

Attachment A: Workshop program

Issues and priorities in the surveillance and monitoring of chronic diseases in Australia

Saville Park Suites
84 Northbourne Avenue, Canberra

Hosted by the Australian Institute of Health and Welfare and the
Commonwealth Department of Health and Ageing

8–9 November, 2001

Day 1: Thursday, 8 November 2001

Time	Event
9:00 am	Registration
9:30 am	Plenary 1 <i>Surveillance and monitoring of chronic diseases and associated risk factors</i> Chair: Robert Griew, Commonwealth Department of Health and Ageing
	Welcome and opening remarks <i>Richard Madden, Director, Australian Institute of Health and Welfare and Co-Chair, National Public Health Working Group</i>
	Surveillance across the continuum of care <i>Richard Smallwood, Chair, National Health Priorities Action Council</i>
	Chronic diseases and associated risk factors in Australia: an overview <i>Kuldeep Bhatia, Australian Institute of Health and Welfare</i>
	Strategic issues and options for chronic disease surveillance in Australia <i>Vivien Lin, School of Public Health, La Trobe University</i>
	Questions and discussion
10:40 am	Morning tea

Day 1: Thursday, 8 November 2001 (continued)

Time	Event									
11:00 am	<p>Plenary 2 <i>Surveillance and monitoring of chronic diseases: State/Territory perspectives</i> Chair: Judy Straton, Commonwealth Department of Health and Ageing</p> <hr/> <p>Chronic disease surveillance and monitoring in South Australia <i>Anne Taylor, Department of Human Services, South Australia</i></p> <p>Applications of surveillance: a practical perspective from the Victorian Department of Human Services <i>Mike Ackland, Department of Human Services, Victoria</i></p> <p>Information base for the surveillance of chronic diseases in New South Wales <i>Margo Eyeson-Annan, New South Wales Health</i></p> <p>Questions and discussion</p>									
12:00 pm	Short break									
12:10 pm	<p>Plenary 3 <i>Surveillance and monitoring of chronic diseases: other perspectives</i> Chair: Paul Magnus, Australian Institute of Health and Welfare</p> <hr/> <p>Chronic diseases: a Commonwealth perspective <i>Colin Sindall, Commonwealth Department of Health and Ageing</i></p> <p>Chronic disease surveillance and monitoring: the non-government organisations' perspective <i>Andrew Tonkin, National Vascular Disease Prevention Partnership</i></p> <p>Perspectives of the users and producers of chronic disease data <i>Hal Swerissen, School of Public Health, La Trobe University</i></p> <p>Questions and discussion</p>									
1:10 pm	Lunch									
2:10 pm	<p>Workshops (concurrent) <i>Effective surveillance and monitoring of chronic diseases</i></p> <hr/> <table border="0"> <thead> <tr> <th>Workshop 1:</th> <th>Workshop 2:</th> <th>Workshop 3:</th> </tr> </thead> <tbody> <tr> <td>An information framework for surveillance and monitoring of chronic diseases</td> <td>Regional and local area issues versus national monitoring</td> <td>Linking chronic diseases surveillance and monitoring to public health interventions and policy development</td> </tr> <tr> <td>Facilitator: Geoff Sims AIHW</td> <td>Facilitator: Kuldeep Bhatia AIHW</td> <td>Facilitator: Mike Ackland DHS, Victoria</td> </tr> </tbody> </table>	Workshop 1:	Workshop 2:	Workshop 3:	An information framework for surveillance and monitoring of chronic diseases	Regional and local area issues versus national monitoring	Linking chronic diseases surveillance and monitoring to public health interventions and policy development	Facilitator: Geoff Sims AIHW	Facilitator: Kuldeep Bhatia AIHW	Facilitator: Mike Ackland DHS, Victoria
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Facilitator: Geoff Sims AIHW	Facilitator: Kuldeep Bhatia AIHW	Facilitator: Mike Ackland DHS, Victoria								
3:30 pm	Afternoon tea									
4:00 pm	<p>Report back from workshop facilitators Chair: Merran Smith, Co-Chair, National Public Health Information Working Group</p>									

5:00 pm	Close
7:00 pm	Workshop dinner The Republic, 20 Allara Street, Canberra Guest speaker: Tony McMichael, National Centre for Epidemiology and Population Health, Australian National University

Day 2: Friday, 9 November 2001

Time	Event			
8:45 am	Plenary 4 <i>Measurement issues in the surveillance and monitoring of chronic diseases</i> Chair: Paul Jelfs, Australian Institute of Health and Welfare			
	The WHO STEPS approach <i>Terry Dwyer, Menzies Centre for Population Health Research, Hobart</i>			
	Australian Health Measurement Survey <i>Jeanette Pope, Population Health Information Development Unit, University of Adelaide</i>			
	The National Health Survey <i>Marelle Rawson, Australian Bureau of Statistics</i>			
	CATI surveys <i>Mark Cooper-Stanbury, Australian Institute of Health and Welfare</i>			
10:00 am	Morning tea			
10:15 am	Workshops (concurrent) <i>Data development issues and priorities</i>			
	<table border="0"> <tr> <td>Workshop 4: Biomedical risk factors and markers Facilitator: Stan Bennett AIHW</td> <td>Workshop 5: Behavioural risk factors and other psychosocial variables Facilitator: Margo Eyeson-Annan NSW Health</td> <td>Workshop 6: Utilisation and harmonisation of various types of data Facilitator: Alan Mackay ABS</td> </tr> </table>	Workshop 4: Biomedical risk factors and markers Facilitator: Stan Bennett AIHW	Workshop 5: Behavioural risk factors and other psychosocial variables Facilitator: Margo Eyeson-Annan NSW Health	Workshop 6: Utilisation and harmonisation of various types of data Facilitator: Alan Mackay ABS
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11:30 am	Report back from workshop facilitators and panel discussion: Where to from here? Chair: Cathy Mead, National Public Health Partnership Secretariat			
12:45 pm	Summation and close of the workshop Richard Madden, Director, Australian Institute of Health and Welfare and Co-Chair, National Public Health Information Working Group			
1:00 pm	Lunch			

Attachment B: List of participants

Dr Mike Ackland	Epidemiology Unit, Department of Human Services, Victoria
Dr Fadwa Al-Yaman	Children Youth and Families Unit, Australian Institute of Health and Welfare
Mr Jason Armfield	Dental Statistics Research Unit, University of Adelaide
Dr Tim Armstrong	Cardiovascular Disease and Diabetes Monitoring Unit, Australian Institute of Health and Welfare
Dr Katrine Baghurst	Health Science Nutrition, CSIRO, Adelaide
Dr Stan Bennett	Cardiovascular Disease and Diabetes Monitoring Unit, Australian Institute of Health and Welfare
Dr Kuldeep Bhatia	Health Monitoring and Development Unit, Australian Institute of Health and Welfare
Professor Helena Britt	Family Medicine Research Centre, University of Sydney
Dr Magnolia Cardona	Queensland Health
Ms Ingrid Coles-Rutishauser	Australian Food and Nutrition Monitoring Unit
Mr Mark Cooper-Stanbury	Population Health Data and Information Services Unit, Australian Institute of Health and Welfare
Ms Jean Douglass	Population Health Division, Commonwealth Department of Health and Ageing
Dr Terry Dwyer	Menzies Centre for Population Health Research, University of Tasmania
Dr Joy Eshpeter	Population Health Division, Commonwealth Department of Health and Ageing
Ms Margo Eyeson-Annan	Epidemiology and Surveillance Branch, NSW Health
Ms Susan Garner	Health Priorities and Quality Branch, Commonwealth Department of Health and Ageing
Dr John Glover	Public Health Information Development Unit, University of Adelaide
Mr Robert Griew	Head, Population Health Division, Commonwealth Department of Health and Ageing
Mr Steve Guthridge	Territory Health Services, Northern Territory
Mr John Harding	Health Registers and Cancer Monitoring Unit, Australian Institute of Health and Welfare
Dr Alison Heywood	AusAID
Professor Ian Hickie	Beyond Blue – The National Depression Initiative
Ms Rosie Hippel	Health Advancement Division, Department of Health and Human Services, Tasmania
Dr Paul Jelfs	Population Health Unit, Australian Institute of Health and Welfare

Dr Wilawan Kanjanapan	Population Health Division, Commonwealth Department of Health and Ageing
Dr Chris Kelman	Portfolio Strategies Division, Commonwealth Department of Health and Ageing
Dr Amanda Lee	SIGNAL (Strategic Inter-Governmental Nutrition Alliance)
Professor Vivian Lin	School of Public Health, La Trobe University
Mr Stephen McDonald	Australia and New Zealand Dialysis and Transplant Registry
Professor Tony McMichael	National Centre for Epidemiology and Population Health, Australian National University
Mr Alan Mackay	Australian Bureau of Statistics
Dr Richard Madden	Director, Australian Institute of Health and Welfare
Ms Ros Madden	Disability Services Unit, Australian Institute of Health and Welfare
Dr Paul Magnus	Medical Advisor, Australian Institute of Health and Welfare
Dr Guy Marks	Institute of Respiratory Medicine, Sydney
Dr Cathy Mead	National Public Health Partnership Group Secretariat
Dr Paul Meyer	Health Monitoring and Development Unit, Australian Institute of Health and Welfare
Dr Graeme Miller	Family Medicine Research Centre, University of Sydney
Ms Jeanette Pope	Public Health Information Development Unit, University of Adelaide
Ms Marelle Rawson	Health Section, Australian Bureau of Statistics
Ms Sally Rubenach	Clinical Outcomes and Epidemiology Centre, The Canberra Hospital
Ms Renata Rustowski	Commonwealth Department of Health and Ageing
Mr Geoff Sims	Health Division, Australian Institute of Health and Welfare
Mr Colin Sindall	Commonwealth Department of Health and Ageing
Professor Richard Smallwood	Chief Medical Officer, Department of Health and Ageing
Dr Merran Smith	Department of Health, Western Australia
Mr Andrew Stanley	Department of Human Services, South Australia
Dr Judy Straton	Commonwealth Department of Health and Ageing
Dr Hal Swerissen	Australian Institute for Primary Care, La Trobe University
Ms Nicola Tatham	Health Monitoring and Development Unit, Australian Institute of Health and Welfare
Dr Anne Taylor	Department of Human Services, South Australia
Ms Margaret Thomas	NSW Health
Professor Andrew Tonkin	National Heart Foundation of Australia
Dr Gavin Turrell	Queensland University of Technology
Ms Kim Walker	Mental Health Branch, Commonwealth Department of Health and Ageing

Ms Victoria White
Dr Xingyan Wen

National Tobacco Strategy, Anti-Cancer Council of Victoria
Disability Services Unit, Australian Institute of Health and Welfare

Attachment C: Background papers for small group workshops

Workshop 1: An information framework for surveillance and monitoring of chronic diseases

Facilitator: Geoff Sims, Australian Institute of Health and Welfare

Background

Presentations in Plenary 1 and the NHP Framework will provide background and form the basis for discussion at this workshop.

Rationale

Information frameworks provide structure and guidance for the development, implementation and utilisation of health information. They inform, enable consistency and comparability, and guide the interpretation and dissemination of information linked to public health programs and strategies.

The NHP Framework (Figure 1.1), was endorsed by the Australian Health Ministers Advisory Council (AHMAC) in August 2001. The NHP Framework has been proposed as the basis for surveillance and monitoring of chronic diseases and associated risk factors in Australia, although other frameworks have been developed and may also be appropriate.

An adaptation of the NHP Framework for surveillance and monitoring of chronic diseases and risk factors has been proposed (Figure 1.2). Two other dimensions of chronic diseases need to be considered in adapting the NHP Framework:

- chronic diseases across various stages of the lifecycle, and
- surveillance and monitoring at regional/local area levels.

Focus

Input on various components of the framework in the context of chronic diseases and associated risk factors surveillance and monitoring.

Focus questions

1. Does the NHP Framework broadly meet the requirements for nationwide monitoring of chronic diseases and associated risk factors?
2. Are there aspects of chronic disease information that are not covered by the Framework and should be introduced?
3. Are there components of the Framework which should receive additional emphasis for information development?
4. Figure 1.2 shows that the La Trobe Consortium has concentrated on the first two tiers of the NHP Framework (health status and outcomes; determinants of health). How appropriate has this been? What about the third tier (health system performance)?
5. What is the applicability of this Framework to strategies for prevention of chronic diseases and associated risk factors and provision of relevant services and care?

Figure 1.1: The NHP Framework

Health Status and Outcomes How healthy are Australians? Is it the same for everyone? Where is the most opportunity for improvement?				
Health Conditions	Human Function	Life Expectancy and Wellbeing		Deaths
Prevalence of disease, disorder, injury or trauma or other health-related states.	Alterations to body, structure or function (impairment), activities (activity limitation) and participation (restrictions in participation).	Broad measures of physical, mental, and social wellbeing of individuals and other derived indicators such as Disability Adjusted Life Expectancy (DALE).		Age and/or condition specific mortality rates.
Determinants of Health Are the factors determining health changing for the better? Is it the same for everyone? Where and for whom are they changing?				
Environmental Factors	Socioeconomic Factors	Community Capacity	Health Behaviours	Person-related Factors
Physical, chemical and biological factors such as air, water, food and soil quality resulting from chemical pollution and waste disposal.	Socioeconomic factors such as education, employment, per capita expenditure on health, and average weekly earnings.	Characteristics of communities and families such as population density, age distribution, health literacy, housing, community support services and transport	Attitudes, beliefs knowledge and behaviours, e.g. patterns of eating, physical activity, excess alcohol consumption and smoking.	Genetic related susceptibility to disease and other factors such as blood pressure, cholesterol levels and body weight.
Health System Performance How well is the health system performing in delivering quality health actions to improve the health of all Australians? Is it the same for everyone?				
Effective		Appropriate		Efficient
Care, intervention or action achieves desired outcome.		Care/intervention/action provided is relevant to the client's needs and based on established standards.		Achieving results with most cost effective use of resources.
Responsive		Accessible		Safe
Service provides respect for persons and is client orientated, and includes respect for dignity, confidentiality, participation in choices, promptness, quality of amenities, access to social support networks, and choice of provider.		Ability of people to obtain health care at the right place and right time irrespective of income, physical location and cultural background.		The avoidance of or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered.
Continuous		Capable		Sustainable
Ability to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time.		An individual's or service's capacity to provide a health service based on skills and knowledge.		System or organisation's capacity to provide infrastructure such as workforce, facilities and equipment, and be innovative and respond to emerging needs (research, monitoring).

Figure 1.2: The NHP Framework, as adapted by the La Trobe Consortium, for chronic disease monitoring

HEALTH STATUS AND OUTCOMES How healthy are Australians? Is it the same for everyone? Where is the most opportunity for improvement?				
Health Conditions	Biological Conditions	Human Function	Life Expectancy and Wellbeing	Deaths
Ischaemic heart disease, Stroke, Certain cancers† Mental health problems/ Depression*, Musculoskeletal disorders (falls)†, Oral health conditions* Type 2 Diabetes Mellitus Renal disease†, Chronic lung disease (COPD and asthma)	Obesity*, Underweight* Hypertension*, Dyslipidaemia* Impaired Glucose Tolerance*, Insulin resistance*, Elevated HbA1c*, Proteinuria* Urinary tract infections* Infections*	Disability days Reduction of function Activity limitation Restriction in participation Deteriorating strength, reflexes, balance & vision	Self-rated health	
DETERMINANTS OF HEALTH Are the factors determining health changing for the better?				
Early Life Factors	Health Behaviours	Community Capacity	Environmental Factors	Socioeconomic Factors
Low birth weight, Low breast feeding rate Intrauterine growth retardation, Poor early childhood development Abuse, neglect & exposure to domestic violence	Tobacco exposure: — smoking — passive Risky alcohol intake Physical inactivity Exercise (asthma) Diet supplements (musculoskeletal disorders) Food chemicals Analgesic use Substance use Medications Preventative dental behaviours	Characteristics of communities & families such as: Housing quality, Community services e.g. support, transport etc. Literacy level Health literacy	Natural environment — Exposure to allergens — Exposure to sunlight Products & technology — Exposure to pollution — Hazardous environs — Lack of exposure to fluorides	Education, Income, Economic capacity, Wealth, Poverty, Ownership of resources Housing, Area of residence, Occupation including employment status, relations & conditions Parents' occupation at time of birth Food security systems, e.g. taxation, social welfare policies
Person-related Factors		Psychosocial Factors Psychosocial stress (life stress) e.g. arising from interpersonal violence, discrimination, etc (cortisol) Support & relationships — Low social capital — Low social support Low resilience		
HEALTH SYSTEM PERFORMANCE How well is the health system performing in delivering quality health actions to improve the health of Australians?				
Effective	Appropriate		Efficient	
Responsive	Accessible		Safe	
	Accessibility to treatments for each of the health conditions above; Accessibility to prevention programs			
Continuous	Capable		Sustainable	
Contact with health system and disease management Contact with health system (inc primary care): Early Detection & Screening; Use of complementary medicine; Clinical management; Management of complications; and, Self management				

* also considered risk factors; † requires further specification; ξ health system performance factors are being considered here only as risk factors for chronic disease.

Workshop 2: Regional and local area issues versus national monitoring

Facilitator: Kuldeep Bhatia, Australian Institute of Health and Welfare

Background

Presentations in Plenary 2.

Rationale

Small area differences in health outcomes constitute an important indicator of both underlying heterogeneity in the distribution of risk factors and possible variations in their prevention and management. Surveillance and monitoring of chronic diseases and risk factors at a small area level is therefore likely to prove extremely useful for tailoring public health prevention strategies and provision of health services.

However, because of small population numbers and low event occurrence – the increasing number and sophistication of health-related data collection and analysis notwithstanding – the interpretation of much health statistics information at levels below State/Territory jurisdiction remains difficult. Synthetic approaches of demography and epidemiology can be used to generate estimates of small area mortality, morbidity and disability, and then applied for estimating attributable fractions for various risk factors. However, these procedures often mean probabilistic assumptions that may make the results redundant or difficult to interpret.

The issue of suitable data collections at a small population level for chronic disease surveillance and monitoring therefore requires careful consideration, in particular because risk factor information (the centrepiece of chronic disease surveillance and monitoring) may at best be obtained indirectly.

Focus

Recommendations to progress information development for chronic diseases.

Focus questions

1. What are the specific data and information requirements for surveillance and monitoring of chronic diseases and associated risk factors at various levels?
2. What are the important issues at local, jurisdictional and nationwide levels?
3. What aspects of chronic diseases and risk factors should be monitored at the national level, and what should be monitored at state/territory or local area level?
4. How are data collections at various levels to be managed?

Workshop 3: Linking chronic diseases surveillance and monitoring to public health interventions and policy development

Facilitator: Mike Ackland, Department of Human Services, Victoria

Background

The presentation in Plenary 1 by Vivian Lin, 'Strategic issues and options for chronic disease surveillance in Australia'.

Rationale

The development and persistence of chronic diseases is often a lifelong process that requires a range of prevention strategies and management. Any public health intervention and policy development therefore must address all risk factors and disease points through the course of life. The surveillance and monitoring of chronic diseases and risk factors must also occur accordingly.

An important strategy in linking surveillance and monitoring with public health interventions and strategies is the identification of critical stages for intervention and suitable information to support and evaluate these interventions across the continuum of care. Another issue in this context is the regularity with which the information should be collected for input to policy development.

Focus

Recommendations as to the means for linking surveillance and monitoring information with public health interventions and policy development.

Focus questions

1. How can surveillance and monitoring of various stages of chronic disease development and management facilitate public health interventions and policies?
2. How can chronic disease information be used for program and process evaluation?
3. How can risk factor information be effectively linked to health outcomes?
4. How can routinely collected information be used for coordination of care?

Workshop 4: Biomedical risk factors and markers

Facilitator: Stan Bennett, Australian Institute of Health and Welfare

Background

Presentations in Plenary 4.

Rationale

A variety of biomedical risk factors have been identified as important pathological and pathophysiological steps in the development and manifestation of chronic diseases (see Tables 4.1 and 4.2). Given that they represent bodily disturbance, these factors can often be more closely and precisely linked to the point of disease and its various complications; but there is no one-to-one correspondence between most of the known biomedical risk factors and disease outcomes. Many of these are no more than mere biomarkers of the impending problem.

Due to this lack of correspondence and the high costs associated with collecting laboratory-based information at a population level, biomedical information on chronic diseases is scanty and many years out of date. There are virtually no reliable national data sets on a whole range of biomedical risk factors. The state of this aspect of health information is inadequate in comparison with developments and collections in other western countries.

Recent developments in molecular genetic and immunological sciences have opened up opportunities for generating information on a range of biomarkers that may be linked to many of the pathophysiological steps leading up to chronic diseases. An added advantage is that a large variety of biomedical risk factors and markers can be easily studied through a small blood sample. Another source of biomedical information that can be tapped into is data from pathology labs.

Ethical and operational issues associated with collecting biomedical information, and storage of blood samples for tests later as the technology develops, require careful attention. Privacy issues in relation to any genetics-based markers also need to be considered.

Focus

Input into the progression of biomedical risk factor data development for effective surveillance and monitoring of chronic diseases.

Focus questions

1. Which biomedical risk factors have the highest priority for inclusion in a surveillance and monitoring system for chronic diseases?
2. How often do we require biomedical risk factor data collection for effective chronic disease surveillance and monitoring?

Table 4.1: Biomedical risk factors and markers proposed in the Australian Health Measurement Survey (AHMS)

Measurement	Relevant chronic disease ¹
Physical measurement	
Blood pressure	CHD, stroke, diabetes complications, renal disease
Height	CHD, stroke, diabetes
Weight	CHD, stroke, diabetes, colorectal cancer, musculoskeletal diseases
Abdominal circumference	CHD, diabetes
Upper arm circumference	CHD
Blood measurement	
Total cholesterol	CHD, stroke, diabetes complications
HDL cholesterol	CHD, stroke, diabetes complications
LDL cholesterol	CHD, stroke, diabetes complications
Triglycerides	CHD, stroke, diabetes complications
C-reactive protein	Nutrition
Homocysteine	CHD, stroke (linked with atherosclerosis & clot formation)
Glucose	Diabetes (prevalence of glycemia)
Oral glucose tolerance test	Diabetes (diagnosis of)
Glycosylated haemoglobin (HbA1c)	Diabetes (indicator of glycemic control/diabetes, marker of diabetes risk)
Insulin	Diabetes (marker for insulin levels)
Creatinine	Diabetes, renal disease (indicates kidney function)
Red cell folate	CHD, stroke (marker of dietary folate inc. supplements)
Carotenoids	CHD, colorectal cancer (antioxidant status indicators— markers of fruit and vegetable intake)
Urine measurement	
Albumin/creatinine ratio	Diabetes, renal disease (indicates kidney function)
Saliva	
Cotinine	Lung cancer, chronic lung disease (marker of recent tobacco exposure, validates self-reported data)
Cortisol	Mental health (marker of psychosocial stress)
Possible blood measurement	
Apolipoprotein A1	CHD (major protein component of HDL)
Apolipoprotein B	CHD (major component of LDL)
Omega-3 fatty acids	CHD, diabetes, COPD

¹CHD, stroke, colorectal cancer, lung cancer, mental health (depression), musculoskeletal, oral health, Type 2 diabetes, renal disease, and chronic lung disease (COPD, asthma).

3. Are the current cut-offs for determining high or low levels of various biomedical risk factors appropriate for surveillance and monitoring of chronic diseases in Australia? For example, are the cut-off points for high blood pressure and high blood cholesterol appropriate to chronic disease monitoring?
4. Is it appropriate to utilise suitable biological markers in the absence of clear-cut risk factor information?

Table 4.2: Biomedical risk factors and markers used in AusDiab

Measurement	Relevant chronic disease
Physical measurement	
Blood pressure	CHD, stroke, diabetes complications, renal disease
Pulse rate	(Heart failure, PVD, arrhythmia)
Electrocardiogram	CHD, arrhythmia, cardiomyopathy
Height	CHD, stroke, diabetes
Weight	CHD, stroke, diabetes
Abdominal circumference	CHD, diabetes
Hip circumference	CHD
Body fat	CHD
Blood measurement	
Total cholesterol	CHD, stroke, diabetes complications
LDL cholesterol	CHD, stroke, diabetes complications
HDL cholesterol	CHD, stroke, diabetes complications
Triglycerides	CHD, stroke, diabetes complications
Fibrinogen	Stroke (haemorrhagic)
Glucose	Diabetes
Oral glucose tolerance test	Diabetes (for diagnosis)
Glycosylated haemoglobin (HbA1c)	Diabetes
Insulin	Diabetes
Creatinine	Diabetes, renal disease
Urine measurement	
Microalbumin/creatinine ratio	Diabetes, renal disease
Haematuria	Renal disease, renal cancer

Workshop 5: Behavioural risk factors and other psychosocial variables

Facilitator: Margo Eyeson-Annan, New South Wales Health

Background

Presentations in Plenary 4.

Rationale

Chronic diseases are mostly the product of multifactorial, multi-step pathophysiological changes, embedded in a behavioural and psychosocial environmental milieu. Strategies aimed at reducing the impact of chronic diseases therefore need to operate at all levels of disease development including its antecedents.

In 1982, the Institute of Medicine of the U.S. National Academy of Sciences released a report suggesting that individual behaviours – such as cigarette smoking, diet and exercise – may be associated with at least 50% of all chronic illness. The Australian Burden of Disease and Injury Project has also attributed a large proportion of disability-adjusted life years to the behavioural risk factors. These numbers clearly indicate that surveillance of behavioural risk factors should be a central plank in the surveillance and monitoring of chronic diseases.

Focus

Input into the progression of behavioural risk factor data development for effective surveillance and monitoring of chronic diseases.

Focus questions

1. Which behavioural risk factors and psychosocial variables have the highest priority for inclusion in a surveillance and monitoring system for chronic diseases?
2. What is the current status of behavioural risk factor data in relation to chronic diseases at national and state/territory levels?
3. Are there any gaps or deficiencies in collecting data on behavioural risk factors and other psychosocial variables?

Workshop 6: Utilisation and harmonisation of various types of data

Facilitator: Alan MacKay, Australian Bureau of Statistics

Background

As chronic disease surveillance and monitoring typically relies on systems designed for some other purpose, the ability to effectively combine data from a variety of sources and levels ('harmonisation') is critical.

Presentations on the WHO STEPS approach to chronic diseases and associated risk factors monitoring, the AHMS, the NHS and CATI surveys set the scene for this workshop.

The harmonisation and discussion papers (provided as background material) produced by the La Trobe Consortium are also relevant for this workshop.

Rationale

A variety of methods are being used to collect behavioural (face-to-face interviews, CATI) and biomedical (health measurement; self-reports; clinical) risk factor information relevant to a range of chronic diseases. The collections are occurring at all levels, both jurisdictional and at specific population levels. Information is also being collected on various disease outcomes (both administrative and non-administrative), although it is not consistent across the continuum of care and disease severity. While most of the information being collected remains under-utilised, information on certain risk factors is being collected with some regularity. In contrast, information on a variety of important biomedical factors is woefully inadequate at both national and jurisdictional levels. It is therefore important to develop a strategy to justify the future collections in an efficient and cost-effective manner. It is also important to tag the collections in a complementary manner so as to allow integration of information at all levels, where possible through record linkage. There is also the need to extract best information from existing collections.

Focus

Utilising and harmonising data from various sources in the most effective and efficient manner.

Focus questions

1. What factors increase a data collection's quality and acceptability to users?
2. What factors increase a data collection's accessibility?
3. How can the useability of data collections be optimised?
4. What are the advantages of integrating administrative and non-administrative data?
5. What would be the most efficient means of integrating data from various sources?
6. How can comparability between data collections be achieved, both over time and between data sources?