

HEART DISEASE SCREENING

The June 1990 issue of the *Public Health Bulletin* drew attention to the recent publication by the NSW Department of Health of the monograph, *Public Screening for Risk of Heart Disease: Guidelines and Procedures for Use by Area and Regional Health Services in NSW* (principal author: Karen Webb)¹.

The guidelines are part of the department's response to the review of heart-disease prevention projects in NSW. The review identified that, with the increasing involvement of public-health agencies in risk factor screening, there was a need to standardise screening measurement and intervention procedures.

Guidelines for Statewide application help to ensure the public receives consistent and accurate advice and appropriate intervention, and that heart-disease risk-factor monitoring is accurate and consistent, both within NSW and nationally.

The guidelines are based on information from several sources. These include relevant policies from the USA, the UK and Australia, expert opinion, contemporary scientific knowledge of sound public screening procedures and associated services, and field workers' perceptions of opportunities and constraints which influence the operation of screening programs.

Important recommendations include case-finding in clinical settings and screening for multiple (rather than single) risk factors. In the case-finding approach, diagnosis and monitoring of treatment requirements and behavioural change can occur in a clinical setting. One of the prime reasons for suggesting the case-finding approach is that 75-80 per cent of the population visit general practitioners at least once a year; access could be obtained to a much larger number of people through general practitioners and occupational health services than would be possible through public screening.

Modifiable risk factors recommended for assessment include elevated serum cholesterol, elevated blood pressure, smoking, excess total dietary fat, saturated fat and cholesterol, obesity, and low levels of physical activity.

Information on the following non-modifiable risk factors should also be obtained: age, sex, occupation and education, ethnicity/Aboriginality, and a personal or family history of premature heart disease and/or diabetes mellitus. This information can be used to identify higher-risk groups, plan tailored interventions and motivate behaviour modification.

The guidelines emphasise that screening should be designed and conducted primarily as a strategy aimed at detecting people with elevated risk, not as a whole-population strategy (aimed at lowering the risk of the whole population). Screening should lead individuals identified as being at high risk of heart disease to reduce their modifiable risk-factor levels.

To this end, the guidelines provide information and recommended procedures on the following essential components of risk-factor screening programs:

- Recruitment strategies to ensure or improve utilisation of programs by the high-risk population.
- Risk-factor measurement and assessment methods and feedback procedures.
- The intervention components of screening — content and process guidelines.
- Procedures for referral to appropriate community and medical services for further assistance with risk reduction.
- Follow-up risk assessment to identify changes, encourage maintenance of positive change, and supply further intervention and referral for those who have not made positive changes.
- Monitoring of the utilisation of a screening program and change in risk status of high-risk participants.

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1. Webb K, Leeder S, Tupling H, Calvert D, Brown I, Carter B, Adams D. *Public Screening for Risk of Heart Disease. Guidelines and Procedures for Use by Area and Regional Health Services in NSW*. NSW Department of Health, Sydney, 1990. State Health Publication No HP89/096.

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We should see the lung cancer rates in women continue to rise, a trend not likely to be altered dramatically in the short term by the moderate decline in smoking among women since 1983.

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EDITORIAL COMMENT

These three examples highlight how information contained in the mortality report can be used to: 1) focus attention on leading age-sex-specific causes of death, 2) take note of causes of death where there have been static or increasing trends, and 3) focus research and public health action.

The NSW Department of Health has made study of SIDS one of its public health priorities. Accordingly, a Statewide SIDS surveillance system is being established.

1. *Health For All Australians*. Report of the Health Targets and Implementation Committee. AGPS, Canberra, 1988.

2. O'Connell DL, Lam P, Gibberd RW. Mortality in New South Wales 1979-1983. A study of spatial variation in cause-specific mortality. Faculties of Medicine and Mathematics, University of Newcastle and Hunter Health Statistics Unit, 1987.

3. Pierce JP, Macaskill P, Hill D. Long term effectiveness of mass medialed anti-smoking campaigns in Australia. *Am J Pub Health* 1990, 80, 565-569.

4. Department of Health, NSW Quit For Life. 1990 Community and Workplace Resource Manual.