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SENTINEL GENERAL PRACTICES

The NSW Public Health Bulletin has recently highlighted the usefulness of sentinel general practices for monitoring non-notifiable infectious diseases such as influenza[1]. Another recent review article shows general practice surveillance need not be confined to infectious diseases, but can cover other conditions such as asthma and injuries and other risk factors like hypertension and smoking[2].

Sentinel general practices have operated in the UK[3], other parts of Europe[4,5] and parts of the US[6] for several years. They have also been running successfully in South Australia[7] and more recently Queensland[8].

The National Health and Medical Research Council recommended at its 97th session in 1986 "that each State and Territory health authority be encouraged to produce sentinel morbidity survey similar to the survey in South Australia"[9].

Although there have been attempts to establish general practitioner sentinel networks in NSW since 1975[10], long-term general practice surveillance has generally been unsuccessful in this State, partly because of a lack of the necessary administrative support. The network of new Public Health Units (PHUs) could be the catalyst in helping set up the schemes throughout NSW.

A network of six sentinel general practices covering five disease entities (Table 1) was established in the Illawarra in June 1990, and has been producing regular reports (Figure 1). Between 500 and 600 patients are seen in participating practices each week. The general practitioners (GPs) also receive regular feedback of the results, and found these sufficiently useful to have asked that the network be expanded to 12 practices (a surveillance base of 1000 to 1300 patients weekly) from October 1990.

The number of conditions under surveillance is likely to be increased to a (maximum) of 12 over a one- to two-year period.

Experience from the Illawarra may be of use to other PHUs in setting up similar networks.

SUCCESSFUL IMPLEMENTATION

Successful implementation depends on an understanding of the strengths and limitations of sentinel general practice surveillance. It is not intended to provide complete prevalence data or a comprehensive data set.

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Sentinel General Practices

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TABLE 1

DISEASE AND CLINICAL DEFINITIONS		DISEASE RECORDING
Number	**Disease**	**Clinical Criteria**
01	Influenza	Fever, chills, headache, myalgia, coryza, sore throat, cough and prostration (six out of eight required); nasopharyngeal aspirate for index cases only (send patient to Path. OPD, Wollongong Hospital).
02	Measles	Fever, coryza, cough, florid rash beginning on the face, conjunctivitis, Koplick's spots. May be modified in vaccinated people.
03	Lower RTI	Fever, new or changed cough, production of new or changed sputum (no pathology initially).
04	Asthma	Recurrent wheeze, cough, dyspnoea (existing and new cases where symptoms/treatment is primary reason for consultation).
05	Infectious Mononucleosis	Fever, sore throat, often exudative pharyngitis or tonsillitis and/or lymphadenopathy; morabilliform rash; splenomegaly or persistence of exudative pharyngitis (for more than 3/7 in spite of antibiotic therapy); FBC (lymphycytosis more than 50 per cent with more than 10 per cent atypical cells); ± positive Monospot.
06	Free Comment	Space is provided for your free comments. This may be an interesting case which you think is worthy of reporting to us if there is a cluster/epidemic occurring.

But it does show changes in incidence (in terms of general practice attendance), allow the GP to make more confident diagnoses, and facilitate an early response to changing incidence or distribution of particular diseases.

Important initial steps are:

- Enlist the support of local GPs. (The sub faculty of the RACGP, or postgraduate education group is an obvious route.)
- Emphasise the value to them of active participation (such as early feedback on changing disease patterns, greater certainty in diagnosis and prescribing and reduced need for confirmatory laboratory tests).
- Form a management committee with majority representation from local GPs.
- Allow the management committee to select participating practices. A good geographic and sociodemographic spread is essential — there should be a minimum of 1 per cent of possible general practices in the area, but more is desirable.
- Allow the management committee to select initial list of diseases and conditions. Keep it short — no more than four or five. There should be one or two relatively common conditions (to maintain interest). Others should reflect local priorities and interests.
- Allow a space on the form for free comment. This will provide early warning of increased incidence of other diseases, such as infantile gastroenteritis, or anything unusual.
- Ensure regular feedback to the GPs.
- Develop an outer circle of interested practices to allow interchange of participating practices over time.
- Have regular meetings of the management committee to fine-tune the network.

CONCLUSIONS

Most people continue to regard the GP as their main source of primary health care and advice[11].

Links formed between PHUs and GPs in setting up a successful sentinel general practice network will be valuable in securing their co-operation in other public health initiatives such as improved immunisation and notification rates.

The Illawarra sentinel general practice network now consists of 12 practices and 14 GPs — about 10 of whom are active at any one time. The network has already proved its value several times:

- It was able to ascertain rapidly the extent of spread of a measles outbreak at Woonona.
- It was able to reassure authorities that a patient with Legionella was an isolated case, and that there was no major upsurge in lower respiratory tract infection at the time.
- It also revealed that despite reports in the media of a 'late flu epidemic' there had been no rise in influenza cases monitored by the network.

There is a proposal for a national network of sentinel general practices — Australian Sentinel Practice Research Network (ASPERN)[12]. The research committee of the NSW Faculty of the Royal Australian College of General Practitioners has been contacted about NSW participation.

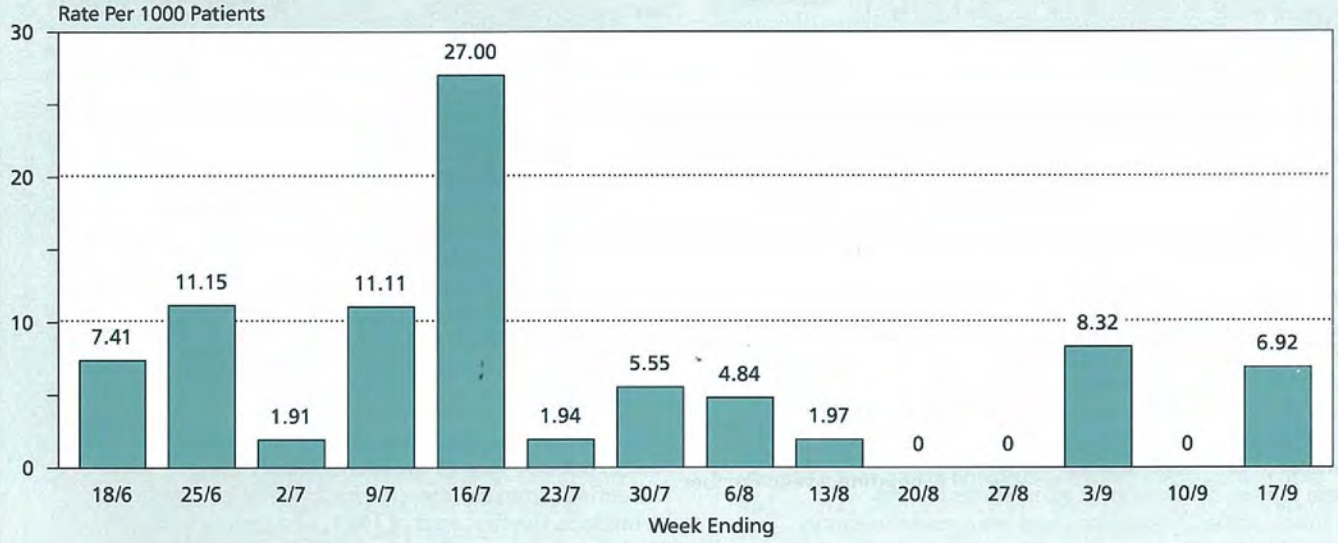
With infrastructure and support provided by the PHUs, a NSW network of sentinel general practices would not only provide additional useful public health data for this State, but would complement the proposed national network. Most unit directors appear to favour such a network. Dr Michael Levy from the Epidemiology Branch will co-ordinate efforts to implement this approach in 1991.

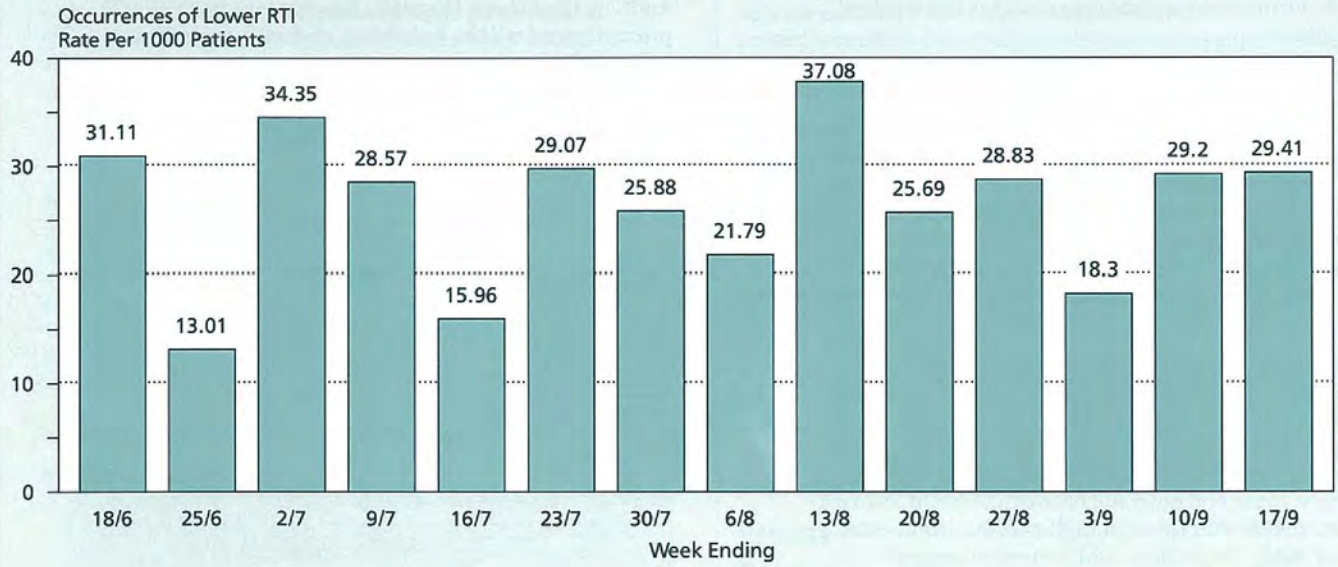
Dr David Jeffs
Director — Illawarra Public Health Unit
Dr Rod McMahon
Chairman — Illawarra Institute of General Practitioners

1. Manning W, Levy M, Sentinel Monitoring of Influenza NSW Public Health Bulletin 1990; 1: (7-9) 22.
2. Dunstone M, Macharper T, Cameron S, White C, Surveillance and Sentinel Systems, *Aust Fam Phys* 1990; 19: (8) 1267-1277.
3. Donaldson R, Donaldson L, Essential Community Medicine, Lancaster 1983; p34.
4. Stroobant A et al, Epidemiological Surveillance of Measles through a Network of Sentinel General Practices in Belgium, *Int J Epidemiol* 1986; 15: (3) 386-391.
5. Valleran A-J et al, A Complete Network of the Surveillance of Communicable Diseases: The French Experiment, *AJPH* 1986; 76: (11) 1289-1292.
6. Green LA, Wood M, Becker L et al, The Ambulatory Sentinel Practice Network: Purpose, Methods and Policies, *J Fam Pract* 1984; 18: (2) 275-280.
7. Dunstone M, Cameron S, Sentinel General Practices — South Australia, South Australian Health Commission 1989; SBNO: 7308-0200-0.
8. Pincus D, Sentinel Practices in Queensland — The First 12 Months, *Aust Fam Phys* 1988; 17: (8) 700-704.
9. National Health and Medical Research Council, Canberra 1983.
10. Fisher S, Swan N, Rozalla M, Morbidity Monitoring in General Practice, *Med J Aust* 1975; 1: 207-213.
11. Australian Bureau of Statistics, Australian Health Survey 1983, Sydney ABS 1986; (Catalogue No 4311.0).
12. Steven ID, Sentinel Network is a Quality Assurance Option, *Aust Fam Phys* 1990; 19: (11) 1625.

FIGURE 1

SAMPLE WEEKLY RETURNS FROM ILLAWARRA SENTINEL GENERAL PRACTICES





STUDY OF HEPATITIS B IN SCHOOLCHILDREN

Horizontal (non-sexual, perinatal or parenteral) transmission of hepatitis B infection may sometimes occur in schools even in countries with low endemicity but where there are small numbers of carriers among the students. Horizontal transmission is documented in households where one person is a carrier but the degree of infectivity of individual carriers, even those who are HBe Ag-positive, may vary widely.

Horizontal transmission of hepatitis B infection has been reported among schoolchildren in New Zealand. But there is little evidence of horizontal transmission between high- and low-carrier rate groups in Australia so routine vaccination of infants in the general population is not advocated. The Australian studies have involved a mixed-race community in Brewarrina, NSW[1], and schoolchildren in the Kimberley region of Western Australia[2]. A third study, soon to be published, was carried out in rural NSW[3] and the National Health and Medical Research Council is supporting a Darwin survey, the results of which have not yet been made public. No attempt had been made to survey schoolchildren in the major urban population centres to help formulate vaccination policy for the whole of Australia.

Children of any race who acquire hepatitis B infection very early (at less than five years of age) probably have a higher risk of becoming chronic carriers of the virus and of developing serious long-term sequelae. Review of data from highly endemic areas has emphasised the importance of documentation of the levels of horizontal transmission among young children[4]. The mode of transmission in these circumstances has not been clarified but is suggested to be by saliva or blood from skin abrasions.

Early in 1990 it was decided to study horizontal transmission of hepatitis B in Sydney schoolchildren. The best study design would have been one in which a cohort of low-risk children was followed from birth through pre-school and primary school, comparing infection rates and outcome between those in low-risk environments and those in high-risk environments. Such a study would have had to involve several thousand children and would have been time-consuming and costly.

A reasonable starting plan for a survey of horizontal transmission was therefore a cross-sectional serological study sampling children in the last year of primary school (aged about 12 years). These children have had a long period of school and in some cases pre-school to be exposed to horizontal risks. A plan was developed to sample a group of 750 low-risk children (children of ethnic groups with a carriage rate of less than 5 per cent) in 'low-risk' schools (schools with fewer than 5 per cent children from ethnic groups with more than 10 per cent carriage rate); and, 750 from 'high-risk' schools (more than 20 per cent of children from ethnic groups with more than 10 per cent carriage rate). A similar number of high-risk children (children of ethnic groups with a carriage rate of more than 10 per cent) would be sampled from the same 'high-risk' schools. The Director General of School Education gave permission for the studies.

The Sydney survey began in August 1990, at the beginning of the third school term. A group of schools has been chosen for the control arm of the study, mainly from the northern metropolitan area. All children taking part are volunteers whose parents have given written informed consent. Nurses and doctors from The Children's Hospital, Camperdown, collect venous blood from the children during school hours. There has been excellent co-operation from the schools and a good participation rate from the children. Some demographic data are being collected as well as information about the schools' lifestyles (such as types of games). The sera are being tested for hepatitis B markers and parents will be given their child's results, which will be confidential. Counselling will be available for the families of chronic carriers. Schools will not be given individual results but will be informed of the overall results of the survey.

Collection of sera from the control group has been completed this year in the fourth school term. Collections from children in the 'high-risk' schools will be made in the first part of 1991. The project is jointly funded and supported by the NSW Health Department and The Children's Hospital. Results will be available promptly and will be helpful in evaluating whether universal hepatitis B vaccination is needed.

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1. Campbell DH, Sargent JW, Plant AJ, The prevalence of markers of infection with hepatitis B virus in a mixed-race Australian community, *Med J Aust* 1989; 150: 489-492.

2. Gill JS, Bucens M, Hatton M, Carey M, Quadros CF, Markers of hepatitis B virus infection in schoolchildren in the Kimberley, Western Australia, *Med J Aust* 1990; 153: 34-37.

3. Campbell DH, Plant AJ, Sargent JW, Mock PA, Barrett ER, Archer KH, Hepatitis B infection of children in a mixed race community in western New South Wales, *Med J Aust* 1990; in press.

4. Davis LG, Weber DJ, Lemon SM, Horizontal transmission of hepatitis B virus. *Lancet* 1989; 1: 889-893.

FACT SHEETS FOR NSW

With this issue of the Public Health Bulletin readers will find the first of a series of NSW Health Indicator Fact Sheets being produced by the Epidemiology and Health Services Evaluation Branch.

Fact Sheets will provide information on priority health goals in a format which is easy to use and understand. Fact Sheet No 90/1 is about the main cause of death in NSW — ischaemic heart disease — and includes time trends, age and sex differences and comparisons between health areas and regions.

Send your comments on the Fact Sheets to Judy Jones, Health Department Epidemiology Branch, Locked Bag, PO Box 961, North Sydney, 2059. The facsimile number is: (02) 391 9232.

HIV TESTING IN METHADONE PATIENTS

Intravenous drug users (IVDUs) with human immunodeficiency virus (HIV) infection are an important potential source of HIV infection through needle sharing and/or sexual contact. There is however a lack of data about HIV prevalence and incidence data for IVDUs in NSW.

The Epidemiology and Health Services Evaluation Branch, with the NSW Methadone Program, recently explored the feasibility of improving data on the HIV status of IVDUs by collecting patient HIV testing data from methadone prescribers in NSW.

The NSW Methadone Program is managed by the Directorate of the Drug Offensive (DODO) in conjunction with the Pharmaceutical Services Section of the NSW Health Department, Area Health Services and Health Regions. The Health Department is responsible for granting approval to doctors to prescribe methadone. Each prescriber's approval is reviewed every six months.

Patients receive treatment at public clinics, from approved private medical practitioners or in the prison methadone program. There are similar numbers of public and private patients in the program. Treatment is available in the Sydney metropolitan area, at several regional clinics and from prescribers at rural centres. The patients represent a sizeable (more than 4000 patients[1]) and accessible group of intravenous drug users and former users. While they are not necessarily representative of IVDUs in general, they may comprise up to one-third of the estimated 12,000 IVDUs in NSW[2].

HIV-RELATED POLICIES

The program has documented policies on HIV testing among patients. These include: counselling, confirmatory testing of those with a positive HIV test and, when patients are being assessed for entry to the program, HIV-related risk assessment and HIV screening when requested by the patient[3]. There is no policy on regular follow-up screening.

EXISTING DATA ON HIV STATUS

Entry and exit forms

Prescribers are required to submit to the Health Department a detailed entry assessment form and a termination form for each patient. They also update selected patient details, such as dosage, every six months for renewal of authority to prescribe methadone. These data are collated by the Department. Neither the termination form nor the six-monthly prescription update includes information on HIV status.

Although the entry form has a three-part question on HIV testing and status, the data it yields are inadequate for surveillance purposes. About half the prescribers do not complete the questions (completion of all items is not enforced) and the information is based on patient self-report so its reliability is uncertain. A 'Review of Methadone Treatment' form which is also due every six months includes questions on HIV status but compliance by doctors in completing this form is poor.

HIV testing practices

There is a variety of screening practices, which range from arranging HIV tests at the methadone clinic for virtually all patients to always referring patients elsewhere (such as clinics specialising in AIDS/HIV) for HIV-test-related action. Neither the Health Department nor DODO has collected systematic data on individual prescribers' or clinics' HIV screening practices.

STUDY OBJECTIVES

Our chief objective was to develop and trial a new procedure for directly obtaining accurate, timely HIV surveillance data from methadone prescribers. The main data of interest were:

- HIV sero-conversion prevalence rates among methadone patients; and,
- HIV sero-conversion incidence rates among methadone patients.

The data would also provide:

- Baseline data on HIV testing status (when and where previously tested) for new patients;
- Information on HIV testing practices of methadone prescribers; and,
- Opportunities to explore relationships between HIV status and selected patient characteristics[4].

METHODS

Ten private prescribers and three public clinics agreed to complete four items of information on patients who had had an HIV test. Prescribers were selected for this study because they were likely to be interested and/or co-operative. Participation was voluntary and of those approached, only one refused to take part. Some prescribers offered to take part without being approached. We discussed the study with the individual prescribers to confirm their co-operation and commitment.

We supplied specially designed data collection forms on which the prescribers recorded, for each patient who had an HIV test, the month and year of the most recent test, where the test took place, the result and whether the result was verified by the prescriber or based solely on the patient's self-report. Patients were identified only by their unique identifying number[5]. Names and addresses were not included. We requested information on the following patients:

- Those on the program at September 30, 1989;
- Those who entered the program in October, November or December 1989; and,
- Those who had an HIV test in October, November or December 1989.

RESULTS

Prescriber response

Of the 13 prescribers who agreed to participate, 10 supplied the information. These 10 prescribers were treating around one-quarter of the patients in the program. Their patients were similar to other patients on the program in terms of sex, age, marital status and duration of narcotic use and dependence.

Most prescribers had to be followed up, some many times, before any forms were returned. The main reasons given for slow completion of forms were a lack of time (especially for those without secretarial support) and having to identify patients by number rather than by name.

HIV testing practices

The private prescribers in this study had incorporated routine HIV testing into their entry procedures and were about to begin or had already started regular re-testing for patients in treatment. In the public clinic, procedures ranged from almost complete testing at the clinic to complete referral. Private patients, therefore,

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were much more likely to have been tested and those who were tested during September-November 1989 were usually tested around the same time either by the prescriber or at a clinic with which that prescriber was associated.

Data quality

Data on HIV testing collected directly from prescribers may be more accurate, complete and/or reliable than that available on the treatment assessment form. Prescribers verified the HIV test results of most (91 per cent) of their patients. For the 70 per cent of patients whose most recent test was in September 1989 or later, this was usually because the prescribers had arranged the test.

As with the total population of methadone patients, HIV-related information for patients in this study was usually missing from their entry assessment forms (for example, HIV testing status had not been recorded for 64 per cent of the patients).

HIV test results

The prescribers indicated that 467 (35 per cent) of their patients had had an HIV test. Of these, 9 (2 per cent) were HIV-positive. All positive results were verified by the prescriber. This low HIV-positive rate is consistent with four recent studies of IVDU in western Sydney, in each of which fewer than 1 per cent of patients were found to be HIV-positive[6,7].

Most patients (95 per cent) had been tested in 1989. Almost half (49 per cent) were tested between October and December 1989, usually by their methadone prescriber. Patients whose most recent HIV test was before October 1989 were similar to those who had not been tested in age, sex, marital status, employment status, partner's drug use, duration of drug use, duration of drug dependence and time spent in methadone programs. Those with children were more likely to have had an HIV test.

CONCLUSIONS

1. Prevalence and incidence data on HIV testing and status of patients in the Methadone Program can be obtained directly from methadone prescribers.
2. Considerable follow-up was needed to obtain voluntarily supplied data from this group of co-operative prescribers. If a system of compulsory supply of HIV testing data were to be introduced, the important issue of how to enforce this would need to be addressed. For example, prescribers tend to comply with the six-monthly prescription update because Departmental authority for them to continue to prescribe methadone is contingent upon it, whereas they leave many sections of the treatment assessment form unanswered because no such consequence applies.
3. The volume and quality of the data available from each prescriber will be related to the HIV testing practices of that prescriber. Those who do not directly arrange testing for their patients have difficulty supplying accurate, verified data, even of the most basic kind (date, place, result of HIV test), since the confidentiality of HIV test results is protected by legislation. Accurate, updated information on individual prescribers' HIV testing practices is needed.
4. The Methadone Program's policy on HIV testing allows prescribers the full range from no testing or referrals whatsoever to the equivalent of comprehensive regular screening. The policy needs clarification.
5. Where prescribers have access to HIV testing information about their clients (for example, because they arrange regular HIV testing), the data supplied are likely to be more timely, accurate and complete than has been available from entry assessment forms.
6. The accuracy and comprehensiveness of data collected would be improved if prescribers were encouraged to arrange HIV testing, for example by making resources available to assist them with testing, counselling and/or data transcription.
7. HIV surveillance data obtained from prescribers can be successfully linked with patient characteristics on the Methadone Stats Unit database via the patients' unique identifying numbers.
8. Introduction of uniform and reliable HIV antibody screening procedures in the Methadone Program would assist efforts to gain a clearer picture of the prevalence and incidence of HIV in the patient population.

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The assistance of the Directorate of the Drug Offensive, in particular Stuart Riley of the NSW Methadone Program, and of the participating prescribers and clinics is gratefully acknowledged.

EDITORIAL NOTE

Following on from this study, a panel of NSW AIDS and drug researchers, clinicians and administrators was formed to draft strategies to improve the monitoring of HIV infection in IVDUs.

1. Forker, P, *NSW Methadone Program Statistical Report for the Third Quarter.* Sydney: Directorate of the Drug Offensive, NSW Department of Health, July 1989. By November, 1990 there were 5250 patients in the program.

2. Sandland, R, *Estimation of the Number of Heroin Users in NSW using Police Arrest Data: Development of a Statistical Model.* Sydney: NSW Drug and Alcohol Authority, April 1986.

3. Directorate of the Drug Offensive, *Policies and Procedures for the Methadone Treatment of Opioid Dependence in NSW.* Sydney: NSW Department of Health (undated).

4. The Methadone Stats Unit (Directorate of the Drug Offensive) supplied a de-identified database of patients in the methadone program (current to October 1989) which was derived from completed treatment admission forms.

5. The Department of Health assigns a unique identifying number to each patient who starts on the methadone program. Patients retain this number through different entries, exits and prescribers.

6. Bell, J, Fernandes, D & Batey, R, Heroin users seeking methadone treatment. *The Medical Journal of Australia, 152* (April 2), 1990.

7. Dwyer, D et al, Low prevalence of human immunodeficiency virus infection in Methadone Program attenders and pregnant intravenous drug users in the western metropolitan region of Sydney. *Australian and New Zealand Journal of Medicine, 19*, 1989.

NSW HEALTH INDICATORS
Health Areas and Regions

NSW HEALTH DEPARTMENT

Fact Sheet No. 90/1
ISSN 1036 0530

This Fact Sheet is part of a series produced by the Epidemiology and Health Services Evaluation Branch and the Information Centre of the NSW Health Department to provide information about important health indicators in the State. Data on deaths are derived from the official mortality statistics for NSW based on deaths reported to the Registry of Births, Deaths and Marriages. Data on hospital admissions are based on the Hospital Inpatient Statistics Data Collection supplied to the Department by all hospitals in NSW. Disease classifications are from the International Classification of Diseases, 9th Revision.

HEART DISEASE 1990

1 - DEATHS DUE TO ISCHAEMIC HEART DISEASE

Heart disease is the leading cause of death in NSW. In 1988, 27 per cent of all deaths were due to ischaemic heart disease. The main risk factors for heart disease have been well-documented — elevated blood cholesterol levels, smoking, elevated blood pressure, overweight and lack of exercise. These have been targeted for both primary and secondary prevention.

- The ICD-9 codes 410-414 cover ischaemic heart disease (IHD), comprising acute myocardial infarction, other acute and sub-acute forms of heart disease, old myocardial infarction, angina pectoris and other forms of chronic ischaemic heart disease. Ischaemic heart disease results from the build-up of fatty and scar-like deposits (atherosclerosis) which cause narrowing of the coronary arteries.
- The main cause of death due to ischaemic heart disease is acute myocardial infarction (AMI). (In myocardial infarction, there is permanent damage to the heart muscle.) Studies carried out by the U. of Newcastle (Dobson et al, *Am J of Epid*, 1988, 128) have shown that although definite AMIs are usually coded into their appropriate IDC-9 category (410), probable AMIs may be coded in any of the five categories. For this reason, deaths in all five categories have been included.
- The IHD mortality rate in Australia has reduced considerably in the past 15 years, but it is still higher than more than half of industrialised countries studied by the WHO in 1988. In NSW, the declining death rate due to heart disease which began in the 1960s has continued into the 1980s. Between 1978 and 1988, the mortality rate fell by almost 15 per cent. Overall, the decline has been greater for males so that the differential between males and females has decreased over time.
- The greatest percentage decrease in deaths between 1984 and 1988 has been in the younger age groups. This may be related to a number of factors, such as lifestyle changes, earlier detection and more effective treatment resulting in prolonged life. For older females, there was very little decrease in the death rate between 1984 and 1988.

DEATHS IN NSW 1978-1988†
ISCHAEMIC HEART DISEASE

YEAR	NUMBER	RATE*
1978	12,480	247.1
1979	11,455	224.5
1980	11,523	223.1
1981	11,731	224.1
1982	12,084	227.8
1983	11,769	219.9
1984	11,559	213.9
1985	11,991	219.4
1986	11,649	210.6
1987	11,936	212.9
1988#	11,996	210.4

† ICD-9 Codes 410-414
** Crude death rate per 100,000 population*
 # Provisional figures only

- In four health areas (Central Sydney, Hunter, South-West Sydney and Western Sydney) the standardised mortality ratio (SMR) for males was significantly higher than would have been predicted on State figures. In the latter two of these, the female SMR was also significantly elevated.

DEATH RATE† IN NEW SOUTH WALES, 1984-1988, BY AGE AND SEX
ISCHAEMIC HEART DISEASE

Age Group	Sex	1984	1985	1986	1987	1988*	% Decr.
25-44	M	22.8	18.9	19.2	13.9	19.5	14.5
	F	5.1	4.2	4.0	3.6	3.0	41.2
45-64	M	345.2	323.9	298.9	297.6	290.4	15.8
	F	104.7	110.7	108.7	88.6	84.7	19.1
65+	M	1931.7	1990.5	1821.8	1855.2	1769.9	8.4
	F	1308.4	1349.3	1302.8	1306.1	1297.0	0.9

† Death rate per 100,000 population
** Provisional figures only*
Note: The large percentage decrease for females aged 25-44 years should be interpreted with caution because of the small numbers

OBSERVED (O) AND EXPECTED (E)* DEATHS DUE TO ISCHAEMIC HEART DISEASE HEALTH AREAS & REGIONS, 1984-1988, BY AGE AND SEX

Area/ Region	Age:	25-44		45-64		65†		Total		Standardised Mortality Ratio*†	
	Sex:	M	F	M	F	M	F	M	F	M	F
Sth. Sydney	O	56	11	738	225	2132	2342	2927	2579	89.0 ↓	94.4 ↓
	E	73	15	867	280	2346	2436	3288	2731		
E. Sydney	O	56	12	650	176	1764	1890	2470	2078	99.6	99.5
	E	56	10	586	179	1837	1901	2480	2090		
Cen. Sydney	O	36	9	526	145	1546	1813	2109	1967	107.3 ↑	105.8
	E	45	8	489	141	1430	1707	1965	1859		
S-W Sydney	O	96	24	859	304	1634	1621	2589	1950	110.5 ↑	119.5 ↑
	E	83	17	790	247	1468	1368	2343	1632		
W. Sydney	O	126	15	862	293	1788	2013	2776	2321	113.2 ↑	122.4 ↑
	E	87	19	790	238	1575	1639	2452	1896		
Wentworth	O	37	7	297	76	686	677	1020	760	105.8	107.2
	E	39	7	259	81	665	620	964	709		
Nth. Sydney	O	61	11	832	238	3131	3672	4026	3922	86.4 ↓	87.1 ↓
	E	109	23	1147	376	3405	4100	4661	4501		
Cen. Coast	O	17	7	335	120	1316	982	1668	1109	98.2	93.6
	E	26	5	320	116	1351	1064	1698	1185		
Hunter	O	79	18	822	275	2195	1994	3097	2287	107.6 ↑	103.0
	E	66	12	733	234	2080	1972	2879	2219		
Cen. Western	O	29	7	259	79	782	673	1071	759	105.7	100.5
	E	23	4	248	76	744	674	1013	755		
Sth. Eastern	O	27	7	289	101	851	714	1167	822	103.5	103.8
	E	26	5	294	89	810	698	1128	792		
Illawarra	O	53	11	526	164	1198	1051	1779	1226	103.5	107.7
	E	40	8	488	149	1192	979	1719	1138		
North Coast	O	37	7	529	163	1728	1244	2294	1414	94.4	85.6 ↓
	E	43	8	534	175	1853	1467	2429	1652		
New England	O	44	6	418	130	1130	961	1593	1097	104.9	102.2
	E	33	7	376	118	1109	950	1519	1074		
Orana/FW	O	29	5	249	76	631	509	910	590	109.6	102.0
	E	20	3	216	62	592	512	830	579		
Sth. West	O	20	6	314	108	968	857	1302	971	91.1	93.3
	E	34	7	366	111	1028	923	1429	1041		
NSW Total		803	163	8505	2673	23480	23013	32798	25852	100.0	100.0

• Expected number of deaths for age group and sex based on State death rate
** Standardised mortality ratio, that is, Observed deaths divided by Expected deaths X 100*
† Whether there were significantly more deaths (↑) or fewer deaths (↓) than for the State

Information about prevention of heart disease is available from the Health Promotion Unit of the NSW Health Department and the National Heart Foundation.

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State Health Publication No. (EP) 90-95

INFECTIOUS DISEASES

MORE UP-TO-DATE INFORMATION

This month we report data up to November 30, 1990. The information includes notifications processed up to December 1. In future issues we will include provisional data for the month preceding the Bulletin issue — the January 1991 edition will contain notification data for December 1990. In 1991 we will aim to reduce substantially transmission times from the doctor/laboratory to PHU and PHU to Epidemiology Branch in an effort to make the data in the Bulletin as up-to-date as possible.

HIV AND AIDS

HIV data are included for the first time in routine reporting of infectious diseases.

The NSW Health Department reports that 9263 people have been infected with the human immunodeficiency virus (HIV) in NSW. This figure is based on information from the three State laboratories that perform confirmatory testing for HIV infection. The laboratories are at St Vincents, Westmead and Prince of Wales hospitals.

The data are incomplete. St Vincents Hospital, which reported 82 per cent of the positive tests in NSW up to June 1989, has provided data only to September 1989 (6905 cases), and Westmead Hospital has provided data through to August 31, 1990 (1940 cases). The data from Prince of Wales are to November 30, 1990 (418 cases). Based on available data it is estimated the overall figures for NSW would be about 9800 cases at November 30, 1990. This is consistent with projections made by the National Centre for Epidemiology and Population Health at the Australian National University.

Information on the transmission category of these 9263 people infected with HIV will be published in the NSW Public Health Bulletin in January 1991.

By November 14, 1468 cases of AIDS had been reported in NSW. Of these, 906 people have died.

Mechanisms are being put in place to ensure that by February 1991 complete NSW data on AIDS and HIV will be published monthly in the NSW Public Health Bulletin. These data will also subsequently be provided to the National Centre for HIV Epidemiology and Clinical Research, the agency responsible for national AIDS/HIV reporting.

NOTIFICATION DELAY

The response of the Public Health Unit to an infectious disease notification depends on timely notification by doctors. Figure 2 indicates the extent of delays in reporting notifications. Only 2 per cent of notifications are received within two days of the onset of the disease, and only 10.2 per cent are received within one week of onset. Fifty per cent of notifications are received within 16 days of onset. These data indicate the need for faster methods of case reporting to PHUs. We suggest that medical practitioners and laboratory staff be encouraged to telephone notifications where feasible. We look forward to seeing your creative solutions to this problem.

Key features of the conditions notified (as occurring in October) are as follows:

Continued on page 59 ►

TABLE 2

INFECTIOUS DISEASE NOTIFICATIONS, NSW
Notifications to the end of November 1990

CONDITION	Number of Cases Notified					
	Period			Cumulative		
	October 1989	October 1990	Nov. 1990*	October 1989	October 1990	Nov. 1990*
AIDS	30	32	–	256	295	295
Amoebiasis	1	–	–	7	9	9
Ancylostomiasis	–	–	–	–	–	–
Anthrax	–	–	–	–	–	–
Arboviral infection (NOS)	1	–	–	1	1	1
Brucellosis	–	–	–	–	5	–
Campylobacter infection	81	154	60	1434	1500	1560
Chancroid	–	–	–	–	–	–
Chlamydia infection (NOS)	8	21	1	35	361	362
Cholera	–	–	–	–	1	1
Congenital rubella syndrome	–	–	–	–	–	–
Diphtheria	–	–	–	–	–	–
Donovanosis	–	–	–	–	–	–
Encephalitis (NOS)	–	–	–	1	1	1
Food poisoning (NOS)	–	1	1	7	22	23
Genital herpes	34	75	1	565	857	858
Giardiasis	25	25	3	562	508	511
Gonococcal ophthalmia neo.	–	–	–	1	–	–
Gonorrhoea	27	20	9	490	338	347
Hepatitis A	3	2	–	56	24	24
Hepatitis B	47	29	1	392	370	371
Hepatitis C	N/A	8	–	N/A	24	24
Hepatitis unspecified	5	–	–	17	3	3
HIV	N/A	N/A	N/A	N/A	N/A	**9263
Hydatid disease	–	–	–	1	2	2
Infantile diarrhoea (NOS)	69	10	4	409	119	123
Legionnaires' disease	1	–	–	48	23	23
Leprosy	1	–	–	10	5	5
Leptospirosis	4	3	2	47	39	41
Lymphogranuloma venereum	–	–	–	–	–	–
Malaria	5	7	–	69	142	142
Measles	21	21	14	42	102	116
Meningococcal infection	2	7	2	46	86	88
Non specific urethritis	101	90	1	1388	1265	1266
Ornithosis	–	–	–	4	–	–
Pertussis	37	1	–	114	125	125
Plague	–	–	–	–	–	–
Poliomyelitis	–	–	–	–	–	–
Q fever	10	7	–	91	124	124
Rabies	–	–	–	–	–	–
Ross River fever	5	2	–	383	246	246
Rubella	3	1	–	3	4	4
Salmonella infection	32	68	39	954	1179	1218
Shigella infection	5	6	–	62	114	114
Syphilis	27	18	12	267	289	301
Tetanus	–	–	1	–	–	1
Trachoma	–	–	–	–	1	1
Tuberculosis	41	20	5	351	406	411
Typhoid & paratyphoid	3	3	1	21	32	33
Typhus	–	–	–	–	–	–
Vibrio infection (NOS)	–	–	13	14	9	22
Viral haemorrhagic fevers	–	–	–	–	–	–
Yellow fever	–	–	–	–	–	–
Yersinia infection	5	12	1	71	117	118

* Preliminary data only

** Cumulative data from St Vincents 1984-September 1989, Westmead 1984-August 1990, Prince of Wales 1984-November 1990

FIGURE 2

NOTIFICATION OF DISEASES
TIMELINESS

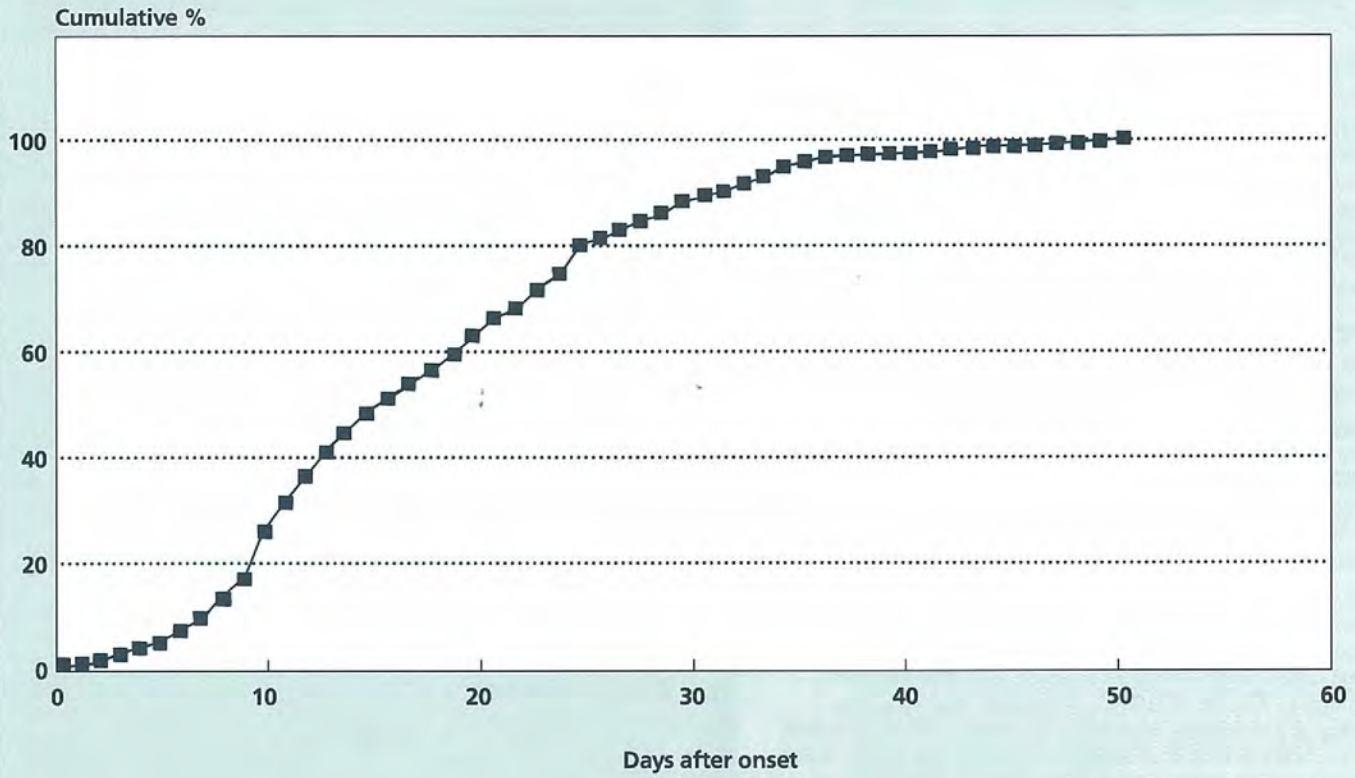

TABLE 3

INFECTIOUS DISEASE NOTIFICATIONS*
BY HEALTH AREA & REGION, NSW,
JANUARY 1 TO NOVEMBER 30, 1990

HEALTH AREA/REGION	DOCTOR NOTIFICATIONS	RATE** PER 100,000	LABORATORY NOTIFICATIONS	RATE** PER 100,000	TOTAL NOTIFICATIONS	RATE** PER 100,000
Central Sydney Area	284	85.2	115	34.5	399	119.7
Eastern Sydney Area	713	220.6	1833	567.1	2546	787.7
Southern Sydney Area	326	61.9	269	51.1	595	113.1
South Western Sydney Area	468	76.3	240	39.2	708	115.5
Western Sydney Area	265	45.0	251	42.6	516	87.6
Wentworth Area	170	63.7	295	110.5	465	174.1
Northern Sydney Area	347	47.8	260	35.8	607	83.6
Central Coast Area	102	47.2	30	13.9	132	61.1
Illawarra Region	204	68.7	76	25.6	280	94.3
Hunter Region	271	56.9	83	17.4	354	74.3
North Coast Region	290	85.0	682	199.8	972	284.8
New England Region	192	78.0	379	154.1	571	232.1
Orana & Far West	181	130.1	86	61.8	267	191.9
Central West Region	64	38.9	71	43.1	135	82.0
South West Region	49	19.5	59	23.5	108	43.1
South East Region	36	18.9	39	20.5	75	39.4
Unknown	33	0.6	60	1.1	93	1.6
Total†	**3995**	**70.1**	**4828**	**84.7**	**8823**	**154.8**

† Notifications on interstate and overseas residents visiting NSW accounted for an additional 100 cases
* Excludes HIV
** Rate per 100,000 population

Notification Delay

► *Continued from page 57*

- Pertussis notifications continue to be lower than the comparable period in 1989.
- Measles notifications do not reflect the current situation of medium to large outbreaks throughout at least nine of the 16 Health Areas/Regions. We encourage PHU staff to elicit formal notifications from medical practitioners.
- Tuberculosis notifications for the year are 13 per cent higher than for the comparable period of 1989 — only 6.7 per cent of notifications originated from the country Regions. The NSW Health Department recently reviewed State tuberculosis services. A report on this will be published in a future issue of the Bulletin.
- Meningococcal infections continue to be notified and are 85 per cent higher than 1989 notification rates. New England Region reports a rate of 6.8 cases per 100,000 population a year. Further discussion of this will appear in the January Bulletin.
- Ross River notifications are low and reflect expected seasonal trends. Arbovirus surveillance through chickens and mosquito trapping will continue in 1991. No activity has been detected in the sentinel chicken flocks.
- AIDS figures appearing in previous Public Health Bulletins have been revised upwards following active surveillance by Epidemiology and Health Services Evaluation Branch, Public Health Medicine Registrars and AIDS co-ordinators. This effort revealed 122 previously unreported cases of AIDS, and of these 117 people remain alive. Finding these extra cases will enhance the NSW AIDS services budget by more than $3.5 million.

INFLUENZA SURVEILLANCE

For the period June 4 to October 28, 1990, the proportions of all general practitioner (GP) consultations for both influenza-like illness and the International Classification of Health Problems in Primary Care, 2nd edition [ICHPPC-2] defined influenza are shown in Figure 3. The proportions are expressed as the number of cases per 100 consultations.

During the study period the Epidemiology Branch received information from 55,663 GP consultations. The proportion of GP consultations relating to influenza-like illness was 3.4 per cent, while the proportion fulfilling ICHPPC-2 criteria was 1.8 per cent.

Of the people presenting with influenza-like illness who had been immunised this year against influenza, 54 per cent were below the NHMRC recommended age of 65 years.

The project was established so any influenza outbreak could be monitored. The study showed that 1990 was not an epidemic year in NSW for influenza. This was in contrast to the predictions, based on the 1989/1990 experience of the northern hemisphere.

The influenza surveillance project provided Epidemiology Branch with experience in sentinel surveillance. Further co-operative projects with the Royal Australian College of General Practitioners are planned for 1991.

Infectious Diseases Section
Epidemiology and Health Services Evaluation Branch
NSW Health Department.

FIGURE 3

RATE OF INFLUENZA-LIKE ILLNESS
June 4 to October 28, 1990

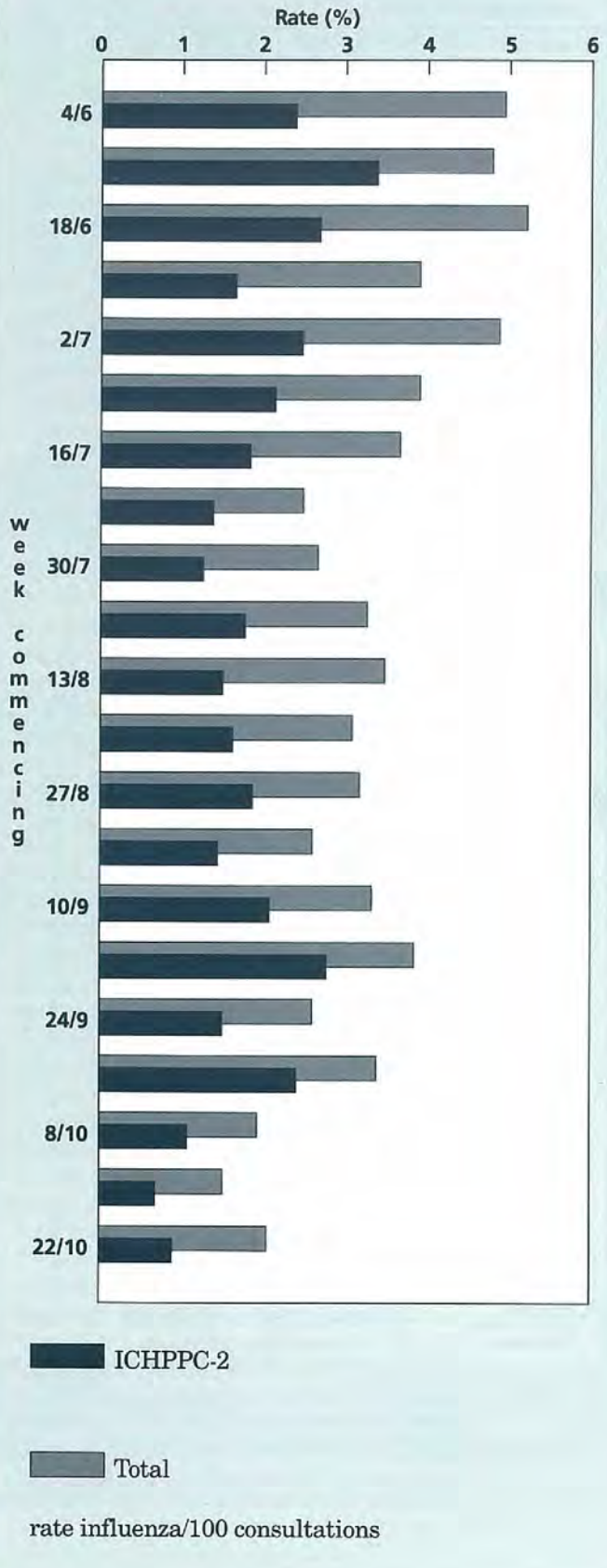

TABLE 4

INFECTIOUS DISEASE NOTIFICATIONS, BY HEALTH AREA & REGION, NSW, FOR MONTH OF OCTOBER 1990

CONDITION	CSA	ESA	SSA	SWS	WSA	WEN	NSA	CCA	ILL	HUN	NCR	NER	OFR	CWR	SWR	SER	IS	U/K	TOTAL
AIDS	6	13	–	2	2	–	6	–	1	–	2	–	–	–	–	–	1	1	32
Campylobacter inf.	6	–	37	8	20	29	12	2	7	4	6	10	1	6	1	1	4	–	154
Chlamydia inf.	–	11	–	–	–	–	–	–	–	–	6	3	–	–	–	–	–	1	21
Food poisoning (NOS)	–	–	–	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	1
Genital herpes	1	60	–	2	–	–	–	–	–	–	8	2	–	2	–	–	–	–	75
Giardiasis	–	–	4	–	1	–	–	2	–	–	17	–	–	–	–	–	1	–	25
Gonorrhoea	–	12	1	1	1	1	–	–	1	–	1	2	–	–	–	–	–	–	20
Hepatitis A	–	–	–	–	–	–	–	–	–	–	–	1	–	–	1	–	–	–	2
Hepatitis B	1	5	–	2	1	1	9	–	1	–	2	3	2	–	1	1	–	–	29
Hepatitis C	–	–	–	–	2	–	6	–	–	–	–	–	–	–	–	–	–	–	8
Infantile diarr. (NOS)	–	–	–	–	–	–	–	–	3	–	7	–	–	–	–	–	–	–	10
Leptospirosis	–	–	–	–	–	–	–	–	–	–	–	–	–	1	–	–	1	1	3
Malaria	–	–	–	–	1	–	3	–	2	–	–	–	–	–	1	–	–	–	7
Measles	–	–	1	–	–	–	2	–	1	–	12	2	–	–	–	3	–	–	21
Meningococcal inf.	1	–	1	–	–	–	–	–	–	4	1	–	–	–	–	–	–	–	7
Nonspecific urethritis	–	77	–	13	–	–	–	–	–	–	–	–	–	–	–	–	–	–	90
Pertussis	–	–	–	–	–	1	–	–	–	–	–	–	–	–	–	–	–	–	1
Q Fever	–	–	–	–	–	–	–	–	–	–	1	6	–	–	–	–	–	–	7
Ross River virus	–	–	–	1	–	–	–	–	–	–	1	–	–	–	–	–	–	–	2
Rubella	–	–	–	–	–	–	–	–	–	–	–	1	–	–	–	–	–	–	1
Salmonella inf.	2	5	8	7	8	8	14	2	1	1	6	2	1	1	1	1	–	–	68
Shigella inf.	–	1	–	–	2	1	–	–	–	–	2	–	–	–	–	–	–	–	6
Syphilis	2	7	2	2	–	–	2	–	–	–	1	–	2	–	–	–	–	–	18
Tuberculosis	2	1	3	2	2	–	4	–	–	4	1	–	–	–	–	1	–	–	20
Typhoid & paratyphoid	–	–	–	–	–	–	–	–	–	2	–	–	–	–	–	1	–	–	3
Yersinia inf.	4	1	–	1	2	–	2	–	–	–	–	1	–	–	–	1	–	–	12

TABLE 5

INFECTIOUS DISEASE NOTIFICATIONS, BY HEALTH AREA & REGION, NSW, 1 January, 1990 to October 31, 1990

CONDITION	CSA	ESA	SSA	SWS	WSA	WEN	NSA	CCA	ILL	HUN	NCR	NER	OFR	CWR	SWR	SER	IS	OS	U/K	TOTAL
AIDS	58	117	18	7	12	7	40	2	5	9	6	3	–	1	2	1	1	–	6	295
Aeromonas Hydroph.	–	–	–	–	–	–	–	–	–	–	–	2	–	–	–	–	–	–	–	2
Amoebiasis	–	2	–	1	–	1	–	–	–	2	3	–	–	–	–	–	–	–	–	9
Arboviral inf. (NOS)	–	–	–	–	–	–	–	–	–	–	1	–	–	–	–	–	–	–	–	1
Brucellosis	–	–	–	–	–	–	–	–	–	–	3	2	–	–	–	–	–	–	–	5
Campylobacter inf.	89	71	267	138	164	211	153	31	22	33	96	127	16	20	6	8	33	2	13	1500
Chlamydia inf.	1	197	2	5	3	–	1	–	25	10	60	45	3	–	2	1	–	–	6	361
Cholera	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1
Encephalitis (NOS)	–	–	–	–	–	–	–	–	–	–	–	–	–	1	–	–	–	–	–	1
Food Poisoning (NOS)	1	–	–	–	6	1	3	–	–	–	–	–	–	1	10	–	–	–	–	22
Genital herpes	2	626	–	16	8	20	3	3	15	21	77	45	8	7	1	–	3	–	2	857
Giardiasis	14	19	51	18	25	26	35	28	–	27	208	30	7	7	–	2	2	–	9	508
Gonorrhoea	11	199	6	16	10	4	1	4	2	11	28	21	16	4	1	1	–	–	3	338
Hepatitis A	1	2	–	–	4	3	5	–	–	1	1	3	–	–	3	1	–	–	–	24
Hepatitis B	8	90	8	64	18	7	22	6	6	4	34	33	56	3	5	4	2	–	–	370
Hepatitis C	2	–	–	–	4	–	13	1	–	–	2	2	–	–	–	–	–	–	–	24
Hepatitis Unspecified	–	–	–	–	–	–	–	–	–	1	–	1	–	1	–	–	–	–	–	3
Hydatid disease	–	–	–	–	–	–	–	–	–	–	1	–	–	1	–	–	–	–	–	2
Infantile diarr. (NOS)	–	–	–	5	4	16	–	–	15	1	67	9	2	–	–	–	–	–	–	119
Influenza Type A	–	–	–	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1
Legionnaires' dis.	–	1	4	3	2	–	4	–	1	3	1	–	–	1	–	1	2	–	–	23
Leprosy	1	1	–	2	–	–	1	–	–	–	–	–	–	–	–	–	–	–	–	5
Leptospirosis	–	1	1	–	3	–	–	–	4	3	6	5	–	2	4	3	3	–	4	39
Malaria	9	18	3	5	11	3	41	3	6	7	4	4	1	4	7	1	1	1	13	142
Measles	–	–	18	3	3	1	3	2	1	6	52	6	–	–	1	5	–	–	1	102
Meningococcal inf.	5	1	10	8	12	4	3	1	–	9	12	14	4	2	–	–	–	–	1	86
Mumps	–	–	–	–	–	–	–	–	–	–	–	1	–	–	–	–	–	–	–	1
Nonspecific urethritis	1	910	2	143	3	1	2	1	85	82	14	8	4	–	1	2	1	–	5	1265
Pertussis	15	2	8	12	8	20	9	10	–	4	10	18	4	3	–	1	1	–	–	125
Q Fever	–	3	–	–	4	–	1	1	2	1	27	30	7	39	4	1	2	–	2	124
Ross River virus	1	4	1	1	–	1	2	1	5	26	96	46	14	7	23	–	12	1	5	246
Rubella	–	–	–	–	–	–	–	–	–	–	2	2	–	–	–	–	–	–	–	4
Salmonella inf.	75	61	100	143	128	93	162	28	51	49	88	66	35	18	28	24	18	–	12	1179
Shigella inf.	4	16	3	8	5	3	13	2	3	4	20	11	8	5	1	–	6	1	1	114
Syphilis	16	109	14	26	1	–	5	–	6	9	14	11	73	–	2	–	–	–	3	289
Trachoma	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	–	–	–	1
Tuberculosis	57	71	56	46	51	9	45	5	12	21	3	10	3	3	5	3	2	–	4	406
Typhoid & paratyphoid	1	6	1	1	2	2	3	1	3	3	6	–	–	–	–	1	1	–	1	32
Vibrio Parahaemolyticus	–	–	2	1	–	1	–	–	–	2	–	–	–	–	–	–	–	–	–	6
Vibrio SPP	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	–	–	–	1
Vibrio Vulnificus	–	–	–	–	1	–	–	–	–	–	–	–	–	1	–	–	–	–	–	2
Yersinia inf.	22	8	11	13	8	4	21	1	1	1	16	5	2	–	–	1	2	–	1	117

Abbreviations used in this Bulletin:
CSA Central Sydney Health Area, ESA Eastern Sydney Health Area, SSA Southern Sydney Health Area, SWS South Western Sydney Health Area, WSA Western Sydney Health Area, WEN Wentworth Health Area, NSA Northern Sydney Health Area, CCA Central Coast Health Area, ILL Illawarra Health Area, HUN Hunter Health Area, NCR North Coast Health Region, NER New England Health Region, OFR Orana & Far West Health Region, CWR Central West Health Region, SWR South West Health Region, SER South East Health Region, IS Interstate, U/K Unknown, OS Overseas, NOS Not Otherwise Stated

Please note that the data contained in this Bulletin are provisional and subject to change because of late reports or changes in case classification. Data are tabulated where possible by area of residence and by the disease onset date and not simply the date of notification or receipt of such notification.

NEWS AND COMMENT

Public Health Unit Meeting

A meeting of Public Health Unit staff was held on November 30 at Rozelle Hospital. The following key points emerged:

Environmental Health Group

The group made several recommendations: that more communication occur between PHUs — directly and through the Bulletin; that all PHUs have a directory of information resources based on the health surveyors policy manual, 24-hour access to computerised databases, and protocols for dealing with health hazards posed by environmental toxins; and that training in environmental health be reviewed.

The group at its next meeting will discuss linkages between organisations concerned with environmental health, prepare a list of environmental health issues, and develop a plan for developing an environmental health strategy.

It was suggested that existing plans for dealing with environmental health hazards and lists of members of relevant committees be made available to PHUs.

That the Fire Brigade has information on the storage of chemicals suggested that the Environmental Health network could improve its links with organisations dealing with environmental pollution.

Infectious Diseases Group Report

The group endorsed the new list of notifiable diseases proposed by the NSW Infectious Disease Advisory Committee and the use of CDC case definitions and made recommendations about information flow from laboratories to PHUs, information content of notification forms, and frequency of meetings.

A general practitioners survey will be conducted in seven PHUs to test notification forms.

The computerised infectious diseases data system is now available. PHUs should start entering data on the system by January 1, 1991.

Country Public Health Unit Meeting Report

The meeting looked at practical issues, aiming to identify differences and commonalities. Issues discussed included a fish kill strategy, pesticides in the cotton industry, overseas travel and linking public health medicine training with PHUs.

Changes to the role of environmental health officer were fully supported and the development of links with food inspectors encouraged.

The cost of travel — in money and time — discouraged quarterly PHU meetings, so annual meetings should be considered. One person should represent all regions on each special interest group.

Travel Health Advice

Travel health advice consumes substantial PHU resources. David Jeffs and others agreed to advance options for handling this load to the infectious diseases group.

Health Promotion

The health promotion budget has doubled since 1986 to more than $18 million. Sixty per cent of this is distributed to Areas/Regions. In the past two years national and State policies have been developed, with priorities given to nutrition, older people, injuries, cancers, and cardiovascular disease.

Michael Ward indicated that the Department has been instructed to develop specific health goals. PHU and health promotion staff can collaborate to set realistic goals and to develop action and evaluation plans.

Gazettal of Medical Officers of Health (MOHs)

The list of MOHs for each Area/Region will be gazetted shortly.

The Legionella Committee Report

Tony Burns outlined the functions of the committee and the recommendations of the report.

AIDS Notifications

A recent search for unreported cases of AIDS netted 122 new notifications. These notifications attract $3.5 million of Commonwealth funding for AIDS services.

To improve AIDS surveillance, each Area/Region was asked to provide an HIV/AIDS surveillance contact person, who should liaise with Tim Sladden of the Epidemiology Branch and regularly contact specialist AIDS treatment centres, base hospitals, sexual health services and other doctors who treat people with AIDS.

There was debate about the AIDS notification mechanism. A handout to assist in AIDS surveillance has been produced, including notification forms, a summary of AIDS notification procedure and CDC definitions.

Health Indicator Fact Sheets

Health Indicator Fact Sheets will be produced from available morbidity and mortality figures. The monthly sheets will aim to be brief and useful to planners, evaluators and program staff. The first appears with this Bulletin issue.

Immunisation

The Health and Education Departments should co-ordinate efforts to improve information on and immunisation levels of schoolchildren. This collaboration will be the one area of focus of the Health Department review of immunisation to be completed by May 1991.

Sentinel Practice in the Illawarra

David Jeffs presented an overview of the Illawarra GP Sentinel Surveillance System (see article on Page 51). When concern was raised about Legionnaires' disease in the Illawarra, the sentinel network was useful in assessing general practice attendances for respiratory tract infections and unusual symptoms. Other PHUs should consider the value of establishing small sentinel surveillance networks.

NEWS AND COMMENT

THE ILLAWARRA LEAD STUDY

Blood lead levels were monitored among 170 children in Illawarra primary schools. The study, which was expensive and difficult to perform, involved concerned companies.

PUBLIC HEALTH BULLETIN

The Public Health Bulletin has been delayed by technical and editorial problems. From January, the target will be for Bulletins to appear every second week of the month. It is important to have a rapid turnaround and for State data to be published locally, before publication in the national forum.

The Bulletin offers an important mode of communication between PHUs. It could include reports of meetings, program successes and failures, debates on issues and ideas.

If production problems continued, a plainer format could be considered. But with the appointment of a new sub editor, timely production is expected.

PUBLIC HEALTH TRAINING

There are six Public Health Medicine Registrars, with four more and two Health Services Management Registrars joining the scheme in 1991. Approval has been given to the selection of three non-medical public health trainees.

A group has been formed to develop a plan for future public health training in NSW.

Public health educational sessions should be timed to allow access to staff outside central administration. Short courses in aspects of public health should be developed.

TUBERCULOSIS

The Department has approved the reorganisation of tuberculosis services into the public health system. Margaret Thomas has moved into the Epidemiology Branch. CEOs will be asked to integrate tuberculosis sisters into the PHUs.

The Department is developing a plan to eradicate tuberculosis. South Australia has set as a target the year 2017. A tuberculosis advisory committee has been formed, consisting of the Deputy Chief Health Officer, representatives from the Thoracic Society, Chest Association and two PHUs.

ASTHMA

In the hours after a thunderstorm on November 1 a large number of people attended Tamworth Casualty with asthma. By the end of the week, 96 cases had been to casualty. Attendances in nearby towns were more than 10 times the rate in other areas.

Stephen Corbett outlined the results of an investigation of the outbreak of asthma in Tamworth. While outbreaks have been investigated elsewhere, this appears to be the first thorough study of a non-point source outbreak.

HIV INJURY SURVEILLANCE

The Department plans to introduce surveillance of health care workers exposed to HIV-infected blood and body fluids. The real risk, number of people exposed and outcomes are unknown in NSW. Surveillance will be hospital-based and linked with zidovudine prophylaxis protocols.

PHUs will be asked to distribute forms and information to all hospitals. Follow-up initially will be arranged centrally. A hospital infection control seminar is planned for next year.

FUTURE MEETINGS

Directors of PHUs will meet in the morning to discuss administrative issues and other interested parties will join in the afternoon for broader discussion. Meetings should be timed to coincide with short courses or special interest group meetings. The next meeting is scheduled for March 7 at the Rozelle Conference Centre. Agenda items should be sent to George Rubin.

IN TOUCH ARTICLE DECEMBER ISSUE

The Public Health Association of Australasia requested an article on the Public Health Units for its December issue. Watch out for it!

Health in New South Wales: Current Indicators is now available. To obtain a copy please call Ashley Curtis on (02) 391 9223 or write to the editor.