

The C&T Bill moves legal levers and responsibilities, so the DG's advice sits at the center of the system. As stipulated in the 'Overview of the Bill' (p.5)-

"The purpose of the Australian Centre for Disease Control (Consequential Amendments and Transitional Provisions) Bill 2025 (the Bill) is to make consequential amendments and transitional provisions to existing related Commonwealth legislation to support the establishment of the Australian Centre for Disease Control (CDC)."

The targeted impact of the C&T Bill provides the lever for near-real-time peri-operative data (OR activity; cancellations by urgency; post-op ICU capacity; anaesthesia workforce). The C&T Bill strongly embeds data fed back to the appropriate decision-maker.

Transparency & Freedom of information obligations

The publication regime of the CDC Bill versus freedom of information exemptions in the C&T Bill presents some potential systemic disruptions for surgeons. However, the surgical implications of the CDC Bill assert a proactive transparency. The C&T Bill may well constrain overall publication by exempting "protected information," which encompasses the assumptions and models that underpinned decisions to possibly defer elective surgery. This trade-off similarly risks a repeat of the opaqueness of the COVID-19 years.

In the CDC Bill, its proactive publication regime under Clause 31 announces the need to publish Advisory Council members (p.13). Clause 24 requires the publication of public health agreements (p.13), Clause 78 provides that the Australian CDC must publish, and table accompanied by a 5 yearly independent review. However, publication is not without limits, but is framed throughout as "reasonable and proportionate," (pp.11-13) and in a manner to minimize harm.

In the C&T Bill, freedom of information under Schedule 3 exemptions for CDC secrecy (unqualified exemption) exist. Schedule 3 of the *Freedom of Information (FOI) Act 1982* (under s38) ensure that information is protected under the secrecy provision and would be exempt from disclosure. This would exempt protected information from publication by reason of the Director-General's duty to publish public health advice and from release under freedom of information requests one would suspect.

Biosecurity, surveillance & the National Focal Point (C&T Bill)

The *Biosecurity Act 2015* appears to transfer some functions in the C&T Bill, such as the role of the Director of Human Biosecurity (DHB) (p.5). Hence, the Director of Human Biosecurity (DHB) from the Commonwealth CMO to the Secretary of the Department where the responsibility to determine listed human disease will transfer to the Director-General of the CDC. The National Focal Point (NFP) as established by the World Health Origination's legally binding International Health Regulations (IHR), will be transferred, ensuring the Australian CDC will be the centralized point of contact for significant public health events coordinating surveillance data for diseases on the National Notifiable Disease List (p.6). However, the surgical impact this will have is determined by the proposition that the CDC publishes the

impact analyses showing what this means for time-critical surgery. The inclusion of listed diseases and the NFP role to transferred to the CDC, the risk settings, for both borders and domestic situations, to determine staff isolation engines, PPE, ICU surge, and theatre process can be logically done.

Confidentiality/offences and safe reporting (CDC Bill)

To reiterate, within the CDC Bill, Clause 71 refers to an offence resulting in a maximum of 2 years imprisonment or 120 penalty units. There is an applicability of good faith exceptions with the evidential burden on defendants who claim, with justification required when demonstrating a behavior as reasonable, necessary, and proportionate. Part 2 of Schedule 1 contains a new defense against the offence under s21 of the *National Health Security Act 2007* where the use and disclosure has been permitted under the CDC Bill (p.7). The impact on surgery is that without clear safe-reporting and de-identification protocols, these offence provisions may inhibit frontline escalation of operating room or ICU hazards associated with deficiencies (e.g. oxygen, PPE, anaesthesia staffing).

Transitional rules (C&T Bill)

Transitional rules under item 5 of the C&T Bill (pp.20-21) aim to facilitate a smooth transition from the old legislative framework to the new legislative framework, but it may not be possible to foresee the full variety of situations that the transitional provisions will need to encompass. It is of limited duration (12 months) and can be retrospective, with appropriate safeguards (no new offences or new penalties, no powers of seizure, etc.). These provisions are set out in the transitional parts of the C&T Bill and the Explanatory Memorandum (EM), including the treatment of pre-transition instruments, pre-transition proceedings and pre-transition references (as exemplified by the NORDR Act). However, there is a surgical impact. During the first year, it may be reasonable to expect the ministerial rules to tidy up peri-operative dataflows and governance, but under no circumstances should they reduce the disclosure of aggregate surgical-impact data (waitlist, time-to-treatment, urgent deferrals) or delay time-critical surgery unless evidence can be produced to support there is a net benefit to life and health.

Why this legislative package is important for surgery and elective surgery

A more improved and streamlined CDC would greatly improve current delays and wait lists if another pandemic or epidemic would transpire onto Australian shores. For example, it has been shown that delays increase mortality in cancer. A 2020 but still relevant and sound international meta-analysis into hazard ratios has shown that every 4-week delay in the delivery of cancer treatment has been associated with a statistically significant increase in mortality across different cancers and modalities (surgery, systemic therapy, radiotherapy) (Hanna et al., *BMJ*, 2020, pp.2-6 of the PDF). This is a critical design requirement for the CDC in which the time-to-treatment curves would need to be explicitly modelled and published alongside implementation of any infection-control measures which would affect theatres and ICU recovery.

The enormity of surgical backlog because of COVID was demonstrated in the prescient and still pertinent COVIDSurg Collaborative models of 2020 at the outset of the pandemic where approximately 28.4 million elective operations were cancelled or postponed worldwide during a 12-week peak disruption. Recovery requires ongoing surge capacity and ongoing operational strategies (e.g., longer sessions or protected "green pathways"). (*Br J Surg*, 2020, pp. 1442–1445 of the PDF) This speaks to the necessity for the CDC to plan, manage, and track backlog mitigation with surgical dashboards linked to the guidance.

The effects on the Australian system and anaesthesia safety have been evident via the Australian Institute of Health and Welfare (AIHW) release which showed continuing disruption to elective activity and long waiting times throughout 2023 and 2024. The Bureau of Health Information (NSW) became

involved in reporting longer waiting times well into 2025. The most updated triennial 2018-2020 ANZCA *Safety of Anaesthesia* (2024) report (pp.14, 29), and its peri-operative literature and anecdotal accounts, continued to emphasize the need for robust national datasets and continuous learning systems to help avoid morbidity and mortality. The CDC could partner with RACS and Australian and New Zealand College of Anaesthetists (ANZCA) to confirm a peri-operative minimum dataset and a national learning loop (the set of sentinel events and corrective actions) and provide publicly available dashboards.

How the two Bills align with and diverge from RACS's position

Collects and applies data to safeguard anaesthesia and surgical care

The alignment appears strong on paper. The CDC Bill has the legal ability to compel information (see cl 45–49, CDC Bill pp.48-51) and provides for publication of a register of directions with reasons (a publication architecture in cl 31 CDC Bill p.41, cl 78 CDC Bill p.68). These are reiterated in the document as "Clause 31 requires the publication of Advisory Council members… Clause 78 provides that the Australian CDC must publish and table… the 5-yearly independent review" (CDC Bill p.13). Despite these assurances, the CDC Bill does not say what peri-operative fields must be collected, or that de-identified surgical dashboards will be published along with constraining advice. Unless these are specified, *a power to collect may not lead to the power to protect*.

RACS Recommendations

This could be rectified by using the Rules (cl 80 CDC Bill p.69) to mandate a CDC-RACS-ANZCA Surgical Continuity Dashboard which comprises the following:

- time-to-treatment for cancer and urgent surgery;
- theatre utilisation and cancellations, by urgency (national/state/local health district)
- post-operative ICU availability and constraints;
- anaesthesia workforce signals (e.g sick leave/isolation peaks, coverage gaps); and screening volumes and recovery plans
- the use of an in-house 'black box' artificial intelligence and privacy protection to assist with the collection of data and evidence

Avoiding opaque processes that limit surgery and impact patient care

RACS alignment with the CDC Bill is partial in this respect. The transparency components in the CDC Bill are a step in the right direction. "Transparency measures… promote freedom of expression… ensuring the public is well informed on the advice that the Australian CDC provides… decision-making process… internal governance." (CDC Bill p.13). However, in the C&T Bill's FOI Schedule 3 places "protected information" outside or "exempt" of both the FOI and the DG's publication duty (C&T Bill p.2). As stated in the document, "This would exempt protected information from publication under the Director-General's duty to publish public health advice." (C&T Bill p.6) This may legitimately protect personal or confidential commercial data, but the carve-out risks inhibiting the public's access to the considerations and modelling that inform theatre closures or the diversion of anaesthesia staff if the definitions explored are not narrow. The EM to CDC Bill states that any limitations are to be "reasonable and proportionate" (CDC Bill p.6), but proportionality without any de-identified and visible obvious core assumptions clouds transparency with an opaque filter of overt and excessive control which may hinder surgical and anesthetic clinical judgement.

RACS Recommendations

- Limit the definition of "protected information" by Rule;

- require a public statement of reasons in whenever surgical-relevant advice was withheld and summary of methods; then,
- assume publication of impact modelling would be appropriate in a de-identified manner.

Protecting time-critical surgical and screening procedures

The C&T Bill's transfer of the NFP function and the surveillance and National Notifiable Disease List (NNDL) responsibilities place the CDC in the position that it needs to be to effectively balance infection control with surgical continuity. This appears as a practical approach. As stated, the NFP will be transferred so as to ensure that the Australian Centre for Disease Control becomes the "centralized point of contact for significant public health events" (C&T Bill p.6) The Bill further articulates that the transference of responsibility for coordinating surveillance data for diseases to the NNDL will be oversighted by the Director General and relevant Minister who will have responsibility for the list to be amended when necessary (C&T Bill p.5).

RACS Recommendations

However, the legislation does not require peri-operative continuity planning to be requisitioned in NFP protocols and risk communication breakdown e.g., Surgery Annex consisting of PPE, oxygen supply, post-operative ICU surge, public private contracting triggers. By "Surgery Annex," we refer to a proposed complementary protocol within the CDC's new National Focal Point (NFP) role that integrates peri-operative continuity into emergency planning. An annex is an addition to the main law or protocol that includes elaborations on more practically oriented action protocols. It is informed by experiences learned during COVID, and would encompass

a) supply of PPE,
b) availability of oxygen,
c) post-operative ICU surge, and
d) triggers for public-private contracting in order to ensure and support urgent and cancer surgery.

Though these were not stated in the Bills, "Surgery Annex" builds on the transfer NFP role to the CDC as reported in the C&T Bill (C&T Bill, p. 6) and follows the WHO and UK practice of adding annexes that identify specialty systems, while also clinical evidence demonstrating that cancellations of surgery were directly caused by lack of PPE, oxygen, and increase patients adding pressure to ICU capacity (AIHW; 2024). Hence RACS recommends that following commencement, a commitment to issue a formal Surgery/NFP Annex to the CDC's operational protocols as developed with RACS and ANZCA would be in the public interest.

Facilitating safe reporting from the front line

The CDC Bill establishes an offence for unauthorised release of information yet acknowledges "good faith" defences and the limits to disclosure are "reasonable, necessary and proportionate." (CDC Bill pp.14, 65) The risk here lies in the absence of clear de-identification guidance and safe reporting pathways. Without these, clinicians and managers may hesitate to report OR/ICU risks (oxygen, ventilators, PPE, staffing). That will suppress the learning signals required for progress which the CDC needs to nurture.

RACS Recommendations

The CDC could publish a *Safe Reporting and De-identification Standard* under cl 80 'Rules' (CDC Bill p.69) that expressly authorizes de-identified reporting of peri-operative risks, aligned with cl. 71 exemptions (CDC Bill p.64).

Conclusion

The legislation package illustrates a significant step in establishing a modern, evidence-based public-health authority. The CDC Bill provides the Director-General with the requisite capability to collect information across jurisdictions (with enforcement) and implement a publication framework (register of directions; governance transparency). The C&T Bill resettled core functions of Biosecurity, NHS Act, NORDR, and IHR/NFP within the CDC to achieve integration of prevention, surveillance and response processes. Nonetheless, the carve-out of FOI Schedule 3 in the C&T Bill (C&T Bill p.3) may erode the transparency needed to inform authorities based on balancing infection control with peri-operative continuity of care. We also risk repeating the conceptually opaque cancellations and dis-skilling witnessed during COVID-19, leading once again to prolongations in urgent surgery and non-urgent surgical management, and escalating mortality, particularly from delayed cancer care.

RACS therefore supports the establishment of the CDC subject to the following: binding Rules under cl 80 requiring public Surgical Continuity Dashboards with time-to-treatment curves, theatre and ICU constraints, anaesthesia workforce signals, and screening recovery trajectories; a narrow definition of "protected information" with a reasons-for-withholding register; a published Surgery/NFP Annex; and safe reporting guidance that enables de-identified escalation of peri-operative risks. With these adjustments, the CDC will be positioned not only to respond to public health threats but to safeguard surgical capacity, and the lives that depend on it.

RACS Summary of Proposal

Let us examine what RACS is proposing once again be it drafting or implementation, but in more detail.

1. Surgical-impact transparency requirement (Rules under cl 80).
- Direct the CDC to publish a Surgical Continuity Dashboard whenever their advice has a significant impact on surgical care. Relate the minimum fields of the Surgical Continuity Dashboard to the DG's register of directions and reasons. (CDC Bill publication/register architecture: cl 31, cl 49, cl 78.)

2. Narrow the FOI carve-out (C&T Bill context).
- Define "protected information" to exclude de-identified modelling assumptions, parameter values, and impact scenarios. Require public logs to proactively provide the reasons for withholding surgical-relevant analytics. (C&T Bill FOI Schedule 3 amendment.)

3. Surgery/NFP Annex.
- Advance peri-operative continuity protocol in NFP operations and risk statements, such as PPE stock and conservation protocols, oxygen supply, ICU surge and step-downs, prioritization for urgent/cancer surgery, and public–private contracting triggers for prioritization. (C&T Bill transfer of NFP and NNDL.)

4. Safe reporting and deidentification advice.
- Establishing a protected channel to escalate peri-operative risk; aligning with "good faith" principles and evidential burden noted in cl 71 (CDC Bill p.64).

5. Transitional provisions remain protected (12 months).
- Require (by regulation or ministerial statement) that no transitional instrument will affect the publication of aggregate surgical metrics and/or delay time-sensitive surgeries, unless a published and de-identified analysis demonstrates a net public health benefit from a transitional provision. (C&T Bill transitional items and examples for transfer instruments/operations).

Counter-Arguments to RACS Summary of Proposal

There are possible objections to these suggestions. The FOI carve-out is important as a required update to protect both privacy and commercial-in-confidence information. RACS agrees, but the carve-out should be narrowly defined and importantly accompanied by rule-based duty to publish all de-identified

modelling and impact assessments that materially impact surgical services. The CDC Bill itself frames limitations as “reasonable and proportionate,” (pp.11-13). However, proportionality means that all reasoning should be visible (though stripped of personal or commercial identifiers). Another argument may suggest that the publication of modelling might confuse the public. Conversely, providing good plain-English summaries, method notes, and other accessible forms of modelling will be enhancing informed discussion and performance. During COVID-19, the absence of visibility around the trade-offs and backlog(s) led to erosion of trust and delayed harm from surgery (AIHW; 2024). One final argument is that directional powers are sufficient, while dashboards are operational detail.
Experience has shown that without explicitly required outputs that data doesn’t flow or is simply not repackaged into actionable peri-operative intelligence.

Final Thoughts

The manifested and expected advantages of RACS’ requests can help in many ways. It will create adequate evidence-rich interventions. Like real-time peri-operative dashboards will allow calibration of public-health interventions to maintain time-critical surgery (especially cancer) wherever safe. By doing so we address the mortality risk from delay as noted by previous research) (Hanna et al., *BMJ*, 2020, pp.2-6 of the PDF). Future recovery of backlog should occur faster with more transparent publications of constraints and recovery plans, allowing sustained surge strategies conducted by the COVIDSurg Collaborative to be published (*Br J Surg*, 2020, pp. 1442–1445 of the PDF). System learning for anaesthesia safety like a CDC ANZCA data architecture and sentinel event loop will ensure the system can learn to improve safety for patients and decrease peri-operative morbidity/mortality over time. And finally, but most importantly, gaining public trust. As assumptions and models are de-identified and published the community and profession can see and debate the basis for hard decisions.

Yours sincerely,

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Key sections: Reductions in activity during restrictions; longer waiting times https://www.aihw.gov.au/hospitals/topics/elective-surgery/covid

Australian and New Zealand College of Anaesthetists (ANZCA). (2024). *Safety of Anaesthesia in Australia and New Zealand 2018-2020: A review of anaesthesia-related mortality reporting.* Melbourne: ANZCA.

Key sections: Data gaps; pandemic impacts; rationale for national peri-operative dataset and learning system (pp.14, 29).

COVIDSurg Collaborative. (2020). *Elective surgery cancellations due to the COVID-19 pandemic: global predictive modelling to inform surgical recovery plans.* **British Journal of Surgery**, 107(11), 1440–1449.

Key finding: **~28.4 million** elective operations cancelled globally in 12 weeks; recovery needs sustained **surge capacity** (pp. 1442–1445).

Hanna, T.P., King, W.D., Thibodeau, S., et al. (2020). *Mortality due to cancer treatment delay: systematic review and meta-analysis.* **BMJ**, 371:m4087.

Key finding: Each **4-week delay** increases **mortality** across several cancers and modalities (see abstract/results, pp. 2–6 in PDF).