DEPARTMENT OF HEALTH AND SOCIAL SECURITY

On the State of THE PUBLIC HEALTH for the year 1983

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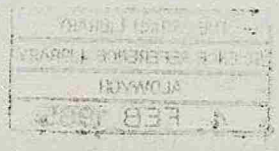
DEPARTMENT OF HEALTH AND SOCIAL SECURITY

On the State of
THE PUBLIC HEALTH

THE ANNUAL REPORT OF
THE CHIEF MEDICAL OFFICER OF
THE DEPARTMENT OF HEALTH AND SOCIAL SECURITY
FOR THE YEAR 1983

LONDON
HER MAJESTY'S STATIONERY OFFICE



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INTRODUCTION

To the Rt Hon Norman Fowler MP

Secretary of State for Social Services

Sir,

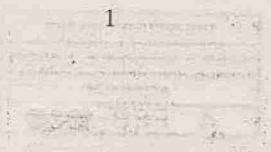
I have the honour to submit my Report on the State of the Public Health in England during 1983.

My colleagues have contributed to this Report and I am grateful to them for the help they have given me. The work described was done when my predecessor, Sir Henry Yellowlees, was Chief Medical Officer. I have therefore considered it right to retain the presentation used while he was in office.

The scope of what the health services can offer the individual and the population as a whole continues to increase. More facilities are required to take advantage of new professional skills and knowledge and the public is becoming increasingly aware of the benefits which may follow these advances. One of the consequences of these developments is that it becomes so much more important to ensure that the most advantageous and cost effective use is made of the available resources. The Report of the Management Inquiry (Chapter 15a) will, it is to be hoped, secure more and speedier progress in making available the resources necessary for better health care.

PREVENTIVE MEDICINE

The term 'public health' goes back 200 years. In the nineteenth century the main effort of the public health movement was concentrated upon the development of a safe water supply. With the subsequent improvements in housing, the elimination of much communicable disease and the control of air pollution, less remains to be done in the traditional areas of the discipline. Today knowledge of the factors underlying ill health is much wider and the specific responsibilities of the Department's medical staff reflect this change. More emphasis is being placed on prevention of those diseases which depend on individual behaviour. Preventable problems of our time include smoking related disease, alcoholism, sexually transmitted diseases and drug addiction. In addition, attention is being directed towards coronary heart disease which is the most important cause of death in the UK. The condition is also responsible for much illness. In many patients with coronary heart disease it is likely that more than one risk factor is present. The balance of opinion is that diet is one of the factors concerned and a review of the complex relationship between diet and cardiovascular disease was undertaken by the Committee on Medical Aspects of Food Policy. An important conclusion was that it would be wise for most people to reduce their intake of fats, especially fats rich in saturated fatty acids. The Committee also recognized the need for manufacturers of food and drink to provide more information about the composition of their products and for health educators to provide advice to the general public on how to minimize the risk of cardiovascular disease. Their conclusions were published in 1984 and will be discussed more fully in this Report for that year.



Smoking

The habit of smoking cigarettes constitutes by far the largest avoidable hazard to health in Britain today, and causes about 100,000 deaths in the UK each year. In 1972 the cigarette was described by one of my predecessors as 'the most lethal instrument devised by Man for peaceful use'. Cigarette smokers are now a minority in all social groups but much remains to be done, both to persuade those who continue to smoke to stop and to discourage young people from starting to smoke. Among manual unskilled male workers 49% smoke cigarettes, but if cigar and pipe smokers were to be included this would push those who smoke in this group to over 50%.

At the end of 1983 the Royal College of Physicians published its comprehensive Fourth Report entitled *'Health or Smoking?'*. This was followed by a new 2-year agreement with the tobacco industry which will lead to a further reduction in tar yields from cigarettes. It is important to point out, however, that reduction in tar levels, while almost certainly helpful in reducing the incidence of lung cancer, is much less likely to influence favourably the incidence of some other important tobacco related diseases such as coronary heart disease and disease of the other arteries. This is why we must also focus on the control of the smoking habit itself. Smoking among secondary school children and the attitudes and behaviour of adults who smoke were the subject of two surveys undertaken by the Social Services Division of the Office of Population, Censuses and Surveys (OPCS). The first revealed a sadly high level of smoking among secondary school children and will be repeated in 1984. The second showed that emphasis on the risks to health probably has less influence on the persistent smoker than emphasis on the benefits to be derived from giving up the habit.

Other Departmental activities and policies for the promotion of health are mentioned regularly in other chapters — environmental health and toxicology (Chapter 3), communicable disease, immunization and vaccination (Chapters 4 and 5), family planning, the safe delivery of normal babies and the healthy development of children (Chapter 7), the abuse of drugs and solvent misuse (Chapter 9), the limitation of the effects of handicap (Chapter 10) and the safety of medicines (Chapter 15).

Environmental health

During 1983 further reductions in the allowable limits for asbestos in work places were announced by the Health and Safety Commission and the Department of Environment published advice on the use and handling of asbestos. The Commission has recommended a ban on the import and use of amphibole types of asbestos, crocidolite (blue) and amosite (brown). The control limit for chrysotile (white asbestos) has been further reduced.

The Committee on Toxicity expressed concern about differences between the legislation affecting certain types of consumer product and drugs, food additives and cosmetics. Discussions were held to see whether more uniform regulations could be set up for these products.

The Government accepted a recommendation for the phasing out of lead additives in petrol and announced its intention to clarify the powers of water authorities to add fluoride to public water supplies. The use of fluoride, particularly in toothpaste, may have improved the dental health of children

(Chapter 8). An OPCS survey has shown a reduction over the past 10 years in the prevalence of dental caries in children at all ages and in all Regions.

Communicable diseases

On the basis of criteria determined by the USA Center for Disease Control the Communicable Diseases Surveillance Centre at Colindale identified 31 cases (16 deaths) of acquired immune deficiency syndrome (AIDS) between February 1982 and December 1983. The groups at risk in the UK appear to be homosexual and bisexual males, drug abusers, and patients with haemophilia A treated with American factor VIII concentrate.

The first cholera death in England since 1909 occurred in an elderly male patient who had recently visited the Philippines and Hong Kong. This incident served as a reminder that cholera remains a threat, albeit a remote one, to those who travel to areas where the disease is endemic.

The Malaria Reference Laboratory received reports of 1,715 cases of imported malaria with eight deaths. *Plasmodium falciparum* malaria occurred in three patients who had not visited malarious areas. One patient had been to Rome and the other two patients lived near an international airport in Sussex. It was felt that very warm summer weather and the arrival in an aircraft of mosquitoes bearing sporozoites at the infective stage had enabled infection to develop in the UK.

The rate of uptake of measles vaccine in England and Wales was disappointing (58%) in 1982. There were 103,700 notifications of the disease in 1983, with 16 deaths. The excess occurred entirely in the first half of the year. There were only 7,795 cases notified in the fourth quarter of 1983 compared with 16,920 in the fourth quarter of 1982 (a reduction of 54%). Significantly higher notification rates than would be expected if national rates for the same period applied, occurred during every fortnight throughout the December quarter 1983 in Cleveland (Langbaurgh, Middlesbrough), West Midlands (Birmingham), and Mid Glamorgan (Cynon Valley). Each of these areas recorded low notification rates throughout the epidemic which affected most parts of the country during 1982 and the first half of 1983.

In view of the substantial amount of illness for which this disease is still responsible in this country, the Joint Committee on Vaccination and Immunization has recommended that strenuous efforts should be made to increase the uptake of measles immunization with the eventual aim of eliminating this disease. Health Authorities are therefore being asked to intensify their measles immunization programmes. Measles vaccination should be offered to all susceptible children entering play groups, nursery schools and primary schools.

Paratyphoid fever occurring in patients who had visited Portugal continued as a problem. Since 1978 the Communicable Disease Surveillance Centre has identified 39 patients in the UK with paratyphoid B phage type 3A VAR 4, 36 of these people having become ill after staying at one resort in Portugal. Typhoid fever also occurs sporadically in Southern Europe and in 1983 there was an outbreak (58 cases) on the island of Kos; 32 UK citizens were affected.

Road accidents

Deaths and injuries from road accidents continue to be a serious problem. The Department shares with the Department of Transport's Transport and Road Research Laboratory and the Medical Commission on Accident Prevention a concern for the prevention of road accidents.

The wearing of seat belts became compulsory on 31 January 1983, and the number of drivers and front seat passengers killed in road traffic accidents during the year showed an encouraging decrease. It is premature as yet to judge the long-term outcome of the effect of seat-belt legislation.

Deaths to pedestrians showed a less satisfactory trend. More elderly pedestrians were accidentally killed in 1983 than in 1982. The wearing of seat belts could not be expected to make the roads safer for them but the statistics for 1983 emphasize the dangers the elderly face on the roads.

THE NATIONAL HEALTH SERVICE

Primary health care

During 1983 the Government provided additional financial assistance for the improvement of unsatisfactory practice premises or to improve practice organization in selected locations, and this assistance will continue for three years. New financial incentives were announced to encourage the setting up of group practices in inner cities and there is also financial support for the training of health visitors and district nurses of the inner city authorities.

In December 1983 the Department issued for consultation a draft circular on deputizing services for general practice. The need for some changes in the arrangements for deputizing had become apparent as the result of the response to a letter which the Minister for Health had sent in July to the Chairmen of all Family Practitioner Committees asking them to review their arrangements for consenting to and monitoring the use of deputizing services. A definitive circular was issued in May 1984 after comments on the draft had been received and after extensive discussions with general practitioners' representatives. A more complete account of the position will feature in this report for 1984.

Mental health

The Mental Health Act 1983 introduced changes in legislation for the treatment of detained mentally disordered patients. Particular attention was paid to the difficult and sensitive area of consent to treatment. However, it is probable that future health historians will see the establishment of the Mental Health Act Commission as the most significant change. The Commission will primarily be concerned with the care and treatment of detained patients but inevitably it will also influence the care of mental disorders generally.

The Artificial Limb, Vehicle and Appliance Service (ALAC) under the NHS?

The ALAC Service began at Roehampton in 1915 to deal with the many limbless soldiers returning from the Great War. By 1948 some 30,000

civilian amputees were also added. Responsibility for the ALAC passed from the Ministry of Pensions to the Ministry of Health in 1953 when an undertaking was given that 'these services would be brought within the National Health Service at the appropriate time'. In the 30 years since then various reports were prepared concerning possible transfer to the NHS but no action followed.

The case for integration is that overall management of the amputee would then be within one organization. Eighty per cent of new amputees are elderly and they often suffer from the medical problems of old age in addition to limb loss. They may be in need of help from the rehabilitation services in order to cope adequately. Many would benefit from home adaptations in order to make effective use of various aids to mobility and for these patients, in particular, the ALAC does not provide total patient care.

It is against this background that on 25 November 1983 the Minister for the Disabled, announced the setting up of an ALAC Review under the Chairmanship of Professor Ian McColl. The terms of reference are wide ranging and recommendations are expected to be made known in early 1985.

Alternative medicine under the NHS?

While everyone knows what is meant by alternative medicine a definition is hard to formulate. A possible working definition is any practice or philosophy designed to heal, prevent disease or promote well-being which is not commonly practised by doctors and for which there is no generally accepted scientific evidence of efficacy.

In England, under the common law, anyone may set out to heal other people by any method providing he obtains their consent, does not pretend to be a registered medical practitioner when he is not, does not say he can treat cancer or venereal disease and does not break any of the laws, such as the Medicines Act, which restrict what he can prescribe or what certificates he can sign. Some of these professions wish to have their qualification recognized and their name protected by law. However, in view of the lack of generally accepted scientific evidence of their effectiveness and the fact that there are several bodies issuing diplomas which do not agree with each other it is difficult to see how agreement could be reached on a basis for action.

The BMA announced in 1983 an enquiry into alternative medicine by a committee under the Chairmanship of Professor Payne. This was in response to the increasing interest in this field and pressures to make certain of these treatments available under the NHS. At present these can only be provided under the NHS when prescribed by a doctor and provided by him or by a person who is in contract with the local health authority and whom the doctor is satisfied is competent to provide that treatment; the health authority would also need to be satisfied of the person's competence, and that such a contract was a proper use of its resources in the light of all the prevailing circumstances.

Acknowledgements

I am pleased to acknowledge the help of my colleagues in the preparation of this Report. In the Department we continue to benefit from the regular

contacts we enjoy with members of the health professions throughout England and I am grateful for the support I have received from all with whom I have been associated in my first year as CMO. Mutually beneficial working arrangements have been maintained with the Medical Research Council, the World Health Organization, the Welsh Office, the Scottish Home and Health Department and other international and government agencies. Special mention must be given to the Office of Population, Censuses and Surveys who contribute to this Report each year.

Finally, as I have mentioned earlier, Sir Henry Yellowlees was in post throughout 1983, and this Report describes events that took place during his term of office. His help in getting the preparation of this Report organized was much appreciated.

I am, Sir
Your obedient servant
E. D. ACHESON

December, 1984

1

VITAL STATISTICS

Population size (England)

The population resident in England on 30 June 1983 is estimated to have been 46,846,000, a figure some 25 thousand (0.1%) higher than in 1981 (Table 1.1). Uncharacteristically, the size of England's population declined between mid-1981 and mid-1982 by around 26 thousand persons before increasing between mid-1982 and mid-1983 by about 51 thousand persons. The decrease was due primarily to net outward migration outweighing the increase in population arising from natural change (births minus deaths). But for the mid-1982 to mid-1983 period the situation was reversed; net outward migration returned to the relatively low levels experienced in the late 1970s and natural change was dominant.

The population of the East Anglian and Oxford Regional Health Authorities (RHAs) showed the greatest growth (1.6% and 1.5% respectively) between 1981 and 1983, while the Mersey, North Western and Northern RHAs experienced population declines of at least 0.6%. At district health authority level population changes between 1981 and 1983 were more dramatic, varying from a loss of 3.5% in Camberwell to a gain of 9.5% in Milton Keynes. Large population increases were associated with relatively high levels of in-migration to the area concerned; and similarly large population decreases with relatively high levels of out-migration. Table 1.2 lists the ten district health authorities in England experiencing the largest proportionate increases and decreases in population during the 1981 to 1983 period.

Age and sex structure of the population (England)

The estimated age and sex structure of the mid-1983 resident population of England is shown in Table 1.3. The changes in the age and sex structure of the population between 1981 and 1983 are similar to those seen in recent years.

The number of pre-school children continued to increase (3.8%) although births have been fairly constant in recent years. The number of children aged 5–16 years continues to fall (−6.3%) but the rate of decrease has now started to lessen reflecting the gradual increase in births from 1978 onwards. The size of the population of working age (males aged 17–64 years, females aged 17–59 years) increased by 1.4% between 1981 and 1983.

Recently there has been a lot of interest in the increasing proportion of people of pensionable age (defined here as men aged 65 years and over and women aged 60 years and over) in the population and the implications for the provision of health and social services. The total number of people of pensionable age increased by 0.7% between 1981 and 1983. But within this age span there were differential changes in the groups aged up to 75 years, 75–84 years and 85 years or more, and between males and females. In the age group up to 75 years, the number of males decreased by 4.4% whereas

the number of females decreased by only 0.2% the former reflecting in part the effects of World War II casualties on the age structure of the population. In the age group of 75–84 years the number of males and females increased by 7.2% and 4.2% respectively. The numbers of very elderly (85 years and over) also increased, males by 5.1% and females by 5.9%.

At 30 June 1983 the proportion of the population of pensionable age stood at 18.1% for England; however it varied considerably across health authorities. The highest proportions of pensionable age among district health authorities are found along the south coast (Table 1.4). Worthing and Hastings are most prominent with over 30% of their population of pensionable age. At the other extreme new towns and commuter areas tended to have low proportions of people of pensionable age; Milton Keynes, for example, had only 11% of its population in this age span.

Table 1.1 Components of population change, England (thousands)

Mid-year to mid-year	Population at start of period[+]	Components of population change (mid-year to mid-year)					
		Births	Deaths	Natural change	Net migration	Other changes*	Total change
1971–1972	46,412	707	544	+163	−18	+15	+160
1972–1973	46,572	662	554	+108	—	+ 6	+114
1973–1974	46,686	615	547	+ 68	−78	+ 7	− 3
1974–1975	46,683	589	554	+ 35	−56	+12	− 9
1975–1976	46,674	560	563	− 3	−22	+11	− 14
1976–1977	46,660	535	544	− 9	−17	+ 6	− 20
1977–1978	46,640	543	548	− 5	−22	+25	− 2
1978–1979	46,638	590	555	+ 36	+13	+12	+ 60
1979–1980	46,698	610	543	+ 67	+18	+ 4	+ 89
1980–1981	46,787	606	542	+ 64	−47	+17	+ 34
1981–1982	46,821	592	552	+ 41	−61	− 5	− 26
1982–1983	46,795	593	545	+ 49	− 2	+ 4	+ 51
1983	46,846						

[+] Revised intercensal estimates for 1971 to 1980 and estimates for 1981 to 1983 are based on a new definition and population base; see *Population Trends 35* and *OPCS Monitor PP1 84/2* for more details.[1,2]

* Changes in numbers of armed forces plus adjustments to reconcile population change between mid-year estimates with estimates of natural change and net civilian migration.

Table 1.2 The ten district health authorities in England with the largest proportionate increase/decrease in population between 1981 and 1983

Largest increase	%	*Largest decrease*	%
Milton Keynes	9.5	Camberwell	3.5
Peterborough	3.4	North Birmingham	3.3
West Birmingham	2.9	Victoria	3.1
Chichester	2.7	Central Birmingham	2.8
Northampton	2.6	Liverpool	2.7
Warrington	2.6	Hampstead	2.7
Basingstoke and North Hampshire	2.5	West Lambeth	2.5
Northallerton	2.4	Paddington and North Kensington	2.5
Mid Downs	2.3	Islington	2.0
Swindon	2.1		

Table 1.3 Population age and sex structure at 30 June 1983, England

Age group (years)	Persons (000s)	%	Males (000s)	%	Females (000s)	%	% change between mid 1981 and mid 1983		
							Persons	Males	Females
0–4	2,942	6	1,509	7	1,434	6	+3.8	+3.8	+3.9
5–16	7.726	17	3,971	17	3,755	16	−6.3	−6.2	−6.4
17–29	9,341	20	4,736	21	4,605	19	+3.1	+3.1	+3.0
30–44	9,313	20	4,684	20	4,629	19	+1.5	+1.3	+1.7
45–64/59*	9,065	19	5,139	22	3,926	16	−0.4	+0.9	−2.1
65/60–74**	5,551	12	1,819	8	3,732	16	−1.6	−4.4	−0.2
75–84	2,368	5	833	4	1,534	6	+5.2	+7.2	+4.2
85+	541	1	125	1	416	2	+5.8	+5.1	+5.9
All Ages	46,846	100	22,815	100	24,031	100	+0.1	+0.1	+0.0

* 45 to 64 for males, 45 to 59 for females
** 65 to 74 for males, 60 to 74 for females

Table 1.4 The ten district health authorities in England with the highest/lowest estimated proportion of population of pensionable age at 30 June 1983

Highest	%	*Lowest*	%
Worthing	30.9	Milton Keynes	10.6
Hastings	30.9	West Surrey and North East Hampshire	12.6
Eastbourne	29.6	Basildon and Thurrock	13.1
Torbay	28.2	Huntingdon	13.1
Chichester	27.0	Bromsgrove and Redditch	13.2
East Dorset	26.7	South Bedfordshire	13.3
Isle of Wight	26.5	South East Staffordshire	13.3
Blackpool, Wyre and Fylde	25.5	North Tees	13.6
Brighton	25.4	Basingstoke and North Hampshire	13.8
Canterbury and Thanet	25.0	Aylesbury Vale	13.9

* Males aged 65 years and over, females aged 60 years and over.

Live births (England and Wales)

In 1983 there were 629.1 thousand live births, 3.2 thousand (0.5%) more than in the preceding year (Table 1.5). The mean age of women at childbearing increased from 26.8 years in 1982 to 26.9 years in 1983 as a result of a decline of births for mothers below 25 years of age and an increase for older mothers, and continued the trend observed in recent years.

The total period fertility rate (TPFR — see definition below Table 1.5) in 1983 was 1.76 the same value as in 1982. The fertility rate for women under 25 years of age declined by 2% for the age group 15–19 years and 3% for the age group 20–24 years whereas there were increases of 4%, 2% and 4% in the women aged 30–34 years, 35–39 years and 40–44 years respectively. At ages 25–29 years the fertility rate remained unchanged. The TPFR was 6% higher in 1983 than in 1977, the minimum year, with higher fertility rates for women of 25 years of age and older but lower fertility rates for younger women. At 15–19 years of age the fertility rate in 1983 was the lowest since 1955 and at 20–24 years of age it was the lowest since 1942.

Table 1.5 Live births and fertility rates by mother's age, England and Wales, 1977–1983

Year of occurrence	Age of mother							Mean age at childbirth (years)
	All ages	Under 20	20–24	25–29	30–34	35–39	40 & over	
	(a) Number of births (000s)							
1977	569.3	54.5	174.5	207.9	100.8	25.5	6.0	26.5
1978	596.4	56.0	182.6	210.6	113.1	27.9	6.2	26.6
1979	638.0	59.1	193.2	222.1	125.7	31.4	6.5	26.7
1980	656.2	60.8	201.5	223.4	129.9	33.9	6.7	26.7
1981	634.5	56.6	194.5	215.8	126.6	34.2	6.9	26.8
1982	625.9	55.4	192.3	211.9	120.8	39.0	6.5	26.8
1983	629.1	54.1	191.8	214.1	121.0	41.3	6.9	26.9
	(b) Rates per 1,000 women*							TPFR†
1977	58.1	29.4	103.7	117.5	58.6	18.2	4.4	1.66
1978	60.1	29.4	106.9	122.6	63.1	19.5	4.5	1.73
1979	63.3	30.3	111.3	131.2	69.0	21.3	4.7	1.84
1980	64.2	30.4	112.7	133.6	70.5	22.3	4.8	1.88
1981	61.3	28.1	105.3	129.1	68.6	21.7	4.9	1.80
1982	59.9	27.4	101.6	126.4	69.1	22.8	4.7	1.76
1983	59.7	26.9	98.5	126.4	71.5	23.1	4.8	1.76

* The rates for women of all ages, under 20 and 40 and over are based upon the populations of women aged 15–44, 15–19 and 40–44 respectively. Population estimates based upon the resident population (new definition) which take into account results from the 1981 Census are used (see OPCS Monitor PP1 83/3)[3].
† The total period fertility rate (TPFR) is the average number of children which would be born per woman if women experienced the age-specific fertility rates of the period in question throughout their childbearing life span.

Table 1.6 Illegitimate live births and illegitimacy ratios by age of mother, England and Wales, 1977–1983

Year of occurrence	Numbers of illegitimate births (000s)					Illegitimacy ratios*				
	Mother's age					Mother's age				
	All ages	Under 20	20–24	25–29	30 and over	All ages	Under 20	20–24	25–29	30 and over
1977	55.4	20.1	17.4	9.8	8.2	97	368	100	47	62
1978	60.6	21.6	19.7	10.4	8.9	102	387	108	50	60
1979	69.5	24.0	22.9	12.3	10.3	109	406	118	55	63
1980	77.4	25.9	26.6	13.5	11.4	118	426	132	60	67
1981	81.0	26.4	28.8	14.3	11.5	128	467	148	66	68
1982	89.9	28.7	32.4	16.1	12.6	144	518	169	76	76
1983	99.2	30.4	36.6	17.9	14.2	158	563	191	84	84

* Illegitimate births per 1,000 live births to all women in the age-group.

The proportion of all live births which were illegitimate increased to 16% in 1983, compared with 14% in 1982 and 10% in 1977 (Table 1.6). The proportion of live births to teenage women which were illegitimate increased to 56% in 1983 from 52% in the previous year, and the proportion for women 20–24 years of age increased to 19% in 1983 from 17% in 1982. The changes in these age groups were particularly sharp because, while the numbers of illegitimate births increased, the total number of births fell. The persistence of these trends throughout the last three years provides the main explanation for the very sharp increase between 1980 and 1983 in the proportion of all births which were illegitimate. The proportions of births which were illegitimate also continued to increase between 1982 and 1983 for women 25 years of age or older.

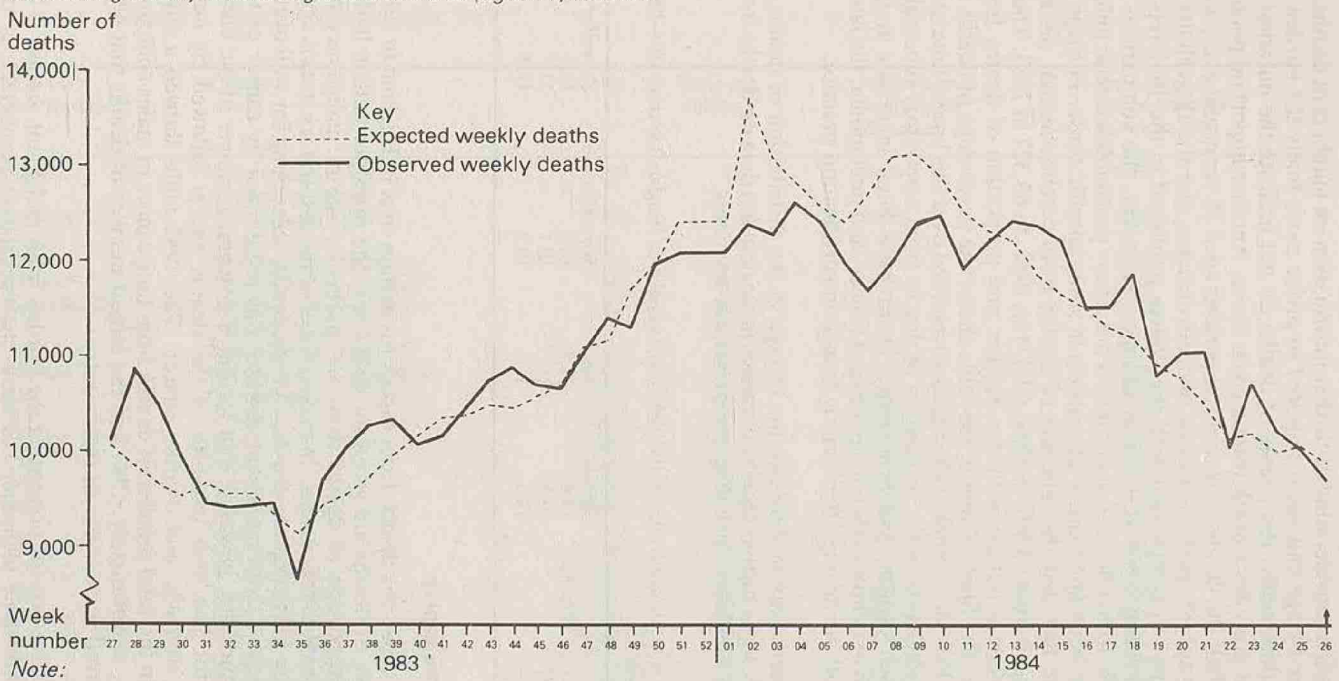
Deaths

The number of deaths in England in 1983 was 542,509; this represents the same crude death rate per 1,000 compared with the preceding few years (11.6 deaths/thousand population). However, of more interest is the long-term trend in overall mortality, best examined by the Standardised Mortality Ratio (SMR), which compares the observed number of deaths with the number that would have occurred if the sex/age specific death rates of a standard year had applied to the current population structure. This takes account of changes in the age and sex structure for the population over time, which can themselves directly influence the total number of deaths or the crude death rate. Again the SMR has decreased, against a standard figure of 100 in 1968 to a new low of 84. The SMR in 1983 was 82 for males and 84 for females. These sex specific SMRs show the progress in the toll from mortality for each sex, but are not directly comparable one against the other, as the standard rates in 1968 were much higher in males than in females.

There are two factors which can produce appreciable major change in mortality rates — epidemics of influenza, and very abnormal weather conditions, especially severe cold. Table 1.7 shows the quarterly death rate for England for the years 1978–82, and separately for 1982 and 1983. Again the usual pattern is observed throughout this period, with higher rates in the first quarter and the lowest rates in the third quarter of the year. For the third successive year, there was no influenza epidemic; there was also neither prolonged cold or hot weather influencing the seasonal swing in mortality. The Office of Population Censuses and Surveys (OPCS) introduced for the winter of 1983–84 a chart for monitoring the observed against the expected seasonal swing in total deaths[4]. This chart is updated week by week and the final position for the epidemiological year 1983/4 is shown in Figure 1.1. This shows that throughout the past winter the level of mortality has been below that which was expected from the general trend in mortality over the past 10 years, taking the size and demographic structure of the population into account.

Table 1.8 shows the principal causes of death in England in 1983. It must be emphasized that such a table is only of value as a preliminary consideration of the burden of disease in the population. These statistics show the total numbers of deaths, the death rate per million and the percentage of deaths from all causes for a list of specific but relatively broad causes of death.

Figure 1.1:
Monitoring weekly deaths England and Wales (ages 1+) 1983/84



Note:
The graph shows the observed and expected weekly deaths (excluding deaths under 1 year) for the epidemiological year 1983/4. The expected deaths incorporate adjustments for trend, population and season. A full explanation of the method of calculation is contained in Population Trends No. 34, Monitoring Weekly Deaths, pp20-25 (method III).
Deaths for the week numbers 83/51, 83/52 and 84/1; 84/16 and 84/17 have been averaged.

More detailed consideration of further information on numbers of deaths or death rates by age and sex is required to probe more finely the burden of disease; additionally, the counts of deaths do not indicate the duration of illness that precedes a death from a given cause. Another important point is that over half the deaths now occur in persons aged 75 years and over; with advancing age, the pattern of cause of death changes, and also the validity of the statistics. In comparison with the figures published in the 1982 report there have been some very minor changes. However, the comparison of such a table from one year to another is not a very profitable exercise unless there have been appreciable alterations in some specific cause. Perhaps of note is the fact that the numbers of deaths from cerebrovascular disease have dropped from 64,947 in 1981, 64,474 in 1982, to 63,327 in 1983. There has also been a reduction in the number and proportion of deaths from bronchitis. The final column in the table shows the percentage of deaths by cause in 1960. More marked changes are observed over this longer time span — with a reduction in the proportion of deaths from respiratory tuberculosis, stomach cancer, and bronchitis. There have been increases in the proportion of deaths from lung and breast cancer, and pneumonia; the latter reflects both an ageing effect and a change in certification practice.

A subsequent section discusses the change in the distribution of deaths in childhood, and a further section discusses more detailed data on deaths from a range of accidents, including motor vehicle accidents.

Table 1.7 Quarterly death rate per thousand home population (England) average 1978–1982, 1982 and 1983.

	March	*June*	*September*	*December*
England average 1978–82	13.6	11.3	10.2	11.8
England 1982	13.5	11.3	10.1	11.7
England 1983	13.6	11.1	10.3	11.4

Deaths from cancer

Table 1.9 shows the deaths from cancer for certain sites in England in 1983; the number of deaths are given for either sex, the rates per million living, and the proportion of deaths from any particular site of malignancy per thousand total cancer deaths. In males cancer of the respiratory tract is again the lead site for malignant disease causing death, accounting for well over a third of deaths from malignant disease; this is followed by cancer of the stomach, prostate, intestine, and rectum. For women, cancer of the breast accounts for just over one-fifth of the deaths and is followed by lung, intestine, stomach, and ovarian cancer. The 1982 table showed a slight decrease in the total number of deaths from lung cancer in males compared with 1981; unfortunately, 1983 had the largest number of deaths that have ever occurred in one year in this country.

An alternative way of presenting the burden from malignant disease is by use of a life table technique, to show the cumulative percentage of the population developing cancer by age and sex. Tables published by OPCS (1983) indicated that for all sites this was 26.8% in males and 23.5% in females up to 75–79 years of age, and included was 7.9% for lung cancer in males, and 5.7% for breast cancer in females[5].

Table 1.8 Mortality — Principal causes, England, 1983

ICD No (9th Revision)	Causes	Deaths	Rate per million	Percentage of deaths from all causes	Percentage of deaths from all causes in 1960
010–012	Tuberculosis of the respiratory system	343	7.3	0.06	0.59
013–018, 137	Tuberculosis, other forms	296	6.3	0.05	0.06
036	Meningococcal infection	63	1.3	0.01	0.02
090–097	Syphilis and its sequelae	43	0.9	0.01	0.18
Rem 001–139	All other infective and parasitic diseases	1,128	24.1	0.21	0.22
	Malignant neoplasms				
140–149	Buccal cavity and pharynx	1,589	33.9	0.29	0.34
150	Oesophagus	3,820	81.5	0.70	0.44
151	Stomach	9,724	207.6	1.79	2.65
152–154	Intestine and rectum	15,803	337.3	2.91	2.81
157	Pancreas	5,469	116.7	1.01	0.75
161	Larynx	714	15.2	0.13	0.16
162	Trachea, bronchus and lung	33,622	717.7	6.20	4.18
174–175	Breast	11,963	255.4	2.21	1.73
179–182	Uterus (female)	3,225	68.8	0.59	0.78
185	Prostate (male)	5,310	113.4	0.98	0.69
204–208	Leukaemia	3,219	68.7	0.59	0.51
Rem 140–208	Other malignant neoplasms	30,401	649.0	5.60	3.72
250	Diabetes mellitus	4,248	90.7	0.78	0.68
290–319	Mental disorders	3,914	83.6	0.72	0.20
332	Parkinson's disease	2,013	43.0	0.37	0.31
340	Multiple sclerosis	661	14.1	0.12	0.17

401–405	Hypertensive disease	4,357	93.0	0.80	3.39
410–414	Ischaemic heart disease	146,090	3118.5	26.92	27.0
393–398, 415–429	Other forms of heart disease	31,316	668.5	5.77	3.92
430–438	Cerebrovascular disease	63,327	1351.8	11.67	14.5
440	Atherosclerosis	6,021	128.5	1.11	2.10
441	Aortic aneurysm (non-syphilitic)	6,604	141.0	1.22	0.48
451–453	Venous thrombosis and embolism	3,981	85.0	0.73	0.30
480–486	Pneumonia	52,164	1,113.5	9.62	4.63
487	Influenza	752	16.1	0.14	0.21
490–493	Bronchitis, emphysema and asthma	15,928	340.0	2.94	5.04
531–533	Peptic ulcer	4,049	86.4	0.75	0.89
571	Cirrhosis of liver	2,022	43.2	0.37	0.24
580–589	Nephritis and nephrosis	4,425	94.5	0.82	0.71
600	Hyperplasia of prostate (male)	569	12.1	0.10	0.62
630–676	Complications of pregnancy, childbirth and the puerperium (female)	51	1.1	0.01	0.06
740–759	Congenital anomalies	2,684	57.3	0.49	0.97
Rem 001–799	All other diseases	42,861	914.9	7.90	9.35
E810–E825	Motor vehicle accidents	4,855	103.6	0.89	1.26
E880–E888	Accidental falls	3,783	80.8	0.70	1.04
E800–E807 and Rem E826–E949	All other accidents	3,313	70.7	0.61	1.07
E950–E959	Suicide and self-inflicted injuries	4,006	85.5	0.74	0.97
E960–E999	All other external causes	1,783	38.1	0.33	0.05
	All causes	542,509	11,580.7	100.0	100.00

Table 1.9 Deaths from cancer of certain sites, England, 1983.

ICD No (9th Revision)		Number of deaths		Rates per million living		Proportion per 1,000 total cancer deaths	
		Males	Females	Males	Females	Males	Females
140–159	Total digestive system	20,608	18,230	903	759	309	313
141	Tongue	200	121	9	5	3	2
140–149	Lip, oral cavity and pharynx	1,017	572	45	24	15	10
150	Oesophagus	2,241	1,579	98	66	34	27
151	Stomach	5,922	3,802	260	158	89	65
152, 153	Intestine (except rectum)	4,319	5,602	189	233	65	96
154	Rectum, rectosigmoid junction and anus	3,175	2,707	139	113	48	46
157	Pancreas	2,791	2,678	122	111	42	46
160–165	Respiratory and intrathoracic organs	26,051	8,900	1,142	370	391	153
161	Larynx	568	146	25	6	9	3
162	Trachea, bronchus and lung	25,055	8,567	1,098	357	376	147
163–165	Other and unspecified	316	96	14	4	5	2
170–175	Total bone, connective tissue, skin and breast	1,051	12,794	46	532	16	220
170, 171	Bone, connective tissue and other tissue	367	342	16	14	6	6
172, 173	Skin	600	573	26	24	9	10
174, 175	Breast	84	11,879	4	494	1	204
179–187	Total genital organs	5,554	7,239	243	301	83	124
180	Cervix uteri	—	1,815	—	76	—	31
182	Uterus (other and unspecified)	—	1,157	—	48	—	20
183	Ovary, fallopian tube and broad ligament	—	3,514	—	146	—	60
184	Other and unspecified female genital organs	—	500	—	21	—	9
185	Prostate	5,310	—	233	—	80	—
188–189	Total urinary system	4,104	2,028	180	84	62	35
188	Bladder	2,915	1,286	128	54	44	22
189.0, 189.1	Kidney	1,133	710	50	30	17	12
190–192	Eye, brain and other parts of nervous system	1,355	1,070	59	45	20	18
193	Thyroid	101	198	4	8	2	3
200–208	Total lymphatic and haematopoietic tissue	4,057	3,533	178	147	61	61
201	Hodgkin's disease	273	179	12	7	4	3
204–208	Leukaemia	1,729	1,490	76	62	26	26
140–208	Total cancer	66,606	58,253	2,919	2,424	1,000	1,000

Stillbirths and infant mortality

Table 1.10 shows the live births, stillbirths and infant mortality in England in the period 1960–83. The stillbirth rate, and early neonatal mortality have both declined — also giving a decrease in the perinatal mortality which combines the two statistics.

Post-neonatal mortality has reduced from the slightly aberrant figures in 1982, and now shows the lowest figures yet recorded. The infant mortality rate also shows a decline from 1982 and again the lowest figure yet recorded.

Table 1.10 Live births, stillbirths and infant mortality, England, 1960–83

Year	Live births	Stillbirths		Early neonatal mortality (deaths under 1 week)		Perinatal mortality (stillbirths plus deaths under 1 week)	Post-neonatal mortality (deaths 4 weeks to under 1 year)	Infant mortality (deaths under 1 year)
	No	No	Rate*	No	Rate†	Rate*	Rate†	Rate†
1960	740,859	14,753	19.5	9,772	13.2	32.5	6.3	21.6
1970	741,999	9,708	12.9	7,864	10.6	23.4	5.9	18.2
1975	563,900	5,918	10.3	5,154	9.1	19.3	5.0	15.7
1976	550,393	5,339	9.6	4,468	8.1	17.6	4.6	14.2
1977	536,953	5,087	9.4	4,070	7.6	16.9	4.5	13.7
1978	562,589	4,791	8.4	3,975	7.1	15.4	4.4	13.1
1979	601,316	4,811	7.9	4,028	6.7	14.6	4.5	12.8
1980	618,371	4,523	7.3	3,793	6.1	13.4	4.4	12.0
1981	598,163	3,939	6.5	3,105	5.2	11.7	4.3	10.9
1982	589,711	3,731	6.3	2,939	5.0	11.2	4.6	10.8
1983	593,255	3,412	5.7	2,746	4.6	10.3	4.2	10.0

* Per 1,000 live and still births
† Per 1,000 live births

Low birthweight babies

There has been little change in the proportion of low birthweight babies (2,500g or less) born in 1983 compared with recent years — see Table 1.11a, though the percentage of low birthweight of all liveborn babies has risen slightly in the past decade. However, the perinatal mortality rates for these low weight births has decreased, especially for those in the very low birthweight subgroups (1,000g or less, and 1,001–1,500g) — see Table 1.11b.

Table 1.11a Premature births, low birthweight babies (2,500g or less) England, 1974–1983

Year	Liveborn			Live and stillborn		
	Numbers of low weight 000s	Numbers of all weights 000s	Low weight as a percentage of all weights	Numbers of low weight 000s	Numbers of all weights 000s	Low weight as a percentage of all weights
1974	38.9	602.5	6.5	42.9	609.0	7.0
1975	36.4	570.0	6.4	40.1	575.9	7.0
1976	35.4	551.5	6.4	38.7	556.8	7.0
1977	35.0	537.5	6.5	38.2	542.5	7.0
1978	37.1	563.7	6.6	40.2	568.4	7.1
1979	40.7	602.0	6.5	43.9	606.7	7.2
1980	42.5	619.4	6.9	45.5	623.9	7.3
1981	40.8	600.0	6.8	43.4	603.9	7.2
1982	40.4	589.4	6.9	42.7	593.1	7.2
1983*	40.2	591.8	6.8	42.3	595.2	7.1

* Provisional figures

Table 1.11b Low weight births — perinatal mortality rates, England, 1977–1983

Birthweight group	Stillbirths and deaths in first 7 days per 1,000 live and stillbirths						
	1977	1978	1979	1980	1981	1982	1983*
– 1,000g	811	792	772	742	679	649	601
– 1,500g	499	437	415	362	298	280	253
– 2,000g	187	173	152	144	120	109	103
– 2,250g	71	64	56	51	46	44	43
– 2,500g	38	31	30	27	24	22	21
All of 2,500g or less	154	142	132	121	105	99	93

* Provisional figures

Congenital malformations

Table 1.12 shows the number and rate of malformations notified for live births and stillbirths with an overall rate per thousand total births. In 1983 the number of notifications rose for liveborn babies with malformations, whilst that for stillbirths continued to fall. The two opposing trends are associated with very different factors. The number of malformed stillbirths may reflect both the incidence of congenital malformation in the fetus, aspects of selective therapeutic abortion, and changes in obstetric practice which may lead to some infants with malformations being born alive and who would hitherto have died. However, the larger change is in relation to malformations in live born babies which shows the highest rate in the table, and the highest rate since notification began in 1964.

Significant increases in the notifications of babies born with hydrocele were identified in the second half of 1982 and early 1983 in the counties of Northumberland and Essex. The monitoring system produced warnings for this condition in June, July, August, September and November 1982 and February 1983 for Northumberland and in October and December 1982 and January and April 1983 for Essex. In addition to the routine warning letters, special enquiries were made of the relevant district health authorities but no contributory factors could be identified in either case.

The notification levels subsequently returned to more normal levels with no further warnings from the monitoring system for either area in 1983.

Table 1.12 Notified congenital malformations among live and stillborn babies showing rates for liveborn and for all babies, England 1977 to 1983

Year	Liveborn babies with malformations		Number of stillborn babies with malformations	All babies with malformations*	
	Number	Rate per 1,000 total births		Number	Rate per 1,000 total births
1977	10,892	20.1	928	11,851	21.9
1978	11,318	19.9	857	12,197	21.5
1979	12,048	19.9	773	12,858	21.2
1980	12,704	20.4	697	13,457	21.6
1981	12,206	20.3	553	12,834	21.3
1982	12,040	20.3	470	12,560	21.2
1983	12,753	21.4	428	13,255	22.2

* Including cases where type of birth was not known or was not stated.

Cause of death in children aged 1–4 years, inclusive

In 1983 for the first time the commonest cause of death was from congenital abnormalities. In view of the changing profile of deaths in young children a special table is provided which sets out the main causes of death for the period 1950–83 (Table 1.13). In 1950 infectious and parasitic disease was the commonest cause and accounted for 25.4% of all deaths in children aged 1–4 years. Since then the death rate from this condition has fallen dramatically and is now responsible for a much smaller proportion of the deaths in childhood. At the same time the overall death rate has fallen. There has also been a reduction in death rate for neoplasms (which has more than halved in the period), in diseases of the nervous system (which has again halved in the period), diseases of the respiratory system (which has come down to less than a seventh of its rate in 1950) and the digestive system (down to a seventh of its earlier rate). The two main causes of death in recent years of children in this age-group have been accidents and congenital malformations. The death rate from accidents has dropped in the 34 year period from 23.3 to 9.5 per 100,000 children. However, the death rate from congenital abnormalities has oscillated (partly due to random factors) and

Table 1.13 Main causes of death in the 1–4 year age group: numbers, rates per 100,000 population, 1950–1983, England and Wales

ICD Chapter		1950	1955	1960	1965	1970	1975	1980	1981	1982	1983
I	Infectious and parasitic diseases (001–139)	1,039	351	141	171	216	150	76	63	69	64
	Rate	34.3	13.3	5.0	5.2	6.7	5.3	3.3	2.7	2.8	2.6
II	All neoplasms (140–239)	352	382	301	322	278	193	139	143	139	123
	Rate	11.6	12.2	10.7	10.2	8.6	6.8	6.0	6.0	5.7	4.9
III	Endocrine, nutritional and metabolic diseases and immunity disorders (240–279)	57	41	48	58	63	44	39	39	35	43
	Rate	1.9	1.6	1.7	1.8	1.9	1.6	1.7	1.6	1.4	1.7
IV	Diseases of blood and blood-forming organs (280–289)	14	19	13	28	19	14	10	18	18	10
	Rate	0.5	0.7	0.5	0.9	0.6	0.5	0.4	0.8	0.7	0.4
V	Mental disorders (290–319)	38	23	25	24	6	7	—	5	1	4
	Rate	1.3	0.9	0.9	0.7	0.2	0.2	—	0.2	0.0	0.2
VI	Diseases of nervous system and sense organs (320–389)	240	173	209	187	164	134	98	108	113	97
	Rate	7.9	6.6	7.5	5.7	5.1	4.7	4.2	4.6	4.6	3.9
VII	Diseases of circulatory system, heart diseases (390–429)	..	..	..	..	33	32	29	31	28	26
	Rate	..	..	..	..	1.0	1.1	1.2	1.3	1.1	1.0
	Cerebrovascular disease (430–438)	..	..	..	..	6	8	6	3	5	10
	Rate	..	..	..	..	0.2	0.3	0.3	0.1	0.2	0.4
VIII	Diseases of the respiratory system (460–519)	877	523	559	610	433	264	172	168	159	107
	Rate	29.0	19.9	19.9	18.7	13.3	9.4	7.4	7.1	6.5	4.3
IX	Diseases of the digestive system (520–579)	315	200	176	180	58	26	41	35	29	37
	Rate	10.4	7.6	6.3	5.5	1.8	0.9	1.8	1.5	1.2	1.5

X	Diseases of the genitourinary system (580–629)	71	43	34	20	17	12	6	15	13	7
	Rate	2.3	1.6	1.2	0.6	0.5	0.4	0.3	0.6	0.5	0.3
XI	Complications of pregnancy, childbirth, puerperium (630–676)	—	—	—	—	—	—	—	—	—	—
	Rate	—	—	—	—	—	—	—	—	—	—
XII	Diseases of the skin and subcutaneous tissue (680–709)	9	6	4	4	4	7	1	3	1	—
	Rate	0.3	0.2	0.1	0.1	0.1	0.2	0.0	0.1	0.0	—
XIII	Diseases of the musculoskeletal system and connective tissue (710–739)	19	5	10	10	4	4	—	2	1	1
	Rate	0.6	0.2	0.4	0.3	0.1	0.1	—	0.1	0.0	0.0
XIV	Congenital anomalies (740–759)	284	340	353	326	372	319	226	237	213	241
	Rate	9.4	12.9	12.6	10.0	11.5	11.3	9.7	10.0	8.7	9.7
XV	Certain conditions originating in the perinatal period (760–779)	3	5	1	1	1	4	7	3	10	3
	Rate	0.1	0.2	0.0	0.0	0.0	0.1	0.3	0.1	0.4	0.1
XVI	Signs, symptoms and ill-defined conditions (780–799)	9	4	8	3	15	16	30	34	26	39
	Rate	0.3	0.2	0.3	0.1	0.5	0.6	1.3	1.4	1.1	1.6
XVII (pt)	External causes of injury and poisoning: Accidents (E800–E949)	706	540	509	653	584	420	275	241	240	238
	Rate	23.3	20.5	18.1	20.0	18.0	14.9	11.8	10.2	9.8	9.5
	Suicide (E950–E959)	—	—	—	—	—	—	—	—	—	—
	Rate	—	—	—	—	—	—	—	—	—	—
	Population (1–4 age group)	3,027.0	2,630.0	2,805.0	3,262.1	3,246.4	2,821.1	2,322.1	2,371.5	2,443.0	2,496.4

the rate in 1983 is slightly higher than that in 1950 — but not the highest that has been reported.

It is useful to examine the trend over time of deaths in this age-group, as this provides a background to consideration of the prevention and health care problems set by this pattern of mortality. It appears that accidents are responding to control measures, and if the trend continues, they should no longer appear as the major cause of death in this age-group. In contrast the congenital malformations stand out as the cause of interest that has oscillated but not shown any indication of a reduction over time.

Deaths from motor vehicle accidents

Because of the interest in the impact of seat belt legislation on injury and fatality from motor vehicle accidents Table 1.14 sets out the number and rate of deaths for persons aged 45–49 years, 55–59 years, and 65–69 years in England in the period 1971–83. Separate statistics are provided for fatalities to drivers, passengers, and pedestrians. As far as drivers are concerned, the lowest figures occur in 1983 with an overall reduction of 40.6% since 1971 in the age-groups examined. The changes for the passengers also show lower figures in 1983 (though as with the drivers, there is one figure in one age-group that is lower at an earlier period). However, the overall picture is of a reduction, but no greater a reduction than had occurred in previous periods; the decrease from 1982 to 1983 is 20.8%.

Table 1.14 Deaths and death rates (per million population) for motor vehicle accidents, for drivers, passengers and pedestrians, by various age-groups and years, England.

Driver		1971	1975	1979	1982	1983
Age-group						
45–49	No	109	67	75	84	69
	Rate	37.0	24.4	28.6	32.7	26.6
55–59	No	120	70	104	81	58
	Rate	42.7	27.6	35.5	30.5	22.2
65–69	No	69	57	65	54	50
	Rate	30.2	24.0	27.3	23.8	23.3
Passenger						
Age-group						
45–49	No	53	35	22	27	27
	Rate	18.0	12.8	8.4	10.5	10.4
55–59	No	60	37	39	32	28
	Rate	21.3	14.6	13.3	12.0	10.7
65–69	No	63	57	54	37	21
	Rate	27.6	24.0	22.6	16.3	9.8
Pedestrian						
Age-group						
45–49	No	76	78	55	46	48
	Rate	25.8	28.4	21.0	17.9	18.5
55–59	No	150	96	113	79	84
	Rate	53.3	37.9	38.5	29.7	32.1
65–69	No	266	189	151	103	103
	Rate	116.5	79.5	63.3	45.4	48.1

An important aspect of road fatalities is the toll to pedestrians, particularly with advancing age. In the age range examined the death rates for those aged 65–69 years are appreciably higher for pedestrians, than for drivers or passengers. The trend over time does not show any decreases in 1983 compared with 1982. Obviously one would not expect seat belt legislation to have a direct impact on risk to pedestrians, and presenting the data alongside that for drivers and passengers indicate the importance of the hazard to pedestrians.

A cluster of deaths in the Republic of Ireland from children burnt in cars, led to the suggestion that this might be associated with children playing in parked cars with cigarette lighters which are live, even with the ignition off.[6] A check was made for such deaths in England in 1981–1983; only two such deaths were identified. In 1982 a 1-year-old boy died following burns in a car that caught fire; in 1983 a girl aged two years was burnt in a parked car and subsequently died. No details of the specific cause of the fire were available, but these statistics (bearing in mind the relative size of Ireland and England) do not suggest the problem noted in Ireland has been of equivalent magnitude in this country.

Deaths from use of morphine type drugs

Table 1.15 shows the number of deaths by quarter from use of morphine type drugs and also poisoning by opiates and related narcotics in the period 1980–83. These deaths are monitored quarterly to check for any increases. The number of deaths rose in 1982 and were higher still for use of morphine type drugs in 1983. However, this was balanced by a slight reduction in deaths from poisoning by opiates, which had been higher in 1982. It must be remembered that the table is based on relatively small numbers of events, and the validity of the specific attribution to these drugs had not been assessed. However, the statistics do indicate a rise, which is in agreement with the more general comments that have been made in the recent past about the extension of this problem in the community.

Table 1.15 Number of deaths from dependent and non-dependent use of morphine type drugs and poisoning by opiates and related narcotics, by quarters. 1980–83, England and Wales.

Year	Quarter	Dependent use of morphine type drugs (304.0)	Non-dependent use of morphine type drugs (305.5)	Poisoning by opiates and related narcotics (965.0)
1980	March	9	—	22
	June	10	—	21
	September	12	—	18
	December	12	—	28
	TOTAL	43	—	89
1981	March	9	—	29
	June	7	—	20
	September	4	—	28
	December	9	1	30
	TOTAL	29	1	107
1982	March	12	2	26
	June	14	1	26
	September	11	—	39
	December	21	—	36
	TOTAL	58	3	127

1983	March	17	—	21
	June	17	1	34
	September	16	—	25
	December	14	—	26
	TOTAL	64	1	106

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[1] Office of Population Censuses and Surveys. Population Statistics Division. Population estimates 1961–81: a new series. *Population Trends* 1984; **35**:30–3.

[2] Office of Population Censuses and Surveys. *Final mid-1981 and revised mid-1971 to mid-1980 population estimates for the local government and health authority areas of England and Wales*, London: OPCS, 1984 (OPCS monitor; PP1 84/2). Footnote to table 1.1 on page 8.

[3] Office of Population Censuses and Surveys. *Revised mid-1981 population estimates for England and Wales and local government areas*. London: OPCS, 1983. (OPCS monitor; PP1 83/3), Footnote to table 1.5 on page 10.

[4] Bulusu L. Monitoring weekly deaths. *Population Trends* 1983; **34**:20–5.

[5] Office of Population Censuses and Surveys. *Cumulative percentage of the population developing cancer by age and sex: tables published in 1983*. London: OPCS, 1983. (OPCS cancer statistics; MB1 1978–1980:10–12),

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SOCIAL SECURITY

This chapter retains the format established last year and discusses a number of changes which have occurred in 1983 to those Social Security and War Pensions benefits which have a medical interest.

Statutory sick pay

From 6 April 1983, under the Social Security and Housing Benefits Act 1982[1], employers have become responsible for paying Statutory Sick Pay (SSP) to their employees for up to 8 weeks sickness in a tax year. SSP now replaces the employee's entitlement to State sickness benefit, which is not payable so long as any employer's liability remains. If the employee's incapacity for work continues after his eligibility for SSP ends, he will then be able to claim State sickness benefit.

Before SSP is payable there must be four or more consecutive days of sickness (including Sundays and public holidays). For SSP purposes a day of sickness is one during which the employee is incapable, because of a specific disease or disablement, of doing work he can reasonably be expected to do for his employer under his contract of service. Employers may require evidence to support a claim for SSP eg a self certificate for 4–7 days or, after 7 days, a doctor's statement.

The arrangement agreed with the medical profession, employers and trade unions is that it is for employers to monitor and control claims for SSP. They do not have any direct access to the Government's Regional Medical Services (RMS) but local offices of the DHSS may refer SSP claimants to the RMS in two circumstances:

(a) Where an employee has had at least 4 self-certified absences for periods of 4–7 days in a 12 month period special control procedures may be instigated by the Social Security local office after the fourth absence if requested by the employer. These will usually involve reference to the RMS for a second opinion on incapacity for work when the next (fifth) absence occurs. It is too early to have any reliable figures as to numbers referred to the RMS under this procedure.

(b) Where an employer refuses to pay SSP because he does not accept that the employee is incapable of work, and the employee asks the Insurance Officer (IO) to decide formally if SSP is payable, the IO may ask for reference to the RMS; to date these have been rare.

General medical practitioners and hospital doctors were informed of the changes so that statements and certificates of incapacity could be given in the knowledge that they would be required by the employer if SSP was involved. General practitioners have been given details of the control procedures. In addition the general practitioner is informed when one of his patients is referred to the RMS and he is asked by them for a report.

It had been estimated that new claims to State sickness benefit would fall by about four-fifths; over the first 9 months the fall has been 77%.

This has resulted in a reduction of 3342 posts in the Department's local offices.

Employers are not required to make returns of the number of spells of sickness for which SSP has been paid or of their duration or cause. Some time after the end of each financial year, employers' returns of the amounts of SSP they have deducted from remittances of national insurance contributions may enable some estimate to be made of the total number of days for which SSP was paid. Most of the incapacity statistics for short term sickness in the insured population will however no longer be available. Those which will be available will relate to special groups (see below), and so may not be representative of the workforce in general. For instance, data for the prevalence of influenza in the epidemic period (1st week in January lasting for 13 weeks) will be obtained from a smaller group of claimants, and therefore the Department will rely more heavily on the returns of the Royal College of General Practitioners and those of virological studies from the Central Public Health Laboratory, Colindale.

From what has been said above it is clear that the introduction of SSP has significantly changed the Department's monitoring of short term incapacity benefit claims levels. Traditional weekly collation of the intake of claims by local offices has ceased since it is no longer of statistical value. Some data on the incidence of sickness among employees will eventually be available from the Continuous Manpower Survey, but this will not include diagnosis.

The claim statistics are still derived from a 100% count of all claims received, but will not include incapacity in respect of any employed earner who has entitlement to SSP. The count covers claimants in the following categories:–

1. Those not covered for SSP eg self-employed people, unemployed people and some mariners.

2. Those whose SSP entitlement has been exhausted in the relevant tax year.

3. Those excluded from SSP for assorted other reasons:–
   - (a) Over age 65 (man) or over age 60 (women).
   - (b) Employed under contract of service for three months or less.
   - (c) Earnings below national insurance earnings level.
   - (d) Links with State benefit.
   - (e) No work done under contract of service.
   - (f) Sickness began during a trade dispute.
   - (g) Sickness during maternity disqualifying period.
   - (h) Sickness when abroad outside the European Community.
   - (i) Sickness when in legal custody.

War pensioners' mobility supplement

It was during the 1914 Great War that an attempt was made to ease the mobility problems of the war disabled. The double leg amputees and the

paraplegics who were not confined to bed could apply for invalid cars or hand propelled 3-wheeled vehicles — 'bath chairs' as they were affectionately called.

The British Red Cross fitted engines to some of those in 1921 and so began the age of powered vehicles for the disabled.

The 1946 National Health Service Act[2] enabled civilians also to benefit, so that in 1948 the Invalid Vehicle Scheme provided motor propelled as well as hand propelled cars, 3-wheeled and invalid chairs and carriages. To maintain the war pensioners' preference, it was decided that it was not essential for the war pensioner to be able to drive his own car; he could nominate another driver. The NHS applicants had to wait until 1964 for this concession, and even then it was made dependent on social circumstances.

Lady Sharp's report in 1974 on *Mobility of Physically Disabled People*[3] pointed the way to an altogether more flexible approach, and in 1975 the Mobility Allowance Scheme for civilians started. A cash allowance replaced the supply of chairs and cars and allowed the applicant to use it in whatever way was appropriate. To help those who wished to buy, rent or hire a car, Motability, a private limited company, was started, registered as a charity and given a Government grant to cover the costs of administration.

The civilian scheme proved to be a great success and the Government decided to alter the war pensioners' scheme to make it also less rigid. In the budget speech in 1983 the Chancellor announced:–

> "The Government intends to introduce more flexible provisions for war pensioners with mobility needs by introducing a cash mobility supplement in place of the existing vehicle scheme which will be progressively phased out. This supplement will be set at a rate £2.10 a week higher than the civilian mobility allowance (£18.30 a week at present), thus maintaining the traditional war pensioners' preference. Recipients of the new supplement will be able to choose how to provide for their mobility needs — they will be able to use this money to run a car, or to obtain greater mobility by other means. If they wish to run a car of their own they will be able to take advantage of the Motability leasing arrangements. About 11,000 war pensioners will be entitled to the new supplement. Of these, some 700 do not drive now. They are unable to benefit under the present arrangements, which provide a car or a cash sum for the upkeep of the pensioners' own car, but a cash allowance will help them. Details of the new scheme will be given in due course."

The war pensioners mobility scheme, a non-taxable cash allowance, was introduced on 21 November 1983. It is similar to the civilian allowance but payable at a higher rate and with no age restrictions. All war pensioners in receipt of private car maintenance allowance under the old War Pensioners Vehicle Scheme automatically switched to the new War Pensioners Mobility Supplement. Those who already have a car have the option of surrendering it or buying it and having automatic title to War Pensioners Mobility Supplement. If they wish to retain the car until it is beyond repair they may do so and then transfer to the new supplement.

In addition to those transferred from the War Pensioners Vehicle Scheme,

any war pensioner who falls into one of the following categories may be eligible:–

1. Double leg amputees with one leg amputated through or above the knee.

2. Those who are unable to walk, or for all practical purposes unable to walk, and likely to remain so for at least 12 months and whose locomotor difficulties are either wholly or mainly due to the pensioned disablement.

Many factors will be taken into account in deciding whether a pensioner is for all practical purposes unable to walk. The distance, speed, manner of walking and discomfort from walking, must all be considered.

Those who qualify for the War Pensioners Mobility Supplement should have a far wider choice when seeking greater mobility. Cars can be bought or hired or leased, and the good offices of Motability can be used to assist the pensioner to do this. Motability will also help to modify these cars if this is necessary. But if the pensioner prefers to travel by taxi or bus or train this too will now be possible and it is hoped that the new supplement will prove to be of even greater value to most pensioners than the scheme it replaces.

Industrial injuries

Abolition of injury benefit and introduction of Section 50A benefit

Before 6 April 1983, most people who were incapable of work because of an industrial accident or a prescribed disease could claim injury benefit. This was payable, for up to 26 weeks, without regard to a claimant's contribution record. Following recommendations made in the White Paper *Reform of the Industrial Injuries Scheme* (Cmnd 8402)[4], injury benefit was abolished with effect from 6 April 1983 and occupationally caused incapacity now attracts sickness benefit in the same way as incapacity from other causes.

Entitlement to sickness benefit, however, depends upon a claimant's contribution record. The White Paper recognized that there was a need to safeguard the position of people who would have qualified for injury benefit but who could not satisfy the contribution condition for sickness benefit eg married women who had elected not to pay full contributions and young people or part-time workers whose earnings were insufficient to incur a contribution liability. Accordingly, the Social Security and Housing Benefits Act 1982 which, inter alia, introduced statutory sick pay and abolished injury benefit, added a new sub-section (Section 50A) to the Social Security Act 1975.[5] This provides that, where the contribution conditions for the payment of standard rate sickness benefit are not satisfied, these conditions shall be treated as satisfied if incapacity for work is due to an industrial accident or a prescribed disease.

Under this provision, people with deficient contribution records can receive standard rate sickness benefit (followed by invalidity benefit after 28 weeks), so long as incapacity continues to be due to an industrial accident or a prescribed disease. The date of the relevant accident or the onset of the disease must be after 4 July 1948.

The revision of the Prescribed Diseases schedule

The Workmen's Compensation Act of 1906[6] was the first under which certain diseases were recognized as being due to the nature of employment, and in respect of which compensation could be paid. At that time 6 such diseases were listed. Between that date and July 1948, when responsibility for the payment of benefit passed under the National Insurance (Industrial Injuries) Act 1946[7] from employer to the State, many more diseases had been added to the list. This has continued since, so that by 1981 there were 51 diseases scheduled. Additions to the list had been made as conditions were recommended for scheduling, and the diseases were numbered accordingly.

In July 1978 the then Secretary of State for Social Services asked the Industrial Injuries Advisory Council "to consider in respect of the diseases prescribed in Part 1 of Schedule 1 to the Social Security (Industrial Injuries) (Prescribed Diseases) Regulations 1975 (S.I. 1975 No. 1537 as amended)[8] whether in the light of experience and of advances in knowledge, adjustments should be made in the terms of their prescription". Pressure for such an enquiry had come not only from within the United Kingdom, but also from the European Community (who in 1962 had published their own list) and from the International Labour Organization (ILO).

A sub-committee of the Council met on 20 occasions to study the question, considered 76 working papers and received evidence from 49 organizations and individuals. The Council made a number of recommendations which were printed in 1981 as Command Paper Number 8393.[9] The recommendations can be divided into 3 headings:

(a) that the schedule, as existing, should be restructured so that, instead of conditions merely having a number as they were added to the existing list, they should be divided on the basis of the causative agent into 4 categories with a letter and a number. The 4 categories are:

A. Diseases due to physical agents, eg occupational deafness;

B. Diseases due to biological agents, eg viral hepatitis;

C. Diseases due to chemical agents, eg occupational vitiligo; and

D. Miscellaneous (for diseases not readily falling into one of the other categories, eg non-infective dermatitis of external origin.)

Although pneumoconiosis and byssinosis were, strictly speaking, outside the terms of reference, the Council nevertheless recommended that the opportunity provided by the restructuring of the Schedule should be used to include them in Part 1 of the Schedule for the sake of completeness.

(b) that the description of certain diseases or the occupational cover prescribed in relation to them be altered in a number of cases. For example the old Prescribed Disease (PD) No. 7 — Decompression sickness — became the new PD No. A3 — Dysbarism, including decompression sickness, barotrauma and osteonecrosis. The old disease PD 45 — adenocarcinoma of the nasal cavity or associated air sinuses occurring in certain categories of wood workers — and PD 51 — carcinoma of the nasal cavity or associated air sinuses occurring in specific groups of persons working with leather or fibre-board — were amalga-

mated to become the new PD D6. For the sake of simplicity the restriction in the wood workers by which only nasal adenocarcinomas were covered was dropped and PD D6 covers all forms of carcinoma affecting the nasal cavity or associated air sinuses in both classes of worker.

(c) that there were a number of conditions which required in-depth study not suitable in the context of a general review of the Schedule, but to which the Council would direct their attention as the opportunity arose. Examples of such conditions were:

1. diseases due to ionizing radiation, including microwaves and lasers;
2. bladder cancer; and
3. extrinsic allergic alveolitis.

The Secretary of State subsequently announced the Government's acceptance of the recommendations. Regulations were duly laid and the revised Schedule came into operation on 3 October 1983. Coincidentally with the revision of the Schedule, 2 new diseases were added to the Schedule as from 3 October 1983. They were:

(a) PD C24(c) — Non-cirrhotic portal fibrosis in workers concerned with the polymerization of vinyl chloride monomer; and
(b) PD B9 — Infection by *Streptococcus suis* in persons whose work brings them into contact with pigs or pigs' carcases, products or residues infected by *Streptococcus suis*.

Occupational deafness

Also from 3 October 1983 the provisions of the occupational deafness (old PD 48; new PD A10) scheme were further extended. These changes affected both the definition of the condition and the occupational cover afforded.

The definition was altered by removing the word permanent so that it now reads "Substantial sensori-neural hearing loss amounting to at least 50 decibels in each ear, being due in the case of at least one ear to occupational noise, and being the average of pure tone losses measured by audiometry over the 1, 2 and 3 Kilohertz frequencies".

The following changes occurred in the occupational cover afforded by the scheme.

1. Two additional occupations were added to the scheduled list:
   a. the use of chain saws in forestry; and
   b. the use of a number of specified tools in wood working.

In addition, the cover provided by all but one of the previous scheduled occupations was extended so that not only those using certain tools, eg pneumatic percussive tools, but also those working wholly or mainly in the vicinity of such tools were within the Scheme.

2. The minimum period which must have been spent in working in one or more of the scheduled occupations was reduced from 20 years to 10 years, and

3. the period during which a claim must be made after leaving a scheduled employment was extended from one year to 5 years. However,

for those claiming under the new rules up to 2 October 1984, this period is further extended to allow claims if the claimant had worked in one of the listed occupations at any time after 8 October 1977.

Statistics

The state of the public health is to a certain extent reflected in the number of claims to medically related Social Security and other benefits. The following is a selection of relevant statistics for 1983.

Industrial injuries —	
Cases boarded in 1983	184,848
Attendance allowance —	
claims	
Initial claims	217,357
Renewal claims	50,551
Reviews	29,843
allowances in payment at 31.3.83 (estimated)	
Higher rate	177,000 (42.6%)
Lower rate	238,000 (57.4%)
War pensions —	
Cases boarded (including treatment examinations)	11,797
Mobility allowance —	
New claims received	121,960
Occupational respiratory disease —	
cases newly diagnosed by medical boards	
Coalworkers pneumoconiosis	402
Asbestosis	199
Pneumoconiosis in other industries	69
Byssinosis (cotton)	67
Byssinosis (flax)	5

In addition, 183 cases of occupational asthma were diagnosed during the year, attributed to:–

Isocyanates	74
Platinum salts	9
Hardening agents	12
Colophony fumes	24
Proteolytic enzymes	3
Animals and insects (mainly in laboratories)	7
Dusts arising from flour and grain	54
	183

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[1] *Social security and housing benefits act 1982.* London: HMSO, 1982. £4.80.

[2] *National health service act 1946.* London: HMSO, 1946.

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[4] Department of Health and Social Security. *Reform of the industrial injuries scheme.* London: HMSO, 1982. (Cmnd 8402).

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[6] *Workmen's compensation act 1906.* London: HMSO, 1906.

[7] *National insurance (industrial benefits) act 1946.* London: HMSO, 1946.

[8] *Social security (industrial injuries) (prescribed diseases) regulations 1975.* London: HMSO, 1975. (Statutory instruments; SI 1537).

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3

ENVIRONMENTAL HEALTH

CHEMICALS IN FOOD, CONSUMER PRODUCTS AND THE ENVIRONMENT

Food additives and contaminants

Sweeteners

The Committee on Toxicity of Chemicals in Food, Consumer Products and the Environment (COT), considered data on the safety of a number of artificial sweeteners. At the start of the year it conducted an extensive review of data on aspartame and concluded that this substance was safe for use in food, as a table top sweetener and in soft drinks. It was noted that aspartame was a source of dietary phenylalanine, and that its use would therefore have to be controlled or avoided by patients suffering from phenylketonuria. The Committee advised that this could best be ensured by informing those responsible for the care of patients with phenylketonuria about aspartame before any products containing this sweetener became available on the market. This was done by means of a letter sent from the Chief Medical Officer[1] to the relevant health care professionals and other interested individuals and organizations informing them about aspartame and the way in which products containing significant amounts of this sweetener could be identified.

Subsequently a number of questions were raised about the safety of aspartame. In particular it was alleged that consumption of aspartame might cause biochemical changes in the brain that could lead to alterations in mood or behaviour, that aspartame might cause harm to the fetus if consumed by pregnant women, and that asymptomatic carriers of phenylketonuria might be harmed by aspartame. The COT looked at existing data on aspartame in the light of these suggestions, and also considered new information as it became available. However, they did not consider that there was any evidence to support the suggestions which had been made, and they remained satisfied as to the safety of aspartame.

The COT also reviewed data on a number of bulk sweetening agents. These are all polyhydric alcohols (polyols) related to naturally occurring sugars and it was noted that polyols, like certain other carbohydrate constituents of normal foods, could cause flatulence and diarrhoea if taken in sufficient quantities. The Committee recommended that pharmacists and the medical community be informed so that they would be aware of the possibility of these untoward effects in patients consuming unusual amounts of bulk sweeteners. Following this recommendation, the Chief Medical Officer wrote to a number of medical and pharmaceutical journals and organisations about the laxative effects of bulk sweeteners, and this information has been widely publicized.

The COT and the Committee on Carcinogenicity have considered a new study on the effect of long-term feeding of saccharin in rats, which showed that large doses of saccharin fed during their entire lifetime caused an increased incidence of tumours of the urinary bladder in male rats. Similar results had been demonstrated previously in the second generation of exposed male rats. After reviewing this and other studies, together with epidemiological data, the Committee reaffirmed their view that the data did not demonstrate a health risk to man arising from anticipated consumption of saccharin in the diet, and that saccharin remained temporarily acceptable for use in food. However, they recommended that further studies should be performed to elucidate the mechanism of tumour formation in male rats and thus allow a better assessment of the relevance of animal studies to man. The Committees will review all new data and will re-evaluate saccharin at regular intervals.

Caffeine

The COT has completed its review by considering the teratogenicity and behavioural effects of caffeine and has advised that consumption of caffeine either as an additive or occurring naturally in beverages would not cause any risk to human health.

Nitrosamines

Analysis of the data on a feeding study on the effects of nitrosamines carried out by the British Industrial Biological Research Association under contract from the Ministry of Agriculture, Fisheries and Food was completed. This study employed an unusually large number of animals and dose levels with a view to determining a precise dose-response curve. The data were considered by the COT and the Committee on Carcinogenicity who concluded that the carcinogenic effects of nitrosamines had been demonstrated down to extremely low dose levels. There was evidence for differing sensitivity between species, and for increased sensitivity of young animals to the carcinogenic effects of nitrosamines.

Both Committees will shortly consider the implications of these conclusions for human health.

Metals in food

The COT, at the request of the Steering Group on Food Surveillance has considered the health implications of dietary levels of the following metals: aluminium, antimony, chromium, cobalt, indium, nickel, thallium and tin. It concluded that the levels reported were not a cause for concern but that more information was needed about the chemical forms of nickel in the diet. The Committee also noted that the levels of antimony reported in infants' diets, although not a cause for concern, were anomalous and recommended further studies. The Committee observed that the raised levels of metals found in dietary surveys in the neighbourhood of a smelter confirm the need for good culinary hygiene where there is a risk that vegetables have been exposed to airborne pollution.

Lead and tin in canned food: The recommendations of the COT and the Food Additives and Contaminants Committee following the Review of Metals in Canned Food are being implemented[2]. An extensive programme

of monitoring of canned foods for lead and tin has been initiated and monitoring of the diet continues.

Mercury: At the request of the Working Party on the Monitoring of Foodstuffs for Heavy Metals the relationship between the intake by man of methylmercury from fish and the concentration of mercury in whole blood has been studied. The results indicate that a regular intake of 1 microgram/day of methylmercury will produce an elevation in blood mercury of about 0.8 microgram/l and show that the relationship between intake and blood mercury concentration is linear over a wide range of intakes.

Cadmium: In its comments on the report *'Survey of Cadmium in Food'*[3] the COT asked for specific information on intakes of cadmium by special groups, especially children, and the absorption by man of cadmium from specific foods. The Working Party on the Monitoring of Foodstuffs for Heavy Metals is arranging for this information to be provided.

Comfrey

During January and February reports were received of 20 cases of illness related to drinking a tea made from comfrey. The implicated batch of comfrey, which was imported and distributed by a single firm, had been contaminated with belladonna. Action was taken to withdraw the suspect batch from sale, the health professions were alerted and a public warning issued. The Department was satisfied that the contamination occurred prior to importation of the comfrey and in a letter to relevant trade organizations drew the attention to the problem and urged increased vigilance.

Polychlorinated biphenyl residues

At the request of the Steering Group on Food Surveillance, the COT considered the report *'Polychlorinated Biphenyl (PCB) Residues in Food and Human Tissues'*[4]. PCB's are a group of chlorinated organic compounds which are widely dispersed throughout the environment as a result of previous use in a variety of applications, notably as heat transfer fluids in industrial plant and as the dielectric in capacitors and transformers. These compounds are environmentally stable and may accumulate in the food chain. There are reports from overseas of toxic effects occurring in humans due to consumption of food which had been contaminated with high levels of PCBs. All manufacture and most uses of PCBs in the UK are now prohibited, and since 1972, steps have been taken to limit their dispersal into the environment. However, there are a number of transformers and capacitors utilizing PCBs as the dielectric still in use. The Steering Group on Food Surveillance has assessed dietary exposure to PCBs by measuring PCB levels in a wide range of foods, in materials which come into contact with food, and in human tissues.

PCB residues were detected in human fat and in breast milk. Levels in fat, on average, were less than 1mg/kg and average levels in breast milk were 18 micrograms per kg of milk. These tissue and milk levels were lower than those reported from overseas, including other European countries and the USA. The COT noted that the average intake of PCBs from food is low, being no greater than 40 micrograms per day and probably below 10

micrograms per day, while the average intake of PCBs by breast-fed babies would be around 15 micrograms a day. These levels were substantially below the levels assessed as being toxic in episodes of human poisoning or in animal experiments, and the Committee concluded that the PCB content of the average national diet is unlikely to constitute a health hazard. The COT endorsed the view of the Steering Group on Food Surveillance that monitoring of foodstuffs and some environmental sites for PCB residues should continue, and recommended that further information should be obtained on the PCB intake of certain sub-groups in the general population, particularly those pregnant and lactating mothers who consume large amounts of fish, and that the levels of PCBs in the breast milk of such mothers should be monitored. In addition every effort should be made to avoid accidental contamination of the food chain arising from the use of PCBs.

In the USA monitoring for PCBs revealed residues in Czechoslovakian canned ham which led the United States Government to ban its importation. The Standing Veterinary Committee of the Commission of the European Communities consequently advised Member States to monitor Czechoslovakian canned meat products for PCB residues. Monitoring is now under way in the UK.

Veterinary product residues in food

Following an incident in France in 1980 involving the illegal use of a stilbene, (a synthetic hormone) for growth promotion in calves, there was public concern in the European Community about the use of anabolic growth promoters for fattening cattle to be slaughtered for human consumption, because of the possibility of adverse effects from any residues in the meat. The European Community adopted a Directive banning the use of stilbenes and requiring further examination of three natural and two synthetic hormone growth promoters by a Commission Scientific Working Party. Following the publication of the first report of the Working Party[5], the UK Licensing Authority for Veterinary Products asked the three relevant DHSS Advisory Committees to consider this report and any additional data available on the toxicity of residues of these hormones in meat for human consumption. The final co-ordinated report from the three Advisory Committees is expected shortly. The European Commission's Working Party is also considering further data and is expected to report in 1984.

Irradiated and novel foods

The Advisory Committee on Irradiated and Novel Foods (ACINF) has been considering evidence and evaluating data on food irradiation during 1983. The Committee has referred certain questions concerning the toxicological, microbiological and nutritional aspects of food irradiation to the appropriate specialist committees, and these committees will be reporting back to enable ACINF to complete its review of food irradiation. The Committee is expected to report to Ministers in the summer of 1984.

During 1983 ACINF prepared guidelines on the testing of novel foods which were sent to selected industrial and research organizations for comment at the end of the year.

Consumer products for internal use or consumption

The COT is regularly asked to advise on the safety of particular consumer products, with specific reference to the safety of chemicals contained in these products. In 1983 the Committee expressed concern at what it considered to be an undesirable anomaly in the current regulatory position regarding certain consumer products intended for internal use or consumption. Examples of these products are: sanitary tampons, certain vaginal douche preparations, and *'Orobronze'* sun-tan capsules. The Committee felt that the safety standards required for these products should be the same as those employed for medicines, food additives and cosmetics. However, they noted that present legislation allows such products to be marketed without prior assessment of safety, and action can only be taken if there is positive evidence that they are not safe. On the other hand medicines, food additives and cosmetics have to be assessed for safety before they, or products containing them, can be allowed on the market, and permission to use them would not be given if there were inadequate information on which to judge their safety.

While the Committee did not consider that any immediate health hazard appeared to be present as a result of the use of these types of consumer product, they did advise that such products should be subject to safety assessment prior to marketing. At present there is a voluntary arrangement which allows prior assessment of new sanitary tampons, but Government is now considering whether it is necessary to take further action on all similar products in order to remove the anomaly identified by the COT.

The Environment

Lead

The 9th Report of the Royal Commission on Environmental Pollution entitled *'Lead in the Environment'* was published in April 1983[6]. The Report reviewed the implications of lead as an environmental pollutant and its pathways in the environment and made recommendations covering all the sources of exposure including air, water, paint, food and drink. It commended the action already taken by Government and recommended further action in certain areas, including the reduction in the lead solvency of certain drinking waters, with the setting of target dates for surveys and any necessary treatment. It also recommended a progressive reduction in the lead level of new household paints, more publicity about the hazards of old leaded paint and how to avoid them; and a tightening up on emissions from lead processing works. In an important recommendation on the future policy on lead levels in petrol the Report endorsed the Government's decision to reduce the maximum permitted level from 0.4 to 0.15g/l by the end of 1985 and recommended that this should be regarded as an intermediate stage in the phasing out of lead additives altogether. The Secretary of State for the Environment announced that the Government had accepted the Royal Commission's recommendations on lead in petrol and aims to achieve the introduction of unleaded petrol by 1990. In a subsequent publication[7] the Department of the Environment set out the Government Response to the Report as a whole.

Nitrate in drinking water

A study of the nitrate levels in surface waters and groundwaters in the UK was undertaken for the Joint National Water Council and Department of the Environment's Standing Technical Advisory Committee on Water Quality, and the Royal Society has conducted an extensive analysis of the nitrogen cycle in the UK[8]. Both studies make it clear that factors such as changes in agricultural practice have led to increased levels of nitrate in these source waters. In some areas, the levels of nitrate in drinking water also have increased over recent years; the highest levels are found in East Anglia, Lincolnshire and Staffordshire. The question of the possible health risks of nitrate in drinking water has therefore been reviewed by the Joint DOE/DHSS Committee on Medical Aspects of Water Quality. Previously advice had been based on the well-established fact that an excessive amount of nitrate in water supplies may cause the rare condition of infantile methaemoglobinaemia. The Committee was aware that there had been no notified instances of this condition attributable to nitrate in water supplies since the advice was issued in 1976, and it considered that the advice should remain unaltered in this respect.

The Committee also reviewed the world-wide epidemiological studies of exposure to nitrate in relation to cancer (in particular, gastric cancer). As is the case in many countries, gastric cancer has become less common in the UK in recent years. Furthermore, the pattern of gastric cancer in England and Wales does not match the pattern of the levels of nitrate in water. For these reasons, and after evaluation of the other epidemiological evidence, the Committee concluded that the levels of nitrate in publicly supplied water in the UK do not constitute a significant cancer risk. Recognizing, however, that there is a plausible biochemical pathway by which nitrate ingestion and cancer could be related, the Committee's statement went on to recommend the continued restriction of nitrate levels in water, and to indicate that the matter would remain under review.

The Committee advised that water undertakings should aim to keep concentrations of nitrate ion below 50 mg/l and that 100 mg/l should not be exceeded, other than in exceptional and transient conditions; where 50 mg/l is exceeded the health authority should be informed and if 100 mg/l is exceeded at any time, suitable low nitrate water should be provided for infant feeding.

Asbestos

A review of recent evidence on the effects on health of asbestos, by Professor E D Acheson and Dr M J Gardner of the MRC Environmental Epidemiology Unit, updating an earlier report[9] was published by the Health and Safety Commission in August 1983[10]. Although the report dealt with evidence from occupational exposure and was made to the Commission, it is on evidence about asbestos-related disease in workers that policy for the protection of the general public must be based. The authors' central conclusion was that, with more studies completed, the range of estimates of the risk of lung cancer had increased, some studies reporting higher rates and some lower than had previously been reported. They concluded that amosite ('brown asbestos') in addition to crocidolite ('blue asbestos') must now be accepted as more dangerous than chrysotile ('white asbestos') and

that mesothelioma has only rarely occurred in relation to exposure to chrysotile alone; they noted that chrysotile is for practical purposes the only type of raw asbestos now imported. Finally they concluded that the evidence that asbestos fibre causes alimentary tract cancer in man is less convincing than before. They recommended further improvements in the control of asbestos and restrictions in its use, with the substitution of safer materials as these become available. The Health and Safety Commission has since decided on further reductions in the limits for airborne asbestos in the workplace to take effect from 1 August 1984. The Commission is recommending a total ban on the import and use of brown and blue asbestos or products containing them and regulations are being prepared to tighten further safety measures in industry. Not only will these measures benefit workers in the asbestos industries but some of them will help to achieve a further reduction in the already very low exposure of the general public.

During the latter part of the year the Department of the Environment issued advice to local authorities[11] and the general public[12] on the identification and use of asbestos and on precautions that should be taken. Any problem is from asbestos dust in the air and not from asbestos materials as such. There is unlikely to be any appreciable risk to the public from asbestos in buildings or the home, unless asbestos materials are damaged and release fibrous dust. Surveys have shown that amounts of asbestos dust in the air are generally so low as to be undetectable by the most sensitive measurement techniques available, even close to asbestos materials in poor condition. Nevertheless it is prudent to take all reasonable steps to reduce the possibility of exposure to asbestos dust to a minimum. In many circumstances asbestos materials are best left in place but sealed or covered if necessary. Where they are liable to damage it may be advisable to replace them, using stringent precautions in the removal and disposal of the asbestos. More detailed advice is available from the environmental health department of the local authorities.

Radiation

Following the Yorkshire Television programme which suggested an increased incidence in cancer in the area around the nuclear reprocessing plant at Sellafield, Cumbria, and particularly in the nearest village to the plant, Seascale, the Secretary of State for Social Services asked Sir Douglas Black, former President of the Royal College of Physicians, to head an inquiry. Sir Douglas invited a team of six experts in relevant fields to assist him with the inquiry, and the Group held their first meeting in November 1983. Oral and written evidence has been taken from many people, including Yorkshire Television, the Department of the Environment, British Nuclear Fuels PLC, the National Radiological Protection Board, the Local Health Authorities, Greenpeace, Political Ecology Research Group, and those involved in running cancer registries.

In November 1983 British Nuclear Fuels PLC reported that an abnormal level of radioactive contamination had been detected on the beaches adjacent to Sellafield following a notified accidental transfer of certain liquid radioactive waste to the low level effluent storage and discharge system during the annual shutdown of the reprocessing plant. Between 500 and 4500 curies, mainly of the radioisotope ruthenium–106 in a mixture of water,

solvent and some solid material was discharged to sea. Subsequently, British Nuclear Fuels PLC reported that beach monitoring had detected occasional pieces of debris contaminated with radioactivity at variable levels that theoretically could result in the International Commission on Radiological Protection's recommended dose limit for members of the public for irradiation of the skin being exceeded, if one of the items were held in intimate contact with the skin for a period of between 15 minutes and several hours, depending on the level of radioactivity. Although the probability of this happening was felt to be low, the Department of the Environment advised the public not to use the beaches unnecessarily for the time being.

Since November, this Department, in close collaboration with the Department of the Environment and the National Radiological Protection Board, has been kept aware of the results of monitoring of the beaches carried out by the British Nuclear Fuels PLC, with check monitoring by the Department of the Environment and the Ministry of Agriculture, Fisheries and Food. It is likely that any risk to the public of increased exposure to radiation from the accident is small. Steps have subsequently been taken to remove contaminated material from the beach and monitoring continues.

Good laboratory practice

There is increasing interest in the need to ensure that data generated for the assessment of the safety or potential toxicity of chemicals are accurate and reliable, and acceptable for international use. The Organization for Economic Co-operation and Development (OECD) has drawn up guidelines for good laboratory practice (GLP). These specify the criteria for the proper conduct of studies by testing laboratories, and also for a competent national authority's monitoring of these laboratories by inspections and study audits, to ensure compliance with GLP[13].

From 1 April 1983 the Department has had the responsibility for monitoring compliance with GLP of the UK laboratories involved in the pre-clinical testing of pharmaceutical products and cosmetics. The GLP guidelines adopted by the DHSS[14] are based on those of the OECD. A number of laboratory inspections have been carried out in 1983.

The DHSS is co-operating with the Health and Safety Executive which has responsibility for monitoring for GLP compliance in respect of data generated on certain industrial chemicals covered by the EEC 6th Amendment Directive[15]. The two organizations have an arrangement for reciprocal acceptance of inspection reports which avoids the need for duplicate inspections. It is also the intention of DHSS to conclude agreements with GLP monitoring authorities in other countries for reciprocal acceptance of guidelines and procedures, thus allowing for the mutual acceptance of data and avoiding the need for UK laboratories to be subject to multiple inspections. An initial agreement between the Governments of the United Kingdom and Japan regarding GLP monitoring of laboratories generating data on pharmaceuticals has been signed.

Discussions are continuing on the form of a comprehensive Inspectorate for GLP monitoring in the UK. A decision is expected in 1984.

Training of toxicologists

A Departmental Working Group comprising representatives from academic bodies, research organizations and industry has been considering the requirements for training of toxicologists in the UK. It concluded that the principal need is for postgraduate training, both in general toxicology and in certain specialist disciplines in which there is currently a shortage of suitably qualified staff. However, the Group also recommended that toxicology be included in the undergraduate medical curriculum, and the Department has accordingly approached the General Medical Council on this issue. Furthermore, it was recognized that advancement of the science of toxicology required an improved academic base — and the Department has asked the University Grants Committee and the Medical Research Council to give consideration to toxicology when funding new lectureships. It was suggested that the possibility be explored of providing training by secondment of toxicologists, among industry, academic bodies and Government. It is hoped that the report of the Working Group will be available in 1984.

DHSS Toxicology Unit

During 1983 the Department concluded negotiations with St Bartholomew's Hospital Medical School and the University of London, whereby the DHSS Toxicology Unit at St Bartholomew's Hospital will become a Department of Toxicology within the Medical School, and its Director will be appointed as Professor of Toxicology. It is anticipated that these changes will come into effect early in 1984. The DHSS Department of Toxicology will continue to carry out research on toxicological problems for Government, and to provide training for Departmental staff.

International work

Many international organizations are active in the field of chemical contamination of the environment, including human health aspects.

The Commission of the European Communities is proposing an increasing number of Directives, which provide both a uniform framework for the abatement of pollution and limits for some individual substances.

Extensive negotiations are undertaken by the Commission with the Member States to ensure that the measures adopted are appropriate in economic as well as environmental terms and that well-proven existing procedures for the abatement of pollution are not unnecessarily disturbed. Departmental advice is given to the British representatives in the negotiations and to the parliamentary committees which scrutinize the Commission's proposals.

Following the signing of an agreement with the WHO/UNEP/ILO's International Programme on Chemical Safety (IPCS) in 1982, the Department, in consultation with the Ministry of Agriculture, Fisheries and Food, Department of the Environment and the Health and Safety Executive, has sponsored several IPCS activities in 1983, including updating principles of methodology for testing and assessing chemicals in food for the WHO/FAO Joint Expert Committee on Food Additives and Contaminants; evaluating health risks from chemicals during infancy and childhood; a collaborative study on short-term tests; and monitoring in a human population for genetic effects.

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4

COMMUNICABLE DISEASES

This chapter reports the events relating to communicable diseases which particularly affected the public health during 1983. A section on general vaccination policy is supplemented by the inclusion of immunization issues with the individual diseases. The report on food poisoning and microbial contamination of food introduces statistics derived from data collected by the Office of Population Censuses and Surveys (OPCS) and by the Public Health Laboratory Service Communicable Disease Surveillance Centre (CDSC). Following a review of the central food poisoning data collection systems, SBL 640 returns will no longer be requested from local authorities.

Acquired immune deficiency syndrome ('AIDS')*

The USA Center for Disease Control criteria for identification of AIDS was fulfilled for 31 cases (16 deaths) reported to the Communicable Diseases Surveillance Centre from February 1982 (first case formally reported in UK) to 31 December 1983.

Twenty-five cases occurred in homosexual or bisexual men, one of whom was also an intravenous drug abuser. There were two cases in heterosexual men whose risk factors were inapparent. Two further male cases occurred in patients with haemophilia A treated with imported American factor VIII concentrate. The two female cases had travelled widely in Central Africa. Death occurred in 3 of the 11 patients with Kaposi's sarcoma, 8 of the 10 patients with *Pneumocystis carinii* pneumonia and 4 of the 9 patients with other opportunistic infections including a Zambian patient who had cerebral toxoplasmosis. A further death occurred in a white female patient who had Kaposi's sarcoma and *Pneumocystis carinii* pneumonia.

The Advisory Committee on Dangerous Pathogens was asked to consider the problem of AIDS in relation to work in pathology laboratories where specimens of tissue, blood and body fluids are received from patients suspected of or suffering from AIDS. Guidelines will be prepared on the procedures to be observed in obtaining and testing samples from patients.

AIDS and the UK blood donor

The Department in conjunction with Regional Transfusion Directors, has issued a leaflet 'AIDS and how it concerns blood donors' which asks people from high risk groups (eg persons with symptoms and signs suggestive of AIDS; sexually active homosexual or bisexual men with multiple partners; intravenous drug abusers) to refrain from giving blood. The leaflet has been distributed in blood transfusion centres and sexually transmitted disease clinics.

AIDS and the general public

Expert opinion suggests that there is no risk of contracting AIDS as a result of casual or social contact with AIDS patients eg on public transport, in

* See also Chapter 5, p 56.

restaurants, or in private dwellings. The spread of AIDS appears to require intimate contact.

UK research

The Medical Research Council (MRC) set up an AIDS Working Party in October 1983 with the aims of reviewing the relevant scientific information and research world-wide, encouraging co-operation between researchers and to advise the MRC (and indirectly the Department) on research matters. The MRC Working Party is the Department's main source of information concerning European and World Health Organization AIDS research initiatives.

The initial research emphasis has been upon the biomedical and epidemiological understanding of the disease.

Cholera

The first death ascribed to cholera in England since 1909 occurred from the 5 cases, all adult male, notified in England in 1983. The patient who died was 64 years old and had visited Hong Kong and the Philippines. The other patients had visited either the Indian subcontinent or South East Asia.

In all cases *Vibrio cholerae* 01 biotype eltor was isolated from the faeces.

Haemolytic uraemic syndrome (HUS)

HUS is a rare disease of young children first described in 1955, and characterized by microangiopathological haemolytic anaemia, acute nephropathy and thrombocytopenia. The fatality rate is approximately 6–10%. Renal failure is common, often requiring dialysis. The syndrome is usually preceded by a prodromal gastrointestinal illness which is often associated with a bloody diarrhoea. In previous years about 12–20 cases of HUS have been identified annually but in 1983 43 cases were reported to the joint British Paediatric Association (BPA)/CDSC Surveillance Scheme, 20 of these occurred in an outbreak in the West Midlands.

Although the cause of HUS is unknown, both viral and bacterial pathogens have been associated with the illness. Recently Vero-toxin producing *Escherichia coli* 0157 H 7 has been isolated from sporadic cases of HUS in children. This rare serotype, which is associated with haemorrhagic colitis, was isolated from cases in Canada and from three of the cases in this country.

Influenza

There were above average rates of clinical influenza reported in the first quarter of 1983 to the Royal College of General Practitioners Research Unit and several outbreaks occurred in boarding schools, residential accommodation for the elderly and hospitals. However, the overall prevalence remained fairly low throughout the winter of 1982 and the spring of 1983 and this was reflected in data on respiratory deaths and deaths from all causes.

Identifications of Influenza A virus, were more numerous than for several years, with a peak in early March. H_3N_2 subtype predominated; most strains

were intermediate, cross-reacting viruses closely related to A/Bangkok/1/79 and A/Texas/1/77, but some resembled A/Philippines/2/82, thus showing antigenic drift. H_1N_1 subtype was much less common and Influenza B viruses were seldom identified.

Malaria:

Notifications of imported malaria in England and Wales showed a downward trend until the middle of the year followed by a sustained increase. The Malarial Reference Laboratory received reports on 1711 cases and 7 deaths compared with 1471 cases and 9 deaths in 1982.

During the summer of 1983 three adult patients who had not visited endemic areas developed falciparum malaria. One patient had visited Rome and was found to have malaria on returning to London. The other two patients lived in Sussex near an international airport and one of these had not been abroad for two years. There was no history of transfusions or injections in any of these patients.

Climatic conditions in this country normally make it impossible for indigenous anopheline mosquitoes to transmit *Plasmodium falciparum* and it is postulated that infected mosquitoes must have arrived with passengers from endemic areas. Such events have also been recorded in other European countries (Belgium, France, the Netherlands and Switzerland) but are exceedingly rare, particularly in view of the volume of international air traffic.

Measles

Since the introduction of immunization against measles in 1968, the biennial epidemic cycle of measles has become less obvious. The fall in incidence in 1976 was followed by two years of higher incidence in 1977 and 1978. Following a record low level of notifications in 1981, this pattern was repeated with two years of higher incidence in 1982 and 1983 (Table 4.1).

Weekly notifications increased from about 2,000 at the beginning of the year to a peak of 4,233 cases during the week-ending 15 April and then averaged 3,000 until August when the numbers rapidly decreased. During the last four months of the year there were 400–800 cases a week.

Table 4.1 Measles: Corrected notifications, deaths and fatality ratios. England and Wales 1976–1983

Year	Corrected notifications	Deaths	Fatality ratio
1976	55,502	14	0.03
1977	173,361	23	0.01
1978	124,067	20	0.02
1979	77,363	17	0.02
1980	139,487	26	0.02
1981	52,979	15	0.03
1982	94,195	13	0.01
1983	103,700*	16	0.02

* Provisional
Source: OPCS

Paratyphoid B

The CDSC identified 5 patients with paratyphoid B phage type 3A VAR4 infection in 1983. Only 39 patients in the UK have been identified as having had infection from this uncommon phage type since 1978 and nearly all (36) became ill after holidays at or near Burgau in Portugal. The remaining 3 had also visited Burgau but may have been secondary cases within families.

Of the 34 primary cases associated with Burgau in the period 1980–83, 25 gave a history with a definite association with a particular cafe-restaurant there. The WHO and the Portuguese Health Authorities have been informed. Investigations have not uncovered the source of infection. It is possible that the apparent association with the restaurant may be misleading and it is thought that the majority of visitors to Burgau would eat or drink there at one time or another. It is, however, the fourth consecutive year that paratyphoid B of this otherwise very uncommon phage type has been reported from this part of Portugal.

Poliomyelitis

During the year four cases of paralytic poliomyelitis were reported, two in patients who acquired their infection abroad and two associated with oral poliovaccine. The first of the vaccine-associated cases was in a three-month old child who developed paralysis after receiving his first dose of oral poliovaccine. The second case occurred in a 54 year-old man who developed a paralytic illness after contact with his recently vaccinated granddaughter.

Rubella

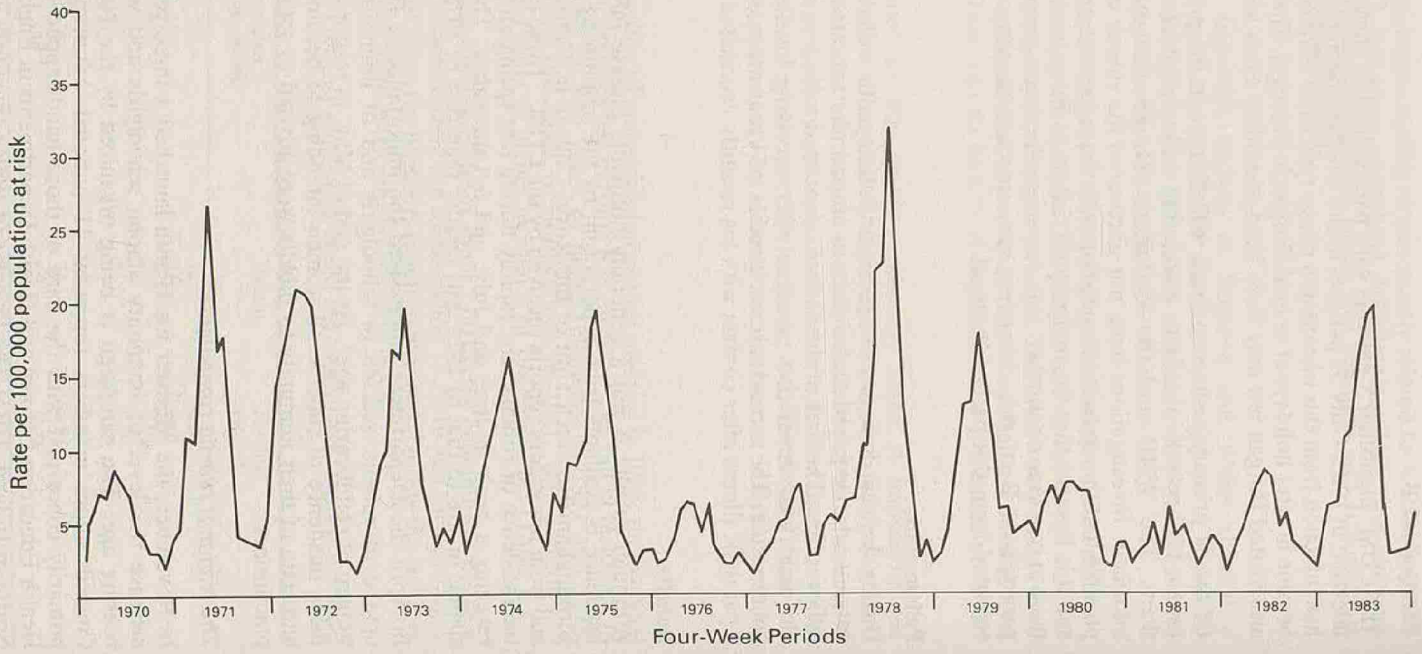
Although rubella is not a generally notifiable disease information on its incidence is available from reports sent by the monitoring practices to the Birmingham Research Unit of the Royal College of General Practitioners and from laboratory reports received by the CDSC. These data showed that the incidence of rubella rose rapidly during late spring and early summer, reaching a peak in June and July, and fell thereafter. The outbreak was similar in size to that of 1979, but smaller than that of 1978 (Figure 4.1).

In April the Department emphasized the importance of achieving a 95% uptake of rubella vaccine in schoolgirls and of immunizing susceptible women of childbearing age[1]. At the end of May, in response to the rapidly rising incidence of rubella, all women intending to become pregnant and uncertain of their immunity to rubella were advised to consult their family practitioner[2].

The National rubella campaign

In November, the Minister for Health launched a three year campaign to increase the level of immunity among schoolgirls and women of child bearing age. The campaign is being organized by the National Rubella Council whose members represent 11 national voluntary organizations primarily concerned with the care of those handicapped by rubella, the Health Education Council and Health Departments in England, Wales and Northern Ireland. HRH The Princess of Wales graciously agreed to be the Patron of the National Rubella Council.

Figure 4.1:
Rubella - Diagnosed in Monitoring Practices Reporting to the Birmingham Research Unit of the Royal College of General Practitioners



A package of publicity material was designed for the campaign, including a personal record card for those who were immunized or had a positive rubella serological test. General medical practitioners and health authorities were asked to co-operate in the campaign by facilitating local publicity activities and by intensifying their immunization programme from January 1984. The campaign is being monitored through statistics collected centrally for the School Health Immunization Programme and information from the Public Health Laboratory Service on the demand for serological testing. The effectiveness of the campaign will be further assessed by a number of other studies[3,4].

Streptobacillary fever

In February 1983 an outbreak of streptobacillary fever, which is a most unusual event, occurred in a school for girls, mainly boarders. Out of a total population of 700 pupils and staff, 234 were affected. *Streptobacillus moniliformis*, an organism whose reservoir host is the rat, was isolated from blood cultures. An epidemiological association was demonstrated between development of the illness and consumption of cold water. The organism was not, however, isolated from water supplies. There were no deaths and all patients recovered without the cardiac complications noted in some previous incidents.

Tuberculosis

Mortality

Deaths in England from all forms of tuberculosis in 1982 were 692 compared with 701 in 1981. Deaths from respiratory tuberculosis were 420 in 1982 compared with 394 for the previous year. Provisional figures for 1983 are 639 (all forms).

Morbidity

In 1982 notifications of all forms of tuberculosis in England totalled 7,226 as against 7,803 in 1981, a decrease of 577. The figure for 1983 is 6,685. Notification rates per 100,000 population for 1982 were as follows, all forms 15.1, respiratory 11.8. The total number of smear positive cases recorded in 1982 was 2,214 compared with 2,178 in the previous year.

BCG vaccination

During 1982, 627,665 school children were tuberculin tested: 557,289 were found to be negative and of these 547,073 were vaccinated with BCG.

Typhoid

At the end of July 1983 the CDSC identified an association between several cases of typhoid occurring in this country and a hotel on the Greek island of Kos. The particular degraded Vi-strain (22) of *Salmonella typhi* isolated from the patients has been identified in only three other instances: from a patient with typhoid fever in Athens (1972) and from two patients who developed the illness after a holiday at the same hotel in Kos, a Swedish national (November 1981) and a Finnish national (April 1982). The Greek health authorities and the WHO were informed. Epidemiological informa-

tion on the UK cases was forwarded to the Greek health authorities. Other countries also reported cases amongst their nationals who had stayed at the hotel in late June and early July. A total of 58 cases was reported in this outbreak, 32 of them UK citizens, 10 Finnish, six Swedish, five Norwegian, two Dutch, one Danish, one Belgian and the 11-year old daughter of the Greek hotel owner.

Investigation by the Greek authorities revealed two possible sources, both asymptomatic carriers of the same phage type. The first was a waiter who had belonged to the hotel staff since 1981 and also used to help in the kitchen for salad preparation, the other a member of the kitchen staff since 1979 who mainly did the washing up but also sometimes assisted in food preparation.

No other cases of typhoid fever were reported from Greece during 1983.

Viral hepatitis

Epidemiological data for monitoring viral hepatitis in England and Wales are derived from notifications of infective jaundice, laboratory reports of hepatitis A and B, and hospital in-patient data relating to viral hepatitis.

Hepatitis A

Variations in the number of notifications of infective jaundice mainly reflect changes in hepatitis A incidence and in 1983 there were 6,383 patients notified compared with 10,602 in 1982. No outbreaks of hepatitis A associated with shellfish were reported during the year, which may account for part of this fall in number. An outbreak of hepatitis A reported in five sewage sludge spreaders introduced a slightly disturbing element into the generally reassuring picture.

Hepatitis B

In 1983 the provisional number of overt cases of acute hepatitis B identified in the United Kingdom (excluding Scotland) was 1,239. The corrected figures for the two previous years are 1,223 in 1981 and 1,249 in 1982 — thus the yearly figures are remaining very much the same. These numbers are from laboratory reports received at the Public Health Laboratory Service (PHLS) which is currently carrying out a five year analysis of acute hepatitis B laboratory reports. A full report will be available from the PHLS in due course.

Whooping cough

During 1983 the most recent epidemic of whooping cough came to an end, although over 19,000 cases of whooping cough were notified in England and Wales with four deaths. Weekly notifications fell from 900 at the beginning of January to 500 at the end of March. Towards the end of the year notifications fell still further to an inter-epidemic level of 100 to 200 per week. The next epidemic rise in whooping cough is expected to occur in the latter half of 1985.

Vaccination and immunization

Table 4.2 Number of children under the age of 16 years completing primary courses of vaccination. (Percentage of children vaccinated before three years of age shown in parentheses), England, 1974–1982.

Year	Diphtheria	Whooping cough	Tetanus	Poliomyelitis	Measles
1974	520,620(83)	428,300(80)	549,600(83)	525,600(82)	348,300(56)
1975	478,960(81)	247,900(78)	499,200(82)	481,500(81)	310,200(55)
1976	487,830(77)	240,600(61)	510,230(77)	495,600(77)	323,650(50)
1977	490,928(78)	191,899(39)	513,116(78)	515,575(77)	304,885(51)
1978	505,987(80)	199,389(41)	524,403(80)	518,829(80)	302,075(52)
1979	528,568(81)	250,250(31)	543,712(81)	533,616(81)	331,700(51)
1980	545,855(82)	285,561(35)	560,194(82)	549,729(82)	351,618(54)
1981	552,198(83)	320,496(46)	564,362(83)	554,481(83)	368,512(55)
1982	558,139(84)	384,827(53)	572,692(84)	562,826(84)	390,715(58)

Table 4.2 shows that the improvement in uptake of immunization which was noted in this Report for 1982 (p. 56) has continued, particularly the increase in acceptance of whooping cough vaccine.

Valuable assistance was given on many immunization matters to the DHSS by the Joint Committee on Vaccination and Immunization (JCVI), and the Joint Committee on Safety of Medicines/JCVI Sub-Committee on Adverse Reactions to Vaccines and Immunological Products.

Food poisoning and microbial contamination of food

Tables 4.3 and 4.4 are based on returns for 1982 made by English local authorities on form SBL640 to DHSS. They are derived from cases of food poisoning and suspected food poisoning notified by medical practitioners, and from other cases ascertained during the investigation of food poisoning incidents. Table 4.4 gives those cases which were associated with general outbreaks of which the source was outside England. Table 4.5 gives cases ascertained during the investigation of non-foodborne Salmonellosis. In all tables the corresponding figures for 1981 are given in parentheses.

Tables 4.3 shows that in 1982 there were 1,288 more cases of food poisoning originating from sources in England than were reported in 1981; this was due to a large increase in sporadic cases. There was a small increase in the number of general outbreaks but a reduction in the number of associated cases; household outbreaks increased by nearly 14% but the associated cases increased by only just over 10%. Outbreaks and cases due to *Salmonella hadar* continued to decrease, but outbreaks and cases due to *Salmonella typhimurium* showed a considerable increase. There was little overall change in the total of outbreaks and cases due to other salmonellae, but within these figures the number of cases in general outbreaks more than halved.

Table 4.4 shows that there continued to be an increase in the number of general outbreaks of food poisoning due to sources outside the United Kingdom, though the number of cases dropped slightly.

Table 4.3 Food poisoning in England 1982, excluding general outbreak cases with source outside England.

	Causative agent	General outbreaks		Household outbreaks		Known sporadic cases	Total no of cases (columns 2 + 4 + 5)
		No of separate outbreaks	No of known cases	No of separate outbreaks	No of known cases		
		1	2	3	4	5	6
1.	*Salmonella typhimurium*	50 (24)	583 (354)	377 (307)	945 (770)	1994 (1308)	3522 (2432)
2.	*Salmonella hadar*	1 (10)	2 (149)	23 (41)	58 (117)	127 (154)	187 (420)
3.	Other salmonellae	50 (51)	296 (779)	427 (373)	1076 (916)	2671 (2334)	4043 (4029)
4.	*Clostridium perfringens*	46 (33)	619 (511)	28 (21)	71 (61)	60 (28)	750 (600)
5.	*Staphylococcus aureus*	8 (6)	52 (89)	3 (4)	7 (10)	27 (24)	86 (123)
6.	*Campylobacter*	11 (15)	90 (105)	104 (105)	238 (249)	2195 (1839)	2523 (2193)
7.	Other causes	4 (8)	196 (195)	46 (43)	170 (125)	261 (369)	627 (689)
8.	Cause unknown	33 (50)	534 (580)	153 (128)	430 (471)	1133 (1010)	2097 (2061)
9.	Totals	203 (197)	2372 (2762)	1161 (1022)	2995 (2719)	8468 (7066)	13835 (12547)

Figures for 1981 in parentheses

Figures for 1981 in parentheses

Table 4.4 Food poisoning in England 1982; general outbreak cases with source outside England.

	SOURCE			
	Outside UK		Wales/Scotland/NI	
	No of separate outbreaks	No of known cases	No of separate outbreaks	No of known cases
Total for 1982	304 (193)	420 (440)	10 (10)	14 (17)

Figures for 1981 in parentheses

Table 4.5 Salmonellosis not associated with food poisoning in England, 1982

Type of salmonella	General outbreaks		Household outbreaks		Sporadic cases identified	Total no of cases (columns 2+4+5)
	No of separate outbreaks	No of known cases	No of separate outbreaks	No of known cases		
	1	2	3	4	5	6
1. *Salmonella typhimurium*	6 (4)	16 (17)	74 (69)	194 (157)	471 (353)	681 (527)
2. *Salmonella hadar*	– (1)	– (24)	9 (7)	21 (14)	17 (45)	38 (83)
3. Other salmonellae	10 (1)	74 (3)	81 (79)	222 (199)	411 (601)	707 (803)
4. Totals	16 (6)	90 (44)	164 (155)	437 (370)	899 (999)	1426 (1413)

Figures for 1981 in parentheses

Table 4.5 shows an increase in general outbreaks of non-foodborne Salmonellosis since 1981 but the total was still lower than in previous years. The overall number of cases shows little change.

As a result of a review of the central food poisoning data collection systems, no further SBL640 returns will be requested from local authorities as broadly equivalent statistics can now be extracted from the data collated by the OPCS (from weekly and quarterly returns by Medical Officers for Environmental Health (MOsEH) and by CDSC (from outbreak reports by MOsEH and PHLS laboratory reports).

Food poisoning due to molluscan shellfish

During the year there have been outbreaks of gastroenteritis due to the consumption of several species of molluscan shellfish which have been eaten raw or inadequately cooked. Shellfish harvested in the UK and exported live to the USA may also have been responsible for outbreaks of gastroenteritis in that country. It is impossible to guarantee that molluscan shellfish are entirely free from infection unless they are known to be very thoroughly cooked. The Department is looking at ways to improve the eatable safety of molluscan shellfish.

References

[1] Department of Health and Social Security. *The congenital rubella syndrome (CRS)*. London: DHSS, 1983. (CMO(83)4) (CNO(83)1).

[2] Department of Health and Social Security. *The congenital rubella syndrome (CRS)*. London: DHSS, 1983. (CMO(83)5).

[3] Department of Health and Social Security. *National rubella campaign*. London: DHSS, 1983. (CMO(83)8) (CNO(83)4).

[4] Department of Health and Social Security. *Rubella immunisation*. London: DHSS, 1983. (Health notice. Health service management: HN(83)33) (HN(FP)(83)34) (Local authority social services letter: LASSL(83)3).

SEXUALLY TRANSMITTED DISEASES

The total number of new cases reported by the clinics in England alone in 1982 exceeded half a million. There were 517,668 new cases (296,675 males and 220,993 females), an increase of 8% over 1981. The problems of recent years outlined in this Report for 1982 (pp 62–64) remain, including that of beta-lactamase producing *Neisseria gonorrhoeae*. A major concern is whether acquired immune deficiency syndrome (AIDS) will continue to increase to the proportions described in the USA.

Diseases which showed an upward trend in recent years in the annual numbers of new cases were non-specific genital infection, candidosis, pubic lice, herpes simplex, genital warts and molluscum contagiosum.

Acquired immune deficiency syndrome (AIDS)

In the USA there had been reported a cumulative total of 3,000 cases of AIDS up to 31 December 1983, with death occurring in 43% of patients. Homosexual or bisexual men comprised 71% of cases and 17% were intravenous drug users.Surveillance of AIDS in the UK is undertaken by the Communicable Disease Surveillance Centre (CDSC) and by the end of 1983 there had been 31 cases (29 males, 2 females) reported to the CDSC. Four of these cases had presented in 1981 and 9 in 1982. Twenty-five (81%) were homosexual or bisexual men. So far, 16 of the 31 cases have died.

The cause remains unknown, but is likely to be a viral agent transmitted by sexual contact, transfusion of blood and certain blood products. The incubation period can be as long as three years or more.
(See also Chapter 4 p.44)

Gonorrhoea

Despite a slight increase in cases in women the overall incidence of gonorrhoea was virtually unchanged for the year ending 31 December 1982 (Tables 5.1, 5.3). The number of infections with beta-lactamase producing (penicillinase-producing) *Neisseria gonorrhoeae* continues to increase and in 1983 there were 1,223 cases reported by laboratories in the UK compared with 1,033 in 1982 and 443 in 1981. Of the 954 cases in 1983 in which the source of infection was stated, only 27% were acquired abroad. A World Health Organization Consultative Group has recently produced recommendations on the treatment of these and other sexually transmitted infections[1].

Syphilis

The incidence of syphilis continued to fall for the year under review (Tables 5.1, 5.3) and there were decreases in all categories. There was a decrease of 8% for primary and secondary syphilis, 6% for males and 23% for females. Cases of late syphilis decreased by 7%. There were 39 cases of cardiovascular syphilis and 89 cases of neurosyphilis. Only 12 of the 126 cases of congenital syphilis were early infections (*ie* in children under 2 years of age).

Table 5.1 Cases of syphilis, gonorrhoea and chancroid reported in England for the year ended 31 December 1982 with the figures for the year ended 31 December 1981 in parentheses (for the incidence rate per 100,000 population see Table 5.3).

	Total	*Male*	*Female*
Syphilis			
Early	2,145 (2,279)	1,804 (1,934)	341 (345)
Primary and Secondary only	1,337 (1,451)	1,187 (1,258)	150 (193)
Late	1,293 (1,396)	877 (969)	416 (427)
Congenital	126 (135)	58 (60)	68 (75)
Gonorrhoea			
All forms	52,156 (52,200)	33,058 (33,454)	19,098 (18,746)
Post-pubertal gonorrhoea			
All ages	52,132 (52,174)	33,049 (33,448)	19,083 (18,726)
Under 16 years	429 (361)	115 (96)	314 (265)
16–19 years	10,449 (10,266)	4,469 (4,351)	5,980 (5,915)
20–24 years	18,532 (18,256)	11,382 (11,000)	7,150 (7,256)
25–34 years	15,534 (16,054)	11,149 (11,943)	4,385 (4,111)
35–44 years	5,347 (5,369)	4,386 (4,446)	961 (923)
45 years and over	1,841 (1,868)	1,548 (1,612)	293 (256)
Chancroid			
	125 (91)	88 (64)	37 (27)

Table 5.2 Other sexually transmitted diseases reported in England in year ended 31 December 1982 together with the figures for year ended 31 December 1981 in parentheses (for incidence per 100,000 population see Table 5.4)

	Total	*Male*	*Female*
Lymphogranuloma venereum	30 (40)	19 (30)	11 (10)
Granuloma inguinale	15 (25)	13 (11)	2 (14)
Non-specific genital infection (NSGI)	128,197 (120,018)	93,983 (90,071)	34,214 (29,947)
NSGI with arthritis	501 (583)	476 (547)	25 (36)
Trichomoniasis	20,162 (20,224)	1,620 (1,662)	18,542 (18,562)
Candidiasis	52,404 (46,947)	10,328 (9,496)	42,076 (37,451)
Scabies	2,044 (2,145)	1,652 (1,748)	392 (397)
Pediculosis pubis	9,799 (8,718)	6,620 (5,970)	3,179 (2,748)
Genital herpes	13,653 (11,147)	7,810 (6,631)	5,843 (4,516)
Genital warts	33,343 (29,704)	20,639 (18,807)	12,704 (10,897)
Genital molluscum	1,378 (1,212)	887 (730)	491 (482)
Other treponemal diseases	833 (878)	532 (556)	301 (322)
Other conditions requiring treatment in a centre	79,019 (67,842)	40,883 (37,288)	38,136 (30,554)
Other conditions not requiring treatment in a centre	117,127 (111,407)	73,506 (69,610)	43,621 (41,797)
Other conditions referred elsewhere	3,318 (2,933)	1,822 (1,551)	1,496 (1,382)

Chancroid

The incidence of reported cases of chancroid infection has trebled since 1979 (Table 5.3). Much of the increase is due to the large number of cases reported from one particular area, where there is special interest in the causative organism and where it was found most commonly as a secondary pathogen in herpetic lesions.

Table 5.3 The venereal diseases – new cases per 100,000 population by age seen at hospital clinics in England, 1978–1982

	1978			1979			1980			1981			1982		
	Male	*Female*	*Total*	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*
Early syphilis															
All ages	10.53	1.74	6.02	9.45	1.48	5.36	9.41	1.60	5.41	8.50	1.44	4.90	7.92	1.42	4.58
Primary & secondary only	6.77	0.92	3.76	5.88	0.80	3.28	5.92	0.87	3.33	5.53	0.80	3.10	5.21	0.62	2.86
Under 16 years	0.11*	0.06*	0.08*	–	0.04*	0.02*	–	0.06*	0.03*	0.06*	–	0.03*	0.04*	0.08*	0.06*
16–19 years	5.07	2.89	4.00	4.87	3.38	4.14	4.06	3.78	3.91	4.40	2.99	3.71	3.04	1.96	2.52
20–24 years	18.10	4.13	11.31	14.12	2.76	8.56	14.83	3.47	9.27	15.27	3.52	9.48	13.34	2.51	7.99
25 years and over	8.23	0.70	4.25	7.29	0.60	3.77	7.29	0.58	3.75	6.48	0.56	3.35	6.29	0.45	3.21
Late syphilis															
All ages	4.56	1.81	3.15	4.22	1.81	2.98	4.16	2.04	3.07	4.26	1.78	2.98	3.85	1.73	2.76
Congenital syphilis															
All ages	0.17	0.36	0.27	0.19	0.35	0.28	0.27	0.24	0.26	0.26	0.31	0.29	0.25	0.28	0.27
Gonorrhoea (post pubertal)															
All ages	157.77	88.41	122.18	154.75	84.22	118.59	150.49	85.26	117.04	146.96	77.94	111.52	145.06	79.46	111.39
Under 16 years	1.82	6.44	4.07	1.50	5.86	3.62	1.75	5.99	3.81	1.82	5.30	3.52	2.22	6.40	4.25
16–19 years	294.39	453.31	372.21	284.80	412.83	347.31	276.65	420.00	345.53	277.54	393.83	334.44	277.65	390.93	332.84
20–24 years	667.20	463.50	569.57	654.29	449.88	554.23	650.23	454.13	554.19	626.78	425.17	527.39	619.77	399.26	510.90
25 years and over	143.78	44.04	91.13	139.67	41.27	87.78	131.52	39.88	83.20	127.04	33.44	77.67	120.66	35.72	75.87
Chancroid															
All ages	0.22	0.01*	0.11	0.16	0.02*	0.09	0.17	0.07	0.12	0.28	0.11	0.19	0.39	0.15	0.27

* These rates were based on fewer than 10 events and consequently their reliability as a measure may be affected.

Table 5.4 Other sexually transmitted diseases and other conditions – new cases per 100,000 population at all ages seen at hospital clinics in England 1978–1982

	1978			1979			1980			1981			1982		
	Male	*Female*	*Total*	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*
Lymphogranuloma venereum	0.10	0.01*	0.06	0.09	0.04	0.06	0.10	0.03*	0.06	0.13	0.04	0.85	0.08	0.05	0.06
Granuloma inguinale	0.04*	0.01*	0.02	0.08	0.05	0.06	0.07	0.02*	0.04	0.04	0.06	0.05	0.06	0.01*	0.03
Non-specific genital infection	347.52	83.91	212.28	356.67	91.41	220.67	383.82	115.02	245.98	395.74	124.65	256.53	412.51	142.47	273.93
Non-specific genital infection with arthritis	1.87	0.13	0.99	1.93	0.08	0.98	2.27	0.13	1.17	2.40	0.15	1.25	2.09	0.10	1.07
Trichomoniasis	7.41	76.15	42.68	7.03	75.33	42.05	8.42	78.62	44.42	7.30	77.26	43.23	7.11	77.21	43.08
Candidiasis	36.23	131.99	85.36	35.61	133.03	85.56	40.68	148.53	95.98	41.72	155.88	100.34	45.33	175.20	111.98
Scabies	7.70	1.89	4.72	7.39	1.70	4.47	7.95	2.05	4.92	7.68	1.65	4.58	7.25	1.63	4.37
Pubic lice (pediculosis pubis)	20.73	8.83	14.62	22.97	9.60	16.12	24.10	10.53	17.14	26.22	11.44	18.63	29.06	13.24	20.94
Herpes simplex	23.20	13.33	18.14	24.16	14.25	19.08	27.16	16.34	21.61	29.13	18.80	23.83	34.28	24.33	29.17
Warts (condylomata acuminata)	69.07	35.94	52.07	69.45	36.94	52.78	79.20	43.00	60.63	82.63	45.36	63.49	90.59	52.90	71.25
Molluscum contagiosum	2.94	1.26	2.08	2.77	1.43	2.09	3.32	1.69	2.48	3.21	2.01	2.60	3.89	2.04	2.94
Other treponemal diseases	3.09	1.61	2.33	3.23	1.49	2.34	2.52	1.48	1.99	2.44	1.34	1.88	2.34	1.25	1.78
Other conditions requiring treatment in a centre	128.74	73.07	100.17	130.27	84.49	106.80	153.48	105.81	129.04	163.83	127.17	145.01	179.44	158.80	168.85
Other conditions not requiring treatment in a centre	276.44	155.07	214.17	273.97	159.18	215.11	295.54	168.75	230.52	305.84	173.97	238.12	332.63	181.64	250.28
Other conditions referred elsewhere	5.54	3.71	4.60	5.97	3.75	4.83	6.52	4.94	5.71	6.81	5.75	6.27	7.99	6.23	7.09

* Rates based on fewer than 10 events and consequently their reliability as a measure may be affected.

Non-specific genital infection

This is now nearly three times more common than gonorrhoea as a cause of urethritis in the male; 40–50% of cases are caused by *Chlamydia trachomatis*. Diagnosis of non-specific genital infection in women is often difficult and the true frequency of this condition is undoubtedly much higher than the reported figures. Improved facilities for growing *Chlamydia trachomatis* are urgently needed if this infection is to be diagnosed in women before pelvic infection supervenes or other partners are infected. New methods of diagnosis employing monoclonal antibody are being assessed.

Trichomoniasis

The incidence of trichomonal infection has remained fairly constant in the past decade. The low reported frequency in men probably reflects the largely asymptomatic nature of the condition and the difficulty of diagnosis in the male.

Candidosis

The number of cases in women increased by 12% and in men by 9%. It is the commonest infection in women reported by clinics, but what proportion is acquired through sexual contact is uncertain.

Genital herpes

The number of cases of genital herpes diagnosed at clinics continues to increase. The overall total rose by 22% in 1982 and in females the increase was 29%. Part of the increase may have been due to public awareness as a result of considerable publicity on this subject in the media.

At present there is no remedy that can prevent subsequent attacks of herpes. Acyclovir will only prevent attacks whilst it is being taken and it is under trial as long-term prophylactic treatment for patients with frequent recurrences. Vaccines are being assessed and may offer protection against infection; they are much less likely to be of benefit to those who are already infected.

Genital warts

The total number of cases diagnosed increased by 12% from 29,704 in 1981 to 33,343 in 1982. There is now considerable evidence of an association between wart virus infection of the cervix and premalignant changes.

The clinics

The steady increase in the numbers of patients that attend the clinics continues to put a strain on the service for sexually transmitted diseases. Many of the clinics were originally designed to deal with a fraction of the patient load that they now have to accept.

The total number of hospital medical staff working in clinics in England and Wales at 30 September 1983 was 415 (244.7 whole-time equivalents (WTE) compared with 418 (252.4 WTE) in September 1982. The figures for 1983 included 115 (109.7 WTE) consultants, 30 (27.7 WTE) senior registrars, 38

(36.3 WTE) registrars and 22 (21.0 WTE) senior house officers compared with 111 (106.3 WTE) consultants, 34 (32.2 WTE) senior registrars, 37 (35.4 WTE) registrars and 25 (24.1 WTE) senior house officers in September 1982. At 30 September 1983 there were 22 (5.5 WTE) hospital practitioners and 173 (35.8 WTE) part-time medical officers (clinical assistants).

Reference

[1] World Health Organization. Consultative Group on Current Treatments in the Control of Sexually Transmitted Diseases. *Current treatment in the control of sexually transmitted diseases: report of a WHO Consultative Group, Geneva, 16–19 November 1982.* Geneva: World Health Organization, 1983. (WHO/VDT/83.433).

6

PRIMARY HEALTH CARE

Inner city practice

The report of a study group on Primary Health Care in Inner London commissioned by the London Health Planning Consortium and chaired by Professor E. D. Acheson[1] highlighted a number of problems hampering the provision of effective primary health care in inner London. Similar problems have been identified in some other inner cities. In October 1983 the Government announced measures to provide additional help for inner cities with the aim of overcoming some of these problems[2].

The problems of unsatisfactory practice premises is being tackled in a number of ways. A higher level of improvement grant has been introduced to enable doctors in selected areas in England to up-grade poor quality surgery premises or improve practice organization. The scheme is temporary and will run for three years at a total cost of up to £2.5 million. The grants will be allocated by the Family Practitioner Committees (FPCs) — those which match or include the areas of local authorities which have the status of Partnership or Programme Authorities under the Government's Inner Cities policy or fall within the area of the London Dockland Development Corporation. Higher grants will be restricted to these local authority areas. At the discretion of the FPC and subject to certain conditions being fulfilled Improvement Grants of 60% of the approved cost may be given, compared with one-third under the existing country-wide scheme.

In addition it is proposed to ask FPCs to adopt a more active role in advising doctors on premises, monitoring standards through regular visiting of surgeries, and promoting improvements. It is intended that minimum standards of accommodation will be set and FPCs will be empowered to withhold the reimbursement of rent and rates which they make to doctors, where these minimum standards are not achieved. New guidance is also being prepared on the design of primary health care premises, including doctors' own surgeries, with a particular emphasis on adapting and improving existing buildings.

Inner London has a high proportion of single-handed doctors — 32% compared with 13% nationally — and some other inner cities are also well above the national average. The Government has decided to offer new financial incentives for a limited period to encourage the setting up of group practices in inner cities. A scheme was agreed with the medical profession and details were published in 1984[3].

The Government has allocated a total of £1 million over 1982/83 and 1983/84 to inner city authorities in London and elsewhere with the greatest problems for the training of health visitors and district nurses. This financial assistance will be continued for a further two years.

In addition £1 million was made available in 1983/84 to regional health authorities containing inner city partnership and urban programme authorities for projects to improve primary health care in those areas.

Together these measures cost almost £2 million in 1983/84, and a total of £3 million will be available in 1984/85 and 1985/86. It is too soon to assess the outcome of some of these initiatives, but by concentrating assistance on the areas of most need the Government is seeking to strengthen primary health care services, in partnership with health and local authorities and the professions.

Family Practitioner Committees

After consultation on the future pattern for administration of the family practitioner services, legislation was included in the Health and Social Services and Social Security Adjudication Bill but the relevant Clauses were lost on the Dissolution of Parliament on 13 May 1983. Similar proposals were subsequently included in Clause 2 and Schedule 2 to the Health and Social Security Bill introduced in December 1983[4] giving effect to the Government's commitment to establish Family Practitioner Committees as employing authorities in their own right. The objectives underlying the provisions are:–

— to simplify and strengthen lines of accountability;
— to improve efficiency by bringing together full management responsibility and day to day control;
— to promote and improve collaboration between FPCs and district health authorities particularly with respect to the planning and delivery of primary care services.

Information on general practitioners' prescribing

Prescribing information sent annually to all gps relating total cost to the number of patients on a doctor's list has often been criticized on the grounds that no account was taken of the varying prescribing needs of patients in different age groups. In particular the elderly were known to receive on average more prescriptions than younger patients. Evidence from a number of sources demonstrated that on average a patient aged 65 years or over received three prescription items for every one received by a patient aged under 65 years. General practitioners with above average numbers of elderly patients are often high cost prescribers when compared with the FPC average cost per person. To allow for this and make more fair comparisons, prescribing information for April 1983 and subsequent months has given, in addition to the actual figures, costs related to list sizes which have been weighted accordingly. Other groups of patients such as young children may also affect prescribing costs disproportionately, but there is no way of identifying by age groups the numbers of patients on gps lists other than the elderly who attract additional capitation fees.

During the year the number of requests from gps for detailed analyses of their prescribing continued to increase. These analyses, prepared by the Prescription Pricing Authority (PPA) and distributed through the Regional Medical Service outnumbered those analyses prepared for doctors whose costs appeared to be unacceptably high ie were more than 25% above the FPC average (Table 6.1). The current capacity for producing analyses is limited.

For many years PPA has referred to DHSS prescription forms (EP10) on which the cost, quantity or frequency of the items is unusually high. The

criteria for selection are necessarily broad resulting in large numbers of forms being referred, and in many instances contact with the prescriber would be inappropriate. A recently revised procedure has greatly increased not only the quality and quantity of medical scrutiny of these prescriptions, but also the amount of feedback of information to doctors. During 1983 25,250 FP10s were processed, resulting in 2,200 contacts between regional medical officers (RMOs) and gps concerning prescriptions costing a total of £611,000. In 41% of contacts the prescriber was unaware of the cost involved. In the opinion of the RMO 64% of contacts were likely to result in more economical future prescribing and 81% of contacts resulted in the provision of information for the prescribing doctor of which he had been unware. Most gps have welcomed this information and for some it has provided a stimulus for them to undertake a review of their prescribing. The procedure is periodically scrutinized to discover whether it can be made even more effective and to what extent that effectiveness can be evaluated.

The Report for 1982 (p.76) described a project in which gps were sent computer printed histograms of their prescribing costs. The final report of the Information Services Project was available in January 1984. The response from these prescribers was encouraging and further consideration is being given to the different ways in which such information can be presented. During 1983 computer pricing of prescriptions by PPA was started and two of the 13 Divisions were operative by the end of the year. The changeover is expected to be completed by 1986 and will facilitate further studies on the provision of information to prescribers and the evaluation of its effect.

A study of prescribing was funded by the DHSS and undertaken by the St Mary's Hospital Department of General Practice. The results were published in January 1984[5] and demonstrated that given information about their own prescriptions and an opportunity to discuss it with colleagues significant prescribing changes took place resulting in fewer prescription items being issued and a consequent financial saving. The project suggested that if gps were to prescribe drugs by their generic name rather than their brand name there would also be considerable saving to the NHS.

After lengthy and widespread consultation Ministers accepted the recommendations in the Report of the Informal Working Group on Effective Prescribing (The Greenfield Report)[6] except for the recommendation that pharmacists should be able to substitute generic products for branded products named on prescription forms unless the prescriber signified otherwise.

Research Advisory Group

The Department does not have a Research Liaison Group covering primary health care research but it has a substantial commitment to research in this field. Consequently the Research Advisory Group was formed to help co-ordinate current research initiatives and advise on a research strategy. The Group will cover a wide range of disciplines and have scientific advisers from general practice, nursing, epidemiology, statistics, social science and economics, and also have service advisers from community medicine, community nursing, social services, general practice and pharmacy. The

general aim of the group will be to review the range and quality of existing research in primary health care and identify key conclusions and important gaps. The outcome of the first meeting on 10 November 1983 was that the initial approach would be to commission research reviews in specific fields as a foundation for the Group's considerations, starting with collaboration in the delivery of primary health care and the quality and efficiency of primary health care.

General practitioner initiatives

In July the Council of the Royal College of General Practitioners debated 'the difficult but vital' issue of improving the quality of care in general practice. The Council recognized that there are genuine pressures on doctors that might, and do, constrain their performance. It nevertheless agreed that the first steps had to be taken and adopted the following aims:

1. Each general practitioner should describe his current work and should be able to say what services he provides for his patients.
2. Each general practitioner should define specific objectives for the care of his patients and should monitor the extent to which these objectives are met.

At the end of the year a report was available on a study *'General Practice — A British Success'*[7] commissioned by the General Medical Services Committee of the British Medical Association. The Committee represents all family doctors working in the NHS. The study reviewed the past and present and set out future objectives for general practice. To this end it seemed timely to the Committee to gather in one document the results of some of the many reports and researches into family doctoring in the NHS since medicine was 'socialized' in 1948. As a commentary, the views of the Committee were set out on the targets at which the Health Service, as a whole, needs to aim and how general practice needs to develop so as to forward these aims.

The Regional Medical Service

Tables 6.2, 6.3 and 6.4 summarize the work undertaken by the Regional Medical Service in 1983. The introduction of Statutory Sick Pay on 6 April 1983 resulted in some reduction in the number of references made. It also produced a small number of references concerning claimants to this benefit in the latter half of 1983 (not shown in Table 6.2).

Table 6.1 Prescription analyses, 1981–83

Type of analysis	Number of doctors for whom reports were prepared		
	1981	1982	1983
High cost	675	1223	741
Self audit	423	1008	1553
Total	1098	2231	2294

Table 6.2: References received, England 1983

Source	Type of reference	Number	(1982 figures in parenthesis)
DHSS	Sickness and invalidity benefit	468744	487800
	Injury benefit	9347	18295
	Maternity benefit	74	95
	Supplementary benefit	655	609
	Repeated short period claims	1818	4651
	Self certification	1850	454
Doctors	Form RM7 (request for 2nd opinion)	4150	4385
	Form Med 6 (vague diagnosis)	3447	3849
Department of Employment		16026	28196
EEC		58	44
	Total	506169	548378

Table 6.3 Sickness and invalidity benefits. Outcome of RMS examination, England 1983

Opinion	of total references		of those examined	
	1983	(1982)	1983	(1982)
Not incapable of work	5.92%	(6.35%)	14.82%	(16.20%)
Incapable of work	29.55%	(27.24%)	70.98%	(69.49%)
Incapable of work at present occupation but capable of suitable alternative work	5.99%	(5.60%)	14.21%	(14.29%)

Table 6.4 Types of RMO visits, England 1983

	Number	(1982)
Routine	2875	3004
Prescribing	934	908
Misuse of Drugs Act	83	76
Practice Premises and organization	910	805
Other	328	408
Total	5130	5201

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2. Department of Health and Social Security. *£9 million towards primary care in inner cities.* London: DHSS, 1983. (Press release; 83/218).

3. Department of Health and Social Security. *Temporary scheme for incentives to group practice in inner city areas: statement of fees and allowances.* London: DHSS, 1984. (Health notice; HN(FP) (84)14).

4. Health and Social Security Bill. London: HMSO, 1983. £4.00. (House of commons bills; session 1983–84; no 69).

5. Harris C M, Jarman B, Fry J S, Woodman E, White P, *Prescribing: a suitable case for treatment.* London: Royal College of General Practitioners, 1984. (Occasional paper; 24).

6. Department of Health and Social Security. Informal Working Group on Effective Prescribing. *Report to the Secretary of State for Social Services of the Informal Working Group on Effective Prescribing.* London: DHSS, 1982. Chairman: P R Greenfield.

7. British Medical Association. General Medical Services Committee. *General practice: a British success.* London: British Medical Association, 1983.

7

MATERNAL AND CHILD HEALTH

Births and birth rate

In 1983 there were a total of 596,667 births in England. This is 3,225 more (0.5%) than the 593,442 total births in 1982. This small upturn in the number of births brings to an end the downward trend which was first noted in 1980. The trend in birth numbers was not even throughout the year. When each quarter is considered separately there was a net reduction compared with 1982 of just under 1% in the first quarter, an increase of almost 3% in the second quarter followed by an increase of just over 1% in the third quarter. In the final quarter of the year the number of births was almost 2% lower than in 1982.

The number of stillbirths in 1983 showed a further reduction of 319 to a total of 3412 compared with the 1982 total of 3731.

In 1981 the birth rate was 12.8. This fell in 1982 to 12.6, rising again to 12.7 (provisional) in 1983.

There were 121,400 legal abortions* during 1983 to women resident in England a decrease of under 1% compared with 1982 for which the final number was 122,450. In 1983 the ratio of abortions to total births to women resident in England was 1: 4.9. The ratio has remained virtually unchanged for the years 1981–83.

Maternal deaths

There were 51 maternal deaths, including abortion, in England in 1983. This is similar to the number in 1981 (52), but more than 1982 when there were only 38 maternal deaths. As the number of maternal deaths are now relatively small this is probably a chance variation. There was no apparent significant difference in any of the individual causes of death.

Table 7.1 shows the causes of death ascribed to pregnancy and childbirth in England in 1983 [and 1982] according to the 9th revision of ICD. The group Rem 640–648 includes ICD code 648 which contains deaths from indirect maternal causes, such as diabetes and cardiovascular disorders associated with pregnancy. The group Rem 660–669 includes ICD code 668 which contains deaths due to complications arising from the administration of anaesthetics in labour and delivery. These are considered to be direct maternal deaths.

Table 7.2 shows the maternal mortality in England for 1979–83.

* Provisional

Table 7.1: Causes of death ascribed to pregnancy and childbirth, England 1982–83

ICD No (9th Revision)	Cause of Death	1982	1983
633	Ectopic pregnancy	2	6
630–632 & 634–639	Pregnancy with abortive outcome	4	1
640	Haemorrhage in early pregnancy†	–	–
641	Antepartum haemorrhage, abruptio placentae, and placenta praevia	5	1
642	Hypertension complicating pregnancy, childbirth and the puerperium.	4	6
643–648	Complications mainly related to pregnancy.	3	8
650–659	Normal delivery, and other indications for care in pregnancy, labour and delivery	1	–
666	Postpartum haemorrhage	2	1
Rem: 660–669	Complications occurring mainly in the course of labour and delivery.	8	12
670	Major puerperal infection	–	1
673	Obstetrical pulmonary embolism	5	7
671–674	Other complications of the puerperium	4	8
	Total	38	51
	Total excluding abortion‡	34	50

† Haemorrhage before completion of 22 weeks gestation
‡ 630–632, 634–639

Table 7.2 Maternal mortality, England, 1979–1983

Year	Total (live and still) births	Maternal mortality from childbearing ICD Nos (633, 640–676)		Maternal mortality from all types of abortion ICD Nos (630, 632, 634–639)		
		Deaths	Death rate per 1,000 live and stillbirths	Deaths	Death rate per 1,000 live and stillbirths	Rate per million women aged 15–44
1979	606,127	62	0.10	5	0.01	0.5
1980	622,894	65	0.10	3	<0.01	0.3
1981	602,102	51	0.08	3	<0.01	0.3
1982	593,442	34	0.06	4	0.01	0.4
1983	596,667*	50	0.08*	1	<0.01*	0.1

* Provisional

Availability of maternity beds

In 1982, the latest year for which information is available, there was a further very small reduction in the number of maternity beds available. On average a total of 18,108 beds were available in NHS hospitals, some 70 less than in 1981; 15,434 beds were in consultant units while 2,675 were designated for general practitioner maternity use. The length of stay per patient, including both antenatal and postnatal stays was 5.3 days in 1982, compared with 5.5 days in 1981. In consultant units length of stay fell from 5.7 days in 1981 to 5.5 days in 1982 while in general practitioner maternity beds average length of stay was 4.1 days compared with 4.2 days in 1981.

Overall, bed occupancy in 1982 was 63.6% compared with 66.3% in 1981. In consultant units bed occupancy was 67.8% compared with 70.6% in 1981; in general practitioner units it was 39.1% compared with 41.7% in 1981. In terms of patient throughput per bed there was in increase to 45.4 patients per consultant bed in 1982 compared with 45.1 in 1981. In general practitioner beds throughput fell from 36.3 cases in 1981 to 35.1 in 1982.

The case/birth ratio of total maternity admissions per NHS hospital birth continued to rise. For 1982 the ratio was 1.37:1. Viewed over a longer timescale there has been very little change in the total number of consultant beds. In the 5 years from 1978–1982 the number reduced by 2.4% from 15,850 to 15,434. During the same period there has been a more substantial reduction of 18% in general practitioner maternity beds from 3,265 in 1978 to 2,675 in 1982.

Maternity Services Advisory Committee

The Maternity Services Advisory Committee (MSAC) was set up in 1981 to advise the Secretaries of State for Social Services and for Wales on all aspects of maternity and neonatal care. The Committee's first report on Antenatal Care was published in September 1982[1]. The second report entitled *'Maternity Care in Action: Part II – Care During Childbirth'* was completed during 1983[2].

The report contains chapters on Preparation for Childbirth, Admission in Labour to the Maternity Unit, Labour and Birth, Complications during Pregnancy and Antenatal Admissions, Complications during Labour and Birth, Planned Home Births, Delivery Suite Design and Equipment, and the Maternity Services Liaison Committees.

The report follows the same format as the preceding report on antenatal care[1]. Each chapter is followed by check-lists for consideration by health authorities, professional bodies and other organizations with an interest in delivery of maternity services. The MSAC gives particular emphasis to the establishment in each district of a Maternity Services Liaison Committee to bring together all those involved in the provision of maternity care to ensure that services are best organized to meet local needs and circumstances.

The MSAC has now started work on its third report which will be concerned with the care of mothers following birth and of neonatal care for infants.

Place of delivery

In 1983 the total number of women confined in England was 590,543. Of these 576,780 maternities (97.7%) took place in NHS hospitals while 7,187 maternities (1.2%) took place in other institutions. There was a small decrease in the number of confinements at home. These totalled 6,117 (1% of all confinements), a decrease of 441 compared with the 6,558 home confinements in 1982, and was also 73 fewer than the 6,190 home confinements in 1981. The increase in the number of maternities ending in a home confinement in 1982 was the first increase in the number of such deliveries since the trend towards hospital confinement began three decades ago. It should be noted these figures in this paragraph relate to the number of mothers delivered rather than the number of infants born.

Surrogate motherhood

During the year there was considerable public interest in the subject of surrogate motherhood. This followed the establishment in the USA of an agency whose objective was to arrange and provide women willing to become surrogate mothers for couples in whom the wife was unable herself to have a successful pregnancy. Following press reports that a similar agency might be set up in this country, Mrs Anna McCurley MP sought leave of the House of Commons to introduce a Bill which would have had the effect of prohibiting the operation of surrogacy clinics in the United Kingdom. The Motion was debated in 1984 when further public and Parliamentary discussion of the subject of surrogate motherhood is expected to follow publication of the report of the Government's Inquiry into Human Fertilization and Embryology[3].

Perinatal mortality

In 1983 there were 6,158 perinatal deaths in England of which 3,412 were stillbirths and the remaining 2,746 deaths during the first 7 days after delivery. These represent a perinatal mortality rate of 10.3, a stillbirth rate of 5.7 and an early neonatal death rate of 4.6. Further details of the trends in perinatal mortality will be found in Chapter 1.

Some more detailed analyses of the cause of perinatal deaths have been undertaken by OPCS for earlier years which involved linking information obtained from birth and death registrations, for those deaths which occurred in the first 4 weeks of life. These analyses for births in 1981 are shown in Tables 7.3 to 7.6. Table 7.3 shows an analysis of stillbirths in England and Wales according to the cause of death and the duration of pregnancy. From this it will be seen that 615 cases (14.6%) of stillbirths were associated with congenital anomalies of which two-thirds were neural tube defects; 441 (10.4%) were associated with maternal conditions and hypertensive disorders of pregnancy; 1,746 cases (41.5%) were associated with complications of the placenta, cord and fetal membranes.

A further 390 cases (9.2%) were due to hypoxia and intra-partum asphyxia. In the remaining 1,015 cases death was ascribed to a variety of causes.

Table 7.4 gives an analysis of perinatal and neonatal deaths in 1981 according to birthweight and also illustrates the distribution of cardiovascular and central nervous system malformations notified and the number of perinatal and neonatal deaths due to cardiovascular or central nervous system anomalies.

A large number of infants with these malformations are also of low birthweight. However whereas the perinatal and neonatal deaths due to cardiovascular malformations are distributed throughout the birthweight groups, for central nervous system malformations this is not so. Most of the perinatal deaths are of low birthweight.

Congenital malformations

Table 7.5 shows the importance of congenital malformations among stillbirths, neonatal and infant deaths, and its lingering importance

Table 7.3 Stillbirths, England and Wales, 1981

Gestation	28–29	30–31	32–33	34–35	36–37	38–39	40 & over	not stated	Total
Congenital Anomalies (ICD 740–759)	55	79	108	89	83	80	81	40	615 (14.6%)
(including neural tube defects, ICD 740 & 741)	(30)	(41)	(74)	(57)	(57)	(60)	(62)	(27)	(408)
Maternal conditions unrelated to current pregnancy including hypertensive disorders (ICD 760)	75	73	72	47	61	53	32	28	441 (10.4%)
Complications of placenta, cord and membranes (ICD 762)	155	171	188	221	278	281	306	146	1746 (41.5%)
Hypoxia, birth asphyxia (ICD 768–770)	28	26	45	42	51	68	99	31	390 (9.2%)
All other causes	117	131	121	135	140	136	148	87	1015 (24.1%)
Total	430	480	534	534	613	618	666	332	4207 (100%)

Table 7.4 Cardiovascular & central nervous system malformations by birthweight group, in birth notifications, perinatal & neonatal deaths, England & Wales, 1981.

Births	All	<1500g	1500–1999g	2000–2499g	2500–2999g	3000–3499g	3500–3999g	>4000g	Not stated
Live	634492	4724	7477	27348	114753	236191	164578	50609	28812
Still	4207	1250	657	590	559	432	216	122	381
Cardiovascular malformations									
Live & stillbirth notifications	844	55	45	81	194	234	163	60	12
Perinatal deaths	248	12	15	22	59	68	42	8	22
Neonatal deaths	392	20	22	34	105	99	62	18	32
Central nervous system malformations									
Live & stillbirth notifications	1229	229	120	164	231	282	124	57	22
Perinatal deaths	636	207	92	97	74	60	28	17	61
Neonatal deaths	321	38	29	49	68	65	34	11	27

Table 7.5 Deaths where some categories of congenital malformations given as underlying cause of death, England & Wales, 1981

	Stillbirths	Early neonatal	Late neonatal	Post-neonatal	Infant	Total years 1–4	5–9	10–14	Total 0–14
All causes	427	3356	870	2795	7021	1180	749	941	9891
All congenital malformations	615	975	370	569	1914	237	75	66	2292
Heart & circulation ICD 745/6/7	15	238	160	295	693	174	53	39	959
All central nervous systems malformations ICD 740/1/2	611	249	197	225	671	42	22	26	761
Musculo-skeletal and limb defects ICD 754–756	25	118	7	12	137	8	2	1	148
Respiratory system ICD 748	1	116	5	10	131	–	–	–	131
Urinary system ICD 753	17	90	4	11	105	3	1	2	108
Chromosomal ICD 758	8	44	19	38	101	6	1	–	108

Table 7.6 Perinatal and neonatal mortality by birthweight and cause, England and Wales, 1981.

Perinatal mortality	Cause of death	All weights	Under 1500g	1500–1999g	2000–2499g	2500–2999g	3000–3499g	3500–3999g	4000g and over	Not stated
Numbers	All causes	7521	2521	997	917	867	721	391	198	909
	Infections and parasitic diseases	9	2	–	3	2	–	1	–	1
	Diseases of respiratory system	36	9	4	8	5	2	1	3	4
	Congenital anomalies	1579	364	234	241	222	188	97	37	196
	Certain conditions originating in the perinatal period	5796	2125	747	656	624	513	280	155	696
	External causes of injury and poisoning	14	1	–	2	3	1	1	–	6
Neonatal mortality										
Numbers	All causes	4176	1477	413	404	476	452	262	107	585
	Infections and parasitic diseases	26	3	1	8	7	4	1	1	1
	Diseases of respiratory system	105	20	9	14	20	23	8	7	4
	Congenital anomalies	1332	161	164	200	262	230	120	37	158
	Certain conditions originating in the perinatal period	2506	1262	225	167	148	146	101	52	405
	External causes of injury and poisoning	21	1	–	2	6	4	1	1	6

throughout youth and adolescence. The table probably under-represents the contribution malformations make to mortality since they may pre-dispose to other causes not included in Table 7.5. As was noted from Table 7.3 two-thirds of all stillbirths attributed to congenital malformations were associated with defects of the central nervous system. In all subsequent ages the largest group of deaths due to malformation were those of the heart and circulatory system.

Table 7.6 shows for each birthweight group the number of perinatal and neonatal deaths, sub-divided by major categories of cause of death.

Family planning

During 1983 the total of 3.8 million people received family planning advice either from their general practitioners or from the family planning clinics run by health authorities. Of these 2,358,000 women attended their own general practitioners while 1,455,000 women and 21,000 men attended the clinics. During the year there was little change in the number of general practitioner principals providing family planning services and the number of family planning clinic sessions at 200,000 was slightly higher than the 197,000 in 1982. Table 7.7 shows the method of birth control adopted by those attending family planning clinics in England. This is based on the method used at the time of the first visit to the clinic. No similar breakdown on the method of family planning is available for those receiving family planning services from their general practitioner, except for IUD insertions. In 1983 there were 108,000 IUD insertions by general practitioners compared with 107,000 in 1982. Table 7.7 shows that there has been little change in the choice of family planning method adopted by those attending clinics. There were small increases in the proportions using the sheath or the oral contraceptives, and small decreases in the proportions using an IUD or a cap/diaphragm.

Table 7.7 Method of birth control adopted at time of patient's first visit to clinic (England)

Method	1983 (thousands)	1982 (thousands)	1981 (thousands)	1980 (thousands)
Oral contraception	847.1	833.4	820.1	799.8
IUD	235.2	245.2	266.9	307.9
Cap/diaphragm	112.2	114.0	119.9	122.0
Sheath	153.6	146.3	144.0	142.4
Chemical methods	7.5	8.4	9.2	10.1
Rhythm method	0.3	0.3	0.6	0.2
Sterilization	2.2	2.2	1.5	1.2
Vasectomy	12.9	14.1	14.8	15.7
Other	8.4	8.1	9.6	8.3
None	93.1	85.7	80.4	80.1
Total	1,472.5	1,457.7	1,467.1	1,487.8

Oral contraceptives

In October 1983 *the Lancet* published two studies which reported an association between the use of the combined contraceptive tablet and the occurrence of cervical and breast cancer. The first, by Professor Vessey and

colleagues in the Oxford Department of Social and Community Medicine which reported on the incidence of cervical neoplasia among women who entered the Oxford Family Planning Association Contraceptive Study[4]. The second, by Professor Pike and colleagues from the Departments of Preventive Medicine, Obstetrics and Gynaecology in the University of Southern California, Los Angeles. This described results of a retrospective case control study of oral contraceptive use by a group of breast cancer patients who had been users of oral contraceptives[5]. The Committee on Safety of Medicines considered these reports and issued a letter to all doctors immediately following their publication in *the Lancet.*

In view of the suggested link between oral contraceptives and cervical cancer Professor Vessey's paper was also considered by the Committee on Gynaecological Cytology who recommended as an interim measure in the absence of fuller information on the relationship between cervical neoplasia and oral contraception that any sexually active women who requested oral contraceptives should have a cervical cytological examination when these are initially prescribed; and that further cervical cytological examinations should be taken at ages 20, 25, 30, 35 and five-yearly thereafter from users and ex-users of oral contraceptives. This advice was accepted by Ministers, and in order to reduce public anxiety about possible cancer risks of oral contraceptives the advice of the Committee on Safety of Medicines and of the Committee on Gynaecological Cytology was widely distributed by the Department on the same day as *the Lancet* published the two reports.

Post-coital contraception

During the year there was much publicity given to post-coital methods of contraception initially about the legality and subsequently about the safety of different hormonal methods. On 10 May the Attorney-General in a Parliamentary reply, prompted by specific cases referred to his office, indicated that he had decided that post-coital contraception, as currently provided in this country, does not constitute a criminal offence under the law relating to abortion. No proceedings were to be taken against doctors who had been reported to the Director of Public Prosecutions for providing this form of contraception.

Following the Attorney-General's statement the Minister for Health announced that in order to allay any doubts about the safety of hormonal post-coital contraception, he was asking the Committee on Safety of Medicines to consider the risks and benefits of this method of contraception. The Committee's advice given in January 1984 was that 'If emergency hormonal post-coital contraception is needed, the Committee considers that at present the most suitable method would be the specific combination oral regime'. Further details of the Committee on Safety of Medicine's consideration of hormonal post-coital contraception can be found in chapter 15b.

'Depo Provera'

During the year hearings took place into the appeal by Upjohn Limited against the decisions by the Licensing Authority not to grant a long-term licence for use of *'Depo Provera'*. Details of the appeal will be found in chapter 15b.

Contraception for the under-16s

In 1981 the Department revised the section of the memorandum of guidance on family planning prescribing in the provision of services for the young. In July 1983 these guidelines were the subject of a High Court action, seeking a declaration that the DHSS guidance was illegal in that it encouraged doctors to aid and abet illegal sexual intercourse with girls under aged 16, and that a girl under 16 years of age could not validly consent to contraceptive treatment. The judgement given by Justice Woolf in the Queen's Bench Division in July was that the guidance was lawful. The case is now subject to an appeal which is expected to be heard during 1984. In response to representations made both for and against the guidance the Minister for Health undertook to consider it again once the outcome of the legal action is known.

Abortion

In January 1983 there were 54 nursing homes approved under the Abortion Act. During the year 9 further applications were received of which 4 were approved and 5 remain outstanding at the end of the year. At the end of December there were 57 nursing homes approved under Section 1.3 of the Abortion Act. Thirty-nine Pregnancy Advice Bureaux were on the register in January 1983. During the year a further 5 were registered of which 2 were transfers of ownership. At the end of the year there were 42 registered Pregnancy Advice Bureaux.

Marketing of breastmilk substitutes

The measures adopted by the United Kingdom to secure the aim and principles of the World Health Organization *International Code of Marketing of Breastmilking Substitutes* came into effect in August 1983, after consultation about the draft proposals with all the interested bodies in the UK. Most of them expressed broad satisfaction and, in the light of comments received, some amendments were made to the two documents which were issued. These were a *Code of Practice for the Marketing of Infant Formulae in the United Kingdom and Schedule for a Code Monitoring Committee*[6], sponsored by the Food Manufacturers' Federation and drawn up in consultation with the UK Health Departments and the Ministry of Agriculture, Fisheries and Food, and a complementary *Health Circular HC(83)13*[7] for the guidance of health professionals.

Adoption

Work on the new Adoption Agency regulations continued throughout the year and included helpful consultation with medical bodies. The new Regulations[8] were finalized at the end of 1983, and will come into operation in May 1984.

Several medical issues were clarified, the most important being that the appointment of a Medical Adviser to adoption agencies, with a specified role and functions, is to be mandatory. The extent, quality and source of health information which is needed on children, natural parents and adopters was agreed. Better arrangements have been sought to provide health information to adopters and to their general practitioner before placement, and for advance notification of placement to be given to the

District Health Authority, and if applicable, to the Local Education Authority. It is intended that the new Regulations will ensure the maintenance of the child's health while adoption is pending, and will provide the Court with information regarding the health implications of the proposed adoption. The new Regulations are also intended to ensure confidentiality of medical information in adoption procedures.

Progress was also made with Section 4–7 of the Children Act 1975[9] which sets up a system of approval of Adoption Societies by the Secretary of State. Consideration of these applications has shown variations in present arrangements for health advice, some of which will be affected by the new Adoption Agency Regulations.

Child abuse

In November 1983 the DHSS announced its intention to formulate proposals for guidance on the conduct of child abuse inquiries. Members of the Department's multi-disciplinary Child Abuse Group began work on the preparations of the consultative document, which will be the first stage in a planned programme of work to revise previous guidance relating to the protection of children.

Services for the 'under-fives'

On 20 October 1983 the Secretary of State announced an initiative to help families with children under the age of five years. It is intended to stimulate voluntary help to disadvantaged families through particular projects which might otherwise fail to find the funding they need. The three groups especially identified are working parents, including single parents, where family income is low; parents at home with young children, usually mothers who may be isolated, depressed and finding life difficult; the families from ethnic minority groups with pre-school children, who may have additional needs due to cultural and language differences.

The DHSS approved a programme of some 80 projects to be managed by fourteen major voluntary bodies working in the pre-school field. In addition, special arrangements were made with the National Council for Voluntary Child Care Organization to deal with applications for funding for projects run by local voluntary bodies, with whom the Department is dealing direct. Expenditure on the initiative is expected to build up to £2 million in 1984/85 and 1985/86.

The programme of projects ranges widely. It includes day-nursery and childminder support schemes and provides for part-day care with help to playgroups, drop-in centres and creche facilities, and to families through volunteer home visiting schemes, day-centres, and mother and toddler clubs.

The Inter-Departmental Consultative Group on the Provision of Services for the Under-fives met representatives of the local authority associations, the National Association of Health Authorities and voluntary organizations in December 1983, and received the report of the Subgroup set up in 1982 to consider the ways authorities could better meet the needs of ethnic minority families with 'under-fives'. It was agreed that the report should be

promulgated, and that consideration should be given to the best means of doing this in 1984.

Hospital accommodation for children

In August the Department issued a Health Building Note on Hospital Accommodation for Children, providing information on the design of accommodation for children for out-patient services, comprehensive assessment and care, in-patient services and day-patient services[10]. This document reflected and developed the current philosophy of care for children. It emphasized that all children (with a very few specific exceptions) should be accommodated in a children's department supervised by a consultant paediatrician, that as much care and treatment as possible should be provided on an out-patient or day-patient basis, and that when in-patient care is necessary, links with family, friends and schooling should be maintained as far as possible. Part of this philosophy is the recognition of the value of parents being with and caring for their children in hospital. In July the National Association for the Welfare of Children in Hospital (NAWCH) published the findings of a survey of parental access and overnight accommodation in children's wards in England[11], which the Department had funded. Of 1143 wards admitting children surveyed, half allowed unrestricted visiting for parents and visiting by young siblings. Although the overall picture disguises wide differences between Regions, and even between wards on the same hospital site, these results show steady improvement on earlier surveys.

The prevention of childhood accidents

Accidents are the commonest cause of death between 1 year and 15 years of age. Responsibility for different types of accident is widely spread among Government Departments, and co-ordinated by the Child Accident Prevention Trust (CAPT), to which DHSS gives grant aid. The work of the Trust continued to expand and develop in 1983, bringing together expertise from many disciplines on child accident prevention. Its object is to act as a scientific advisory and co-ordinating body, and its members include paediatricians and nurses as well as representatives from voluntary organizations, professional bodies and Government departments.

A major step forward during the year has been to encourage the formation of a Joint Health Education Council (HEC) and Child Accident Prevention Trust Consultative Group on Child Accident Prevention. This Group will advise the HEC on its activities in this field, particularly the HEC Education and Preparation for Parenthood Programme.

An important development in the work of CAPT relates to the Computerized Accident and Emergency Record System project (CAER). A child accident module has been developed which will be included in the project, and the scheme will be tried initially in three accident and emergency departments.

The Working Parties on Burns and Scalds, and on Local Initiatives, continued their work throughout the year. The latter's main task has been a follow-up study as part of the evaluation of the BBC TV *Play it Safe* series, mentioned in *this Report for 1982* (page 80). Both Working Parties will report in 1984.

Special educational needs: Education Act 1981

The Act which builds on the proposals recommended by the Warnock Committee[12] became fully operational on 1 April 1983 following the issue of a joint DHSS/DES circular[13]. It abolished the previous system for categorizing children according to handicap and introduced procedures for the assessment of children with special educational needs. Where such needs arise the Local Education Authority (LEA) is required to produce a statement describing the needs of the individual child and what services are planned to meet these needs. The purpose of the assessment and statement is to ensure that all relevant factors are taken into account and that the needs and the services planned to meet them are made known to parents, who are invited to comment. The Act sees the involvement of the child's parents as essential and stresses the need for close relationships being established and maintained with parents at all stages of the exercise.

Health service staff have a significant role to play in the professional assessment of individual children.

a. The health authority is required to *inform* the LEA after consultation with parents, if they believe a child may have special educational needs. In particular this helps the LEA to identify early children under 5 years of age with special educational needs.
b. The health authority is directly involved in the assessment of individual children. In making an assessment under the Act LEAs must seek medical advice from a designated medical officer of the health authority who will incorporate the views of specialist medical colleagues and collate advice from the specialized support services provided by the DHA (eg speech therapy and physiotherapy). LEAs are also required to advise a designated health authority nursing officer of the planned assessment of an individual child so as to enable her to offer advice.
c. Non-educational facilities are required. In addition to the child's special educational provision a formal statement must include details of any *non-educational facilities* which, following consultation, the LEA is satisfied will be made available by the appropriate body and of which it considers advantage should be taken. Health authorities would be responsible for providing such services as speech therapy or physiotherapy.

The new procedures do not alter the general responsibility of health authorities to advise local authorities. There is an important change of emphasis insofar as the designated medical officer is only required to offer advice on the medical aspects of a child's special educational needs and not on his health generally and this particular medical advice, together with that of other professionals, is made available to the parents.

Arrangements to introduce the new procedures are being established in ways that reflect the local situation and build on existing services with interauthority and interprofessional co-operation and collaboration. Training (for those in the education and health services concerned with the implementation of the Act), frequently of a joint nature, has been arranged in many parts of the country.

DHSS has arranged to study how the procedures will be applied and their impact on the working arrangements within health authorities by means of a

number of Regional study/workshop days. These have been set up by departments of Paediatrics and Child Health, the health authorities, and postgraduate medical departments, and in Leeds, Coventry and Winchester with the support of DHSS and an input from DES. The aim has been to stimulate local health personnel to prepare themselves for their part in the implementation of the Education Act, 1981[14]. Subject to the outcome of such studies the need for general advice to health authorities and for an appropriate contribution to the training of health professionals will be considered.

Mentally handicapped children

At the end of 1982 the number of mentally handicapped children in mental handicap hospital units had fallen to 1600. Some of these children, mostly very severely handicapped, are in small, homely units; but others are still living in large hospitals and, however committed the staff, hospital wards do not provide a favourable environment in which a mentally handicapped child may grow up. It has been amply shown that even the most severely handicapped children benefit from living in domestic settings in the community.

In 1981 a circular[15] had asked health authorities to make sure that all mentally handicapped children in their care were identified and their needs reviewed, jointly with the relevant local authority.

Under a new scheme £3m a year was set aside for 1983/84 and for each of the following two years. These sums were to help health authorities with special problems to meet the capital and revenue costs of moving children aged 16 years and under, who were currently living in hospital and in need of health care, into more homely, domestic settings in their own local community. A Dear Administrator letter and a follow-up circular were issued[16]. These explained the role of regional reviews in monitoring progress and offered the services of the Development Team for the Mentally Handicapped to authorities who would like specific guidance on providing for the children in their care.

By early 1984, only a year after the initiative was launched, over 80 applications for funding had been received; and 31 projects involving 250 children were planned and approved, thus demonstrating the commitment of health authorities to establishing a new pattern of care for these children.

Other measures to encourage the movement of children out of hospital include the provision of £1m under the pound for pound scheme to support voluntary bodies who are making alternative arrangements for children at present in hospital, and to fund the Dr. Barnardo's Liverpool project for severely mentally handicapped children, officially opened by the Secretary of State in December 1983.

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8

DENTAL HEALTH

General dental services

The number of estimates submitted by dentists and authorized for payment in 1983 was 30,505,781, an increase of nearly 2% over the 1982 figure and more than 12% higher than in 1979 (5 years ago). Whilst the number of permanent teeth filled in 1983 increased by 1.14%, the number of permanent teeth extracted decreased by 2.04%. This produced an overall slight increase in the total of permanent teeth filled or extracted. The number of teeth root treated increased by 9.34%, a slightly lower rate of increase than that recorded last year. Courses of treatment including crowns, decreased by 6.91%, the numbers of teeth crowned decreased by 2.94% compared with an increase of over 7% in 1982. The number of bridges provided increased by nearly 40% almost as great a rate of increase than that which occurred in 1982. The number of courses of treatment including the provision of a bridge or bridges increased by 34.75%. The numbers of treatments requiring general anaesthesia declined by 13.3% a greater rate of decrease than that observed in 1982. From April 1983, fees for single handed general anaesthesia were no longer included in the Scale of Fees. There were 1,917,180 courses of treatment including treatment of chronic periodontal disease carried out during the year, an increase of 23.7% over the 1982 figure. Treatment involving scaling and polishing and simple periodontal treatment increased by 1.01% from 9,024,080 in 1982 to 9,127,910 this year. There were 77,890 courses of treatment including periodontal surgery and occlusal equilibration, a decrease of 36% since 1982. In children's dentistry, the number of deciduous teeth filled amounted to 1,708,300, a decrease of 2.28% from last year: the number of deciduous teeth extracted also declined from 1,235,084 to 1,173,330, a decrease of more than 5% from the 1982 level. Overall, the total number of deciduous teeth filled or extracted declined by 3.74%. For children up to the age of 16 years, the number of permanent teeth filled was 3,484,690 showing a 6.64% decline from the 1982 level of 3,732,690. This supports the commonly held view that dental caries experience among children is decreasing. In orthodontics 152,100 courses of treatment were completed of which 49,600 did not require prior approval by the Dental Estimates Board. These figures show a rise of 3% compared with the previous year. On the other hand 4,500 cases were concluded for people over 18 which represented a decrease of 17.6% from the 1982 figure of 5,460.

In 1983 dental officers in the reference service of the department examined 20,888 patients in regard to the provision of treatment under the general dental services but for whom orthodontic treatment was not involved. Where proposed treatment was being considered, the dental officers were in complete agreement, or with modification in some cases, to 61.4% of the treatment plans. For patients whose treatment had been completed 57.3% were in the dental officers' opinion dentally fit but 36.9% were not completely satisfactory. In 4.7% of the patients seen the dental officers considered that they had not had the majority of the treatment completed satisfactorily. In connection with the provision of orthodontic treatment,

1,729 patients were examined, this number represents an increase of 61% over the previous year's figure. This significant increase can be explained by the fact of a new dental officer having joined the staff and by the application of improved management techniques. Some 1050 cases were referred for examination before commencement of treatment. Throughout the country less than 10% were given unqualified approval, and in the London/South area this dropped to just over 2%. At the end of treatment examinations were carried out on 653 patients, and of the 430 examined in the London/South area, only 3 cases were considered to have been completed satisfactorily in all respects. The presentation of cases continues in general to be poor, but could be expected to improve if the use of a separate FP17, currently under discussion, is introduced. Evidence is accumulating of abuse of the system by a few practitioners. It is to be hoped that their colleagues, who of course make up the majority of practitioners, may be able to exercise a favourable influence on them.

Hospital dental services

The number of dentists working in the hospital dental service in England and Wales (excluding hospital practitioner and paragraph 107 appointments), at 30 September 1983 was 1,311 an increase of 5 over the previous year. The number of women working in the service continues to grow and currently amounts to 20.1% of the total. This compares with 19.3% of all dentists registered on 7 January 1983 being women. 3.8% of consultants are women as opposed to 3.1% last year. Paediatric dentistry is now classified as a separate specialty and 7 consultants are in post.

Community dental service

By the beginning of 1982 the maintained school population in England was less than 8.0 million. Just over 5.3 million school children were inspected and there was a slight reduction to under 1.2 million in the number who received treatment. The number of children under 5 years inspected and treated has increased by 10.9% from 57,580 to 63,844 and there has been a large increase from under 10,000 in 1981 to over 14,000 in 1982 in the number of handicapped adults treated by the service.

Children's dental health

A survey on children's dental health was carried out early in the year and the preliminary results published in an OPCS monitor in November show a significant improvement in children's dental health over the last 10 years[1]. The proportion of children 5 years of age in England and Wales with some known decay experience decreased from 71% in 1973 to 48% in 1983. The average number of teeth in 5-year-olds with known decay experience has decreased from 3.4 teeth in 1973 to 1.7 teeth in 1983. Improvements were found in all groups from 5 years to 15 years of age and were apparent in all regions in England and Wales. The survey extended over the UK and there are very large differences between countries in the average decay experience of older children. Among 15-year-olds in England there was an average of 5.6 teeth with known decay experience, and in the same age group, 6.7 in Wales, 8.5 in Scotland and 9.2 in Northern Ireland. It is too early to speculate on the reasons for the difference and the full report should be published in Autumn 1984.

Dental manpower

The first consideration of dental manpower requirements was carried out in 1946 by the Teviot Committee[2] which concluded there was a need for at least 20,000 dentists in active practice within a 20 year period. In 1956 the McNair Committee[3] restated the target as 20,000 dentists on the Dentists Register implying a rather smaller target for numbers in active practice. The annual target entry figure to dental schools was set at 954 in 1958 but this was not achieved until the mid seventies whilst the McNair Committee target of 20,000 dentists on the Register was not achieved until 1979.

The Royal Commission (1979) on the National Health Service[4] recommended that no decision should be taken to alter the annual dental student intake until the implications of the move towards prevention became known and the 1980 Nuffield Inquiry into Dental Education[5] took a similar view but did recommend that some machinery for keeping dental manpower questions under continuous review should be established. In 1981 the Dental Strategy Review Group Report[6] recommended a 10% reduction in dental school intake. It was decided that it would be premature to take up the Review Group's recommendations until a further Manpower Study had taken place and this commenced in 1981 and reported early in 1983 to Ministers[7].

The Group had a remit to review likely trends in the supply and demand for dental manpower over the next twenty years or so but in the event looked further ahead to longer term stable levels in supply and demand which can be projected to occur a decade or so into the next century.

Ministers accepted the Group's recommendations that there should be a 10% reduction in dental school intake. This will still allow for a 40% growth in the estimated number of UK dentists from around 22,500 to some 32,000 by the year 2020. The Study Group also recommended regular reviews of dental manpower to allow for any re-adjustment that may be necessary. The first of these regular reviews will take place in 1984.

Fluoridation

With regard to fluoridation, judgement was given by Lord Jauncey on 29 June 1983 following the Strathclyde fluoridation court case which lasted for 201 days.

In his detailed opinion, Lord Jauncey reached the conclusion that the addition of fluoride to the public water supply at a concentration of one part per million would be likely to reduce considerably the incidence of dental caries in the Strathclyde Region and he considered that there was no evidence that the addition of fluoride at such a concentration was harmful to health. However, he also concluded that current Scottish water legislation did not contain the necessary legal vires to permit Strathclyde Regional Council to add fluoride to the water supply. The Government considers that Lord Jauncey's judgement provides ample justification for its continued support of fluoridation and, as announced by the Secretary of State for Social Services on 6 December 1983, it is therefore intended to bring forward legislation to clarify the power of water authorities in Scotland to add fluoride to the water supply at the recommendation of the appropriate

health boards. Lord Jauncey's judgement is not binding outside Scotland, but for the avoidance of any doubt, it is intended that the legislation should also cover statutory water undertakers in England and Wales and that corresponding legislation should be enacted for Northern Ireland.

General dental anaesthesia

During 1983 considerable concern was expressed in Parliament and in the media about the practice of operator administered general dental anaesthesia. In January 1983 the Chief Dental Officer wrote to all practitioners in the general dental services reminding them that general anaesthesia for dentistry of any kind should only be considered when there were clinical indications of the need for it and that, where it was justified, the roles of anaesthetist and operator could not be combined without risk. This advice was reinforced by guidance on general dental anaesthesia and sedation agreed by the General Dental Council in April 1983 in which it was stipulated that where a general anaesthetic was administered, the Council considered that it should be by a suitably qualified and experienced person other than the operator and that proper equipment and resuscitation facilities must be available. The guidance made clear that a dentist who failed to observe its terms would be liable to disciplinary proceedings.

The Dentists Act 1983

The Dentists Act 1983[8] received Royal Assent in May and makes a number of changes to the functions of the General Dental Council as the governing body of the dental profession. The Council itself will have an increase in the number of elected dentists and of lay members and will for the first time include a dental auxiliary. The Disciplinary Committee has been renamed the Professional Conduct Committee and the Preliminary Proceedings Committee has been given the power to suspend a dentist prior to a Professional Conduct Committee hearing where this is considered necessary for the protection of the public. A Health Committee is to be established with powers of conditional registration and suspension where the fitness of a dentist to practice is judged to be seriously impaired by reason of his or her physical or mental condition.

The preparation of a Consolidation Act was also commenced to bring together the various elements of the 1957 and 1983 Dentists Acts to make them readily understandable by dental practitioners.

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9

MENTAL HEALTH

Introduction

The Mental Health Act 1983[1] came into operation on 30 September 1983. The Act incorporates substantial amendments to the Mental Health Act 1959 notably in the area of consent to treatment. Perhaps most significantly, however, it establishes the Mental Health Act Commission as a Special Health Authority to monitor the care and treatment of detained patients, and report to the Secretary of State.

The 'Rising Tide' of elderly people with psychiatric disorder remains a matter of concern. Shortfalls in services, as well as examples of good practice were highlighted in the Health Advisory Service Report with that title[2]. A central initiative was launched to stimulate the development of local services.

Fifty local schemes with central funding were introduced as a response to the continuing increase in drug abuse; information on solvent misuse and advice about how to cope with it was distributed; and *Alcohol Concern* a National Voluntary Agency which will support the development of services for problem drinkers was formed.

These developments in particular fields of concern have occurred within a strategy which is still that as outlined in the 1975 White Paper '*Better Services for the Mentally Ill*'[3]. Broadly this is that authorities should continue to emphasize the development of community-based services for people suffering from mental handicap or mental illness. '*Care in Action*'[4] confirmed these as priority groups, and health authorities are asked to report their plans for developing appropriate services at Department Annual Reviews.

Mental Health Act 1983

The Mental Health Act 1983[1] received Royal Assent in May 1983 and came into operation in September 1983. This is a consolidated Act bringing together the provisions of the Mental Health (Amendment) Act 1982 and the Mental Health Act 1959. The principal changes and amendments to the 1959 Act were described in this Report for 1982 (page 85)[5], and in a Circular (HC(82)17)[6].

The Department of Health and Social Security has published an Explanatory Memorandum[7] which describes the main provisions of the Act and the Regulations and Orders which have been made under the Act, including Mental Health (Hospital, Guardianship and Consent to Treatment Regulations), 1983; the Mental Health (Nurses Order) 1983; and the Mental Health Act Commission Orders and Regulations (HC(83)11)[7].

There are new forms prescribed by the Regulations for the detention of patients in hospital or for guardianship and forms for use in connection with the new consent to treatment procedures. The need to inform both patients

and their relatives has been emphasized and leaflets have been drawn up explaining patients' rights under the Act. Mental Health Review Tribunal Rules have been revised and published (HC(83)17)[8].

The passage of the Bill through Parliament and the implementation of the Mental Health Act 1983 occasioned much debate. For those interested in the detail a list of further reading is given at the end of this chapter.

The Mental Health Act Commission

The Mental Health Act Commission became operative as a Special Health Authority on 30 September. Its Chairman, Lord Colville of Culross, was appointed in August and the Commission met for the first time in early September. The Commission has about 90 members — laymen, lawyers, doctors, nurses, social workers, psychologists and other specialists. Offices are located in London, Nottingham and Liverpool, with regional groups of Commissioners and a small Central Policy Committee. Establishment of the Commission is seen as a landmark in mental health legislation. The work is demanding and is seen as highly important by the professions and all with an interest in mental health.
The main functions are as follows:–

i. To keep under review the use of the legal powers of detention, to visit hospitals and nursing homes and to investigate the complaints of individual patients.

ii. To monitor the use of the consent to treatment procedures for the treatment of mental disorder in detained patients and to appoint consultant psychiatrists to give second opinions, where these have to be sought before certain forms of treatment can be given.

iii. To make proposals to the Secretary of State on a Code of Practice giving guidance on the admission of patients to hospitals and mental nursing homes under the Act and matters relating to the medical treatment of patients suffering from mental disorder.

iv. To report biannually to the Secretary of State in a report that will be laid before Parliament.

Elderly people with psychiatric disorder

Fifteen per cent of the population are more than 65 years of age and their numbers are growing. Further, the proportion of very old people is rising and by the end of this century the numbers aged over 75 years will increase by 20% and those over 85 years by 50%. About 75% of those over 85 years are women, often widowed and living alone. The prevalence of psychiatric disorder in the elderly increases with age. The principal forms of psychiatric disorder occurring in old age are the 'functional' mental illnesses such as depression, organic mental conditions such as confusional states (which may be reversible) and the dementias (which are usually irreversible). Surveys[9–10] over the past decade in Europe and the United States suggest that the prevalence of moderate or severe dementia for all those over 65 years of age is between 6.2% and 7.1%. On the basis of these surveys it is estimated that there are 500,000 people in England aged 65 years or over who suffer from moderate or severe dementia. Many more will be suffering from mild

dementia. The prevalence of dementia increases with age to about 22% in those aged 80 years and over. About a quarter of the half million people with moderate or severe dementia will be aged 85 years and over. Most will be living at home.

These facts have been known for years and concern about the slow so-called 'epidemic of dementia' which might develop as the numbers of very old people rise has been expressed. In the mid-1970s the Medical Research Council (MRC) identified the dementias as conditions to which priority should be given for research purposes and in 1977 it produced a Report[11] which recommended areas for research. In 1981 a Working Party set up by the Royal College of Physicians led to the publication of *'Organic Mental Impairment in the Elderly*[12]. This describes the disease process in organic mental disorder with particular reference to the Alzheimer type of senile dementia and to the prospects for early diagnosis, assessment and treatment. Guidelines for the development of services were also included. In 1981 the White Paper (*'Growing Older'*)[13] and a handbook of policies and priorities for health and social services (*'Care in Action'*)[4] identified the need to provide services for the elderly mentally ill as an urgent priority.

The Health Advisory Service (HAS) had shown concern about the serious deficiencies in services for the elderly mentally ill in many parts of the country but had also been impressed by the small but growing number of pioneering and progressive services that had been developing. Each region had at least one good service led by a committed group of professional people. HAS therefore set up a study team to look at a wide range of services, in an attempt to identify key elements that were common to those that seemed to be progressive and successful. This exercise took over 2 years and produced *'The Rising Tide'*, a commentary on the services for mental illness in old age[2]. At the same time Lord Trefgarne, Parliamentary Under Secretary of State, wrote to the Chairmen of Regional Health Authorities (RHAs) to say that £6m would be made available to support the development of district services. He suggested that regions might organize a competition in which each health authority might bid for funds on the basis of its proposals for developing a local service. Such proposals would have to represent a local jointly-agreed health and local authority commitment. There was an impressive response. Nearly every district — and some had recently been restructured — submitted proposals and 29 districts have now been selected by regions and DHSS for a share of the funds. The proposals from the health authorities include various schemes such as the introduction of a travelling day hospital, the extension of 'night-sitting' services, the provision for dental care research, the appointment of additional community psychiatric nurses and the creation of a teaching laboratory. Each RHA has been sent a list of the proposals received.

Alcohol misuse

In January 1983, following a decision by Ministers that they would prefer a single new national voluntary organization to deal with alcohol misuse, a Steering Group was set up to advise the Minister for Health on how the new body might best be established, funded and organized. The Group comprised an independent Chairman, a secretary provided by the Department and two representatives from each of the four existing national bodies — the National Council on Alcoholism, the Medical Council on Alcoholism,

the Federation of Alcoholic Rehabilitation Establishments, and the Alcohol Education Centre.

The Steering Group reported to Ministers in June. Ministers then agreed on an Interim Executive Committee to set up the new organization. Financial support for a Secretariat was provided. The Medical Council on Alcoholism decided that it should remain independent of the new body although it would continue to co-operate with all organizations concerned with the prevention of alcohol misuse.

The new organization, called *Alcohol Concern,* the *National Agency on Alcohol Misuse,* was launched in November 1983. *Alcohol Concern* will consult the Health Education Council, district health authorities, local authorities and local councils on alcoholism, stimulate the formation of more local councils on alcoholism and extend and improve the network of local voluntary agencies and their collaboration with statutory authorities. The organization will also collect information on alcohol misuse, review and assess the training needs of the voluntary sector, and plan training activities which fit in with those for which the professions and statutory bodies are responsible. By the end of the year a full-time Director had been appointed and detailed planning had commenced.

In September 1983 another new organization, *Action on Alcohol Abuse* was formed under the auspices of the Conference of medical Royal Colleges and their Faculties. It aims to campaign for the public to be better informed about the problems associated with drinking and to press for improved services for problem drinkers.

Following earlier consultation on the Blennerhassett Committee's proposals[14,15] on drinking and driving the Department of Transport introduced new procedures on 6 May 1983 for dealing with offenders who are at high risk of driving while under the influence of alcohol. The main aims of these procedures are to promote safe driving and to encourage offenders with an alcohol problem to seek help and rehabilitation. The scheme is expected to involve about 3,000 drivers each year coming within three main categories:

1. Those disqualified twice within 10 years for driving, or attempting to drive a vehicle, when, on both occasions, their alcohol concentration was more than 2½ times the legal limit.
2. Those disqualified twice within 10 years, once for driving with more than 2½ times the legal alcohol limit, and once for failing to provide a specimen of breath, blood or urine for analysis when requested to do so.
3. Those disqualified twice within 10 years for failing to provide a specimen for analysis where police evidence suggest that there are reasonable grounds for suspecting that the driver has an alcohol problem.

When applying for a driving licence after the second period of disqualification drivers included in these categories will be subject to investigation by the Department of Transport's Medical Advisory Branch. Those who fail to demonstrate that any drinking problem which they may have had has not been brought under control will not regain a licence and will be advised by the Department of Transport to seek help.

Drug abuse and solvent misusers

Drug abuse

Despite an increase in the number and size of seizures by the police and customs, the availability of illicit heroin on the streets continued to increase. Medical practitioners notified 5,900 addicts to the Home Office during 1983 — an increase of 50% over the total for 1982. The provisional end-of-year total for individuals recorded as receiving notifiable drugs in the treatment of their addiction was 5,100; others, however, may still be in treatment, but without the use of controlled drugs.

Early in the year the Department consulted statutory, professional and voluntary bodies, seeking their views on the Treatment and Rehabilitation Report of the Advisory Council on the Misuse of Drugs[16]. As part of this consultation, the Secretary of State convened a medical conference in January 1983 to provide an opportunity for representatives of the profession to give early consideration to recommendations of particular relevance to them.

During the course of the year, some 50 schemes were approved, under the Central Funding Initiative, announced in 1982, to improve services for drug misusers. Projects approved included nurse-training courses, additional health and social work posts (both to expand existing drug treatment teams and to initiate community-based responses), extension of community counselling services, and capital funding to improve the availability of toxicological screening, and to provide additional residential rehabilitation facilities. Emphasis was placed on improving the geographical distribution of services, and the sharing of available resources between statutory and voluntary bodies.

In December amending legislation, the Misuse of Drugs (Notification of and Supply to Addicts) (Amendment) Regulations 1983,[17] was made by the Home Secretary, to come into force in April 1984, extending the licensing restrictions on the prescribing of drugs in the treatment of addiction to include dipipanone (*'Diconal'*).

Solvent misuse

Solvent misuse among young people continued to cause concern. Following Departmental consultations early in the year the policy of supporting a low key multi-disciplinary response was endorsed. This is based on education and persuasion. The Government's view that legislation to create offences associated with the misuse of solvents would be inappropriate was confirmed.

In December the Government announced measures to help professionals and agencies provide an effective response to solvent misuse. A post in the National Children's Bureau to collate and disseminate good practice was funded, and discussions were held with the Home Office to consider the issue of a circular setting out the options open to police forces when dealing with solvent misusers.

The Health Education Council and local authority associations were

consulted about the possibility of preparing further educational material for parents and professionals. The Department sponsored a seminar dealing with the care of solvent misusers in 1983, and continues to contribute to the cost of regional seminars, and to consider funding research and small local studies.

A film *'Illusions'* co-sponsored by Government Departments with an interest in solvent misusers was released in September. It provides information on the problem and demonstrated what can be done in health, community care and education settings. An explanatory handbook is available with the film.

Agreement was reached by retailers' associations in December on voluntary restrictions to the sale of solvents including information for retail assistants and management, and material for display to the public.

Forensic psychiatry

By the end of 1983 five permanent regional secure units in Northern, Trent, North East Thames, South Western and Mersey Regions, providing 180 beds, had admitted their first patients. Two other units, one in East Anglia (36 beds) and the other in North Western (20 bed adolescent unit) were at the commissioning stage. Three other permanent regional secure units — Yorkshire, Wessex and North Western — and a multi-site scheme in South East Thames Region were under construction. These will provide a further 257 places. Five more units, giving a further 215 places in North West Thames, South West Thames, Oxford, South Western and West Midlands, are at planning and design stage. Building work is expected to start in North West Thames in 1984.

At the end of 1983, nearly 300 places were available in interim secure units and a variety of special care units and wards, though this number is tending to fall as some interim units are replaced by permanent units. Some interim arrangements will cease to function when the permanent regional secure units become available, but others, providing a range of care, may become permanent features in an integrated psychiatric service.

In addition, nearly 900 places are available in other secure facilities such as a ward which is lockable, or beds under special supervision.

Efforts continued to encourage the development of a widening range of provision for psychiatric patients requiring security, not only in special units but in the mental health service as a whole so that a comprehensive pattern of services could be achieved. This policy was described in a report '*Secure Facilities for Psychiatric Patients — A Comprehensive Policy*'[18]

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10

SERVICES FOR THE PHYSICALLY HANDICAPPED AND THE ELDERLY

Services for the physically disabled

This year has seen a continued awareness of the place of disabled people within the community and also of their own desire for a more independent style of living. At the same time, however, advances in clinical care and technology have increased the numbers and longevity of high dependency patients. While many will continue to need residential care, statutory and voluntary bodies are making considerable efforts to further the independence of disabled people by providing a variety of clinical, caring and supportive services in the community. Whilst no-one would argue with this philosophy it is important that plans for social integration go hand in hand with plans for community care to ensure that isolation is not exchanged for institutionalization.

Spinal Units

The new replacement Spinal Unit at Stoke Mandeville was opened during the summer of 1983. Building of the two additional Spinal Units at Odstock Hospital in Salisbury, and the Royal National Orthopaedic Hospital at Stanmore had been completed in 1983 though the official openings were not held until the New Year. When these additional new Units are fully operational the load on the Stoke Mandeville Unit should be reduced and it is hoped that early admission to Spinal Units for all patients in the south of the country will be possible, as is already the case in the north.

Epilepsy

A Working Group in which the Department of Education and the Welsh Office also took part has been considering the recommendations of the Reid Report[1] in the light of the findings of Professor Bennett's research[2] and of other recent developments. The group's task is to recommend ways of improving the services provided for epileptics while taking account of current financial constraints. The Working Group met regularly throughout 1983 and is expected to report early in 1984.

Policy development for the visually handicapped

The start of a fact finding exercise on services for the visually handicapped was noted *in this Report for 1982* (page 93). Seven visits to different parts of England took place in 1983. On each occasion a multidisciplinary team met a wide range of representatives of health and local authorities, and voluntary organizations, to discuss the organization of services for the visually handicapped in their locality.

There was a wide spread of opinion and practice. The information obtained is being collated to form the basis for further work.

Revision of Form BD8

Consultation on a revised form began on 1 August 1983. Thirty-five bodies were consulted, and it proved necessary to extend the deadline from 31 October to the end of the year.

Communication aids centres

The four new English Centres mentioned in *this Report for 1982* (page 92) had all appointed staff and were functioning on a small scale by December 1983. Charing Cross opened officially on 3 November. Frenchay Hospital, the original Centre, has reported an increase in its activities; and with patient needs becoming more widely understood, commented on the need to adapt the management and organization of the Centre.

The staff of the Centres started regular meetings to exchange views, under the auspices of the Royal Association for Disability and Rehabilitation, and have also met Departmental staff twice during the year. A Health Notice about the Centres is now in the final stages of preparation and when issued, information about the Centres' work will be more widely available and more patients should be sent for assessment.

During the year, Supply Division pump priming funds have been used for the following communication aids to help stock the Communication Aids Centres.

Convaid — This is a portable synthetic speech output communicator with a changeable vocabulary and symbolic selector panel. It is suitable for users with moderate physical disablement.

Toucan — This is a portable alpha-numeric message device with two-way display. It is operated by actuators and is suitable for users with severe physical disablement.

Hector — This is a wearable speech rate monitor with an audible alarm. It is designed to help people with certain types of stammer.

Environmental controls

The Department has supplied Environmental Control Equipment for very severely physically disabled people since 1966. Provision for many years centred on two systems, the PSU1 and the PSU3, both manufactured by Possum Controls Limited. With the recent advances in technology based on microprocessors both systems have become technically obsolete and also extremely costly for their purpose. Steps to replace the simpler device (PSU1) came to fruition in 1983 when Hugh Steeper Limited obtained a contract to manufacture and supply a basic environmental control known as the SEC1.

The SEC1 enables a disabled person, using a single switch, to talk by intercom to one internal location, or to a caller at the front door, unlock the door, operate a telephone, sound an emergency alarm, and switch on and off up to 5 domestic appliances. This equipment has an improved facility for control from two sites. The first sets were issued to patients in September 1983 and 18 had been issued by the end of December 1983.

The Department is continuing to supply the more complex Possum PSU3 device but at the end of the year the necessary processes to replace this system too were about to begin.

BBC B microcomputers in occupational therapy departments

The Department of Trade and Industry, under its Information Technology Awareness Programme, has funded 32 BBC B Microcomputers for Occupational Therapy Departments in England. These computers were placed in two phases, in February and October 1983, and sites included hospitals, day centres, and occupational therapy schools.

These microcomputers are very flexible communication and learning tools. They can be used, with appropriate programmes, for many tasks, such as the assessment of intellectual processes, and of dexterity and co-ordination, and training in these areas. They can also be used for work assessment, and for recreation. The development of special controls enables severely physically disabled people to operate the computer. The occupational therapists have found the computers generate much interest among patients of all ages, with a variety of disorders, including physical disabilities, mental illness and mental handicap.

The value of the microcomputer as a therapeutic medium is being recorded by the therapists. Regular meetings are being held so that the therapists can exchange views on techniques and appropriate software.

The Aids Assessment Programme

The Aids Assessment Programme, which undertakes studies of the usefulness of aids to daily living, was last mentioned in *this Report for 1980* (page 107). This programme is running extremely smoothly.

By the end of 1983 a total of 17 projects had been completed and 10 reports were available. The reports are widely circulated among therapists and are greatly valued by them.

Projects approved are as follows:–
Royal National Hospital for Rheumatic Diseases, Bath —
  Car Aids
New Addenbrooke's Hospital, Cambridge —
  Potty Chairs for Handicapped Children
The London Hospital —
  Food Preparation Aids — light-weight and double handed saucepans and pots, cooking baskets and steamers
Norfolk and Norwich Hospital —
  Furniture used by handicapped children in main stream schools
Southampton General Hospital —
  Lower Limb Dressing Aids

The project at St Pancras Hospital entitled *A Community Study on Incontinence Garments* included detailed investigation into the constituents of the pads and pants. The report suggests that the qualities of these constituents determine the absorptive capacity and other properties of the devices. This work seems of fundamental importance and is being carried further by work commissioned by Supply Division Research Liaison Group.

Hearing impairment

The needs of those whose hearing is impaired has received considerable attention in Parliament and the media. While much remains to be done, there have been some exciting technological advances — mostly funded by the Department of Trade and Industry — and the general public have been made more aware of the problems of deafness, and ways in which they can be alleviated, through the Sympathetic Hearing Scheme, to which this Department has given considerable grant aid.

The importance of early diagnosis of deafness is now widely acknowledged; the screeing of children at 8–9 months is important and ways to accelerate the present screening assessment and treatment procedures are being explored and discussed with the profession. The Department has also continued to fund the evaluation and follow-up of the screening of neonates using an auditory response cradle. First results are encouraging and are to be published soon. A seminar to demonstrate and discuss the value of the cradle is to be held at the Kings Fund Centre in May 1984.

Research by the National Foundation for Educational Research on the setting up, training and work of the first hearing therapists has been completed. The report will be published in early 1984[3].

THE ELDERLY

During the year the Department sponsored four seminars.

Effective geriatric medicine

(1) '*Effective Geriatric Medicine*'[4] was the title of a seminar which aimed to record how consultant geriatricians approach their everyday work. Text-books of geriatric medicine deal with the presentation and treatment of disease in elderly people but say little about the ways departments of geriatric medicine can be organized, and the resources needed for each type of department to function effectively. It was hoped that a seminar dealing with the administrative aspects of geriatric medicine would help health planners and also doctors in other specialties.

Geriatric medicine as a specialty began with the work of Dr Marjory Warren in the 1930s. Dr Warren recognized that elderly patients could be treated and rehabilitated, and could often be discharged home. However, to make rehabilitation possible resources must be made available. Examples of necessary developments include space around beds for walking aids and wheelchairs; low beds and high armchairs to allow patients to move about the ward independently; non-slip flooring to increase confidence; lavatories within easy reach of beds and sitting areas to encourage mobility and continence; and increased numbers of nursing and remedial staff to give patients individualized care.

It was pointed out that while departments of geriatric medicine still rehabilitate elderly patients who have been treated in the general wards most also treat acutely ill elderly patients. This came about because geriatricians felt specialist skills should be made available from the moment of admission. In order to have hospital beds available for emergency

patients doctors must discharge their existing patients as rapidly as possible. To reduce the length of stay of elderly patients to a minimum geriatricians, like other doctors, find they have to admit them to beds within the district general hospital. X-ray and laboratory investigations can then be arranged without delay, and assistance from colleagues in other specialties is readily available.

Some departments of geriatric medicine have enough beds in the district general hospital to provide an age-related service to which all medical patients over a particular age (typically 75 years) can be admitted. However, it will be many years before all health authorities will be able to provide such a service.

The seminar discussed the policies open to geriatric departments with a limited number of beds in district general hospitals. The first possibility would be to admit only a proportion of acutely ill patients, but to admit preferentially those with complicated clinical problems and those likely to require prolonged rehabilitation. An alternative policy would be to merge the limited number of district general hospital beds available to the department of geriatric medicine into a common pool with general medical beds. Medical patients of all ages would then be admitted to this single 'integrated' department, in which consultant geriatricians would work within medical teams.

Some difficulties were inevitable when the newly-formed departments of geriatric medicine became impatient to expand their influence within general hospitals. This led the Royal College of Physicians of London to establish a working party to consider 'the problems which have led to uneven and sometimes inadequate service for the medical care of the elderly and the difficulties of recruitment of doctors to that service'. The working party recommended 'integration of the diagnostic and therapeutic services of physicians and geriatricians' into common clinical departments[5].

Integrated departments of general and geriatric medicine

(2) Five years after the College report approximately one geriatrician in five practiced in a joint service, and to review progress the Department organized a study group to consider the experience of doctors who work in this way[6]. Many advantages are claimed for such departments:–

(i) elderly patients receive prompt admission and the temptation for separate departments to evade responsibility no longer exists; (ii) specialist skills can be made available speedily to all elderly patients so that length of stay in hospital is reduced; (iii) patients of all ages benefit from free association, and integrated medical and geriatric wards are better for mobilizing elderly people; (iv) the stigma associated with admission to a 'geriatric' ward is absent; (v) staff benefit as well as patients; knowledge about geriatric medicine spreads rapidly to junior doctors and nurses, so that a greater proportion are taught the special needs of the elderly; (vi) recruitment of staff (particularly medical) is better to integrated departments[7].

The group agreed that integrated departments would only work well if properly planned. Doctors appointed as physicians with special responsibil-

ity for geriatric medicine should have been trained in the specialty at senior registrar level, to ensure they had been adequately trained and had shown a sincere commitment to the care of elderly people. Integrated departments needed enough beds to meet requirements.

Support for elderly people living in the community

(3) In recent years the Department of Health, the Department of the Environment and other agencies active in this field have funded studies relating to community care for the elderly. A guide was prepared which described work completed and the studies which are still in progress[8]. A seminar was then arranged at which various speakers discussed the quality of life of elderly people and the potential for community care; acknowledged the key role of careers and the problems which faced them and described the role of convenient housing in maintaining independence[9]. Although this seminar summarized studies which had already been done it was hoped it would also provide a framework which future research would supplement.

Residential care for elderly people

(4) To complement the seminar on community care a meeting was organized to discuss research on residential care. Synopses of important research studies were prepared and several background papers were read[10]. The papers reviewed issues which included historical trends in provision and staffing, the factors which influenced the quality of residents' lives, and the features of residential homes which most influenced costs.

Experimental NHS nursing homes

The first of three experimental nursing homes for elderly people was opened this year at Chapeltown in Sheffield. This will form part of a research study designed to evaluate a style of continuing care which is more domestic than the conventional long-stay ward, and which it is hoped will promote greater independence than is generally possible in hospital. An account of the thinking which led up to the project was published[11] and a paper was prepared which described the operational policies of the homes[12]. The design notes which guided the capital works were also published[13].

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11

THE ARTIFICIAL LIMB, VEHICLE AND APPLIANCE SERVICE

The artificial limb service

On 25 November the Minister for the Disabled announced that a Review of the Artificial Limb Vehicle and Appliance Service (ALAC) under the Chairmanship of Professor Ian McColl would take place. The possible integration of the ALAC into the NHS would be one of the topics to be considered.

Also in November a team from the Office of the Chief Scientist visited the Bioengineering Centre at Roehampton which has been administered by the University College, London since 1980, although it is still funded by the DHSS. The inspection was to establish that projects undertaken were relevant to the clinical needs of amputees. A report is expected during 1984.

At the beginning of the year the Department commissioned Research Surveys of Great Britain Ltd to undertake a survey of artificial limb users to point out in what respects the Artificial Limb Service might be improved and identify areas of dissatisfaction. Approximately 500 amputees who attend the Roehampton, Sheffield, Liverpool and Exeter Centres were interviewed. All aspects of the limb users' existence, problems associated with the prosthesis, the level of service received from the ALAC, and the quality of the amputee's life at home and outside the home were investigated. The report should be available in 1984.

The annual DHSS/RCS Symposium took place on 28 October 1983 at the Royal Devon and Exeter Hospital.

Two new developments

It is generally conceded that if an artificial limb service were to be set up today it would not be placed in the DHSS. Over a period of time the greatest handicap to the ALAC Service has been the lack of in-patient facilities. With the advantage of overnight, even hostel-type accommodation an elderly amputee would often be spared a long and exhausting daily ambulance ride to and from the Walking Training School. A small number of beds at the Royal Star and Garter Home at Richmond are to become available for patients receiving prosthetic rehabilitation, thus enabling them to be treated rapidly and more effectively. This pilot scheme will commence in April, 1984.

Norwich ALAC is one of the two remaining Centres that are not purpose-built structures situated in hospital grounds. The present accommodation is inadequate because it is situated in the city centre where parking is very difficult. The ALAC is on the first floor with access only by lift or stairs and thus presents difficulties and dangers for disabled patients. A new Centre is now to be constructed on the site of the West Norwich Hospital and is expected to be completed in 1986.

Statistics

In 1983 there were 5,606 new patients (82 more than 1982) — Table 11.1; 187 of these were non-amputation cases, 141 having congenital limb deficiencies or malformations.

The overall ratio of male to female amputees was 2.04:1 (2:1 in 1982). There was no change in the male to female ratio between 1982 and 1983 for the 40–79 age groups (2.3:1). In all other age groups — 0–9, 10–59, 60–79, and over 80 there were only minor changes from last year — 1.2:1, 3.4:1, 2.1:1 and 1:1.2 (1:1, 3:1, 2:1 and 1:1.2 in 1982).

Injuries due to trauma

Table 11.2 shows the total number of attendances for injuries resulting from trauma leading both to amputation and to non-amputation. Non-amputation resulted mainly from injuries causing nerve damage. Leg and arm amputations followed industrial injury in 91 cases (47 arm, 44 leg).

The ratio of arm to leg amputations following trauma was 1:3.18 (1:3.41 in 1982). The corresponding ratio of arm to leg amputations due to disease was 1:73 (1:72 in 1982).

Prostheses for non-amputees

Table 11.3 lists the reasons for providing a prosthesis to non-amputees — nearly three-quarters of such cases had congenital defects.

Table 11.1 First attendances at Artificial Limb Centres, England, 1983.

(Total first attendances for 1982 in parentheses)

	Male	Female	Total
Single arm amputations	125	55	180 (192)
Single arm non-amputations*	85	67	152 (137)
Single leg amputations	3,160	1,611	4,771 (4810)
Single leg non-amputations*	19	7	26 (32)
Double arm non-amputations*	1	0	1 (0)
Double leg amputations	351	105	456 (510)
Double leg non-amputations*	1	2	3 (6)
Other multiple amputations	12	0	12 (11)
Other multiple non-amputations*	4	1	5 (8)
	3,758	1,848	5,606 (5707)

(* eg congenital shortening, polio, etc)

The overall ratio of arm amputations to leg amputations was 1:15.7 (1:28 in 1982)

Table 11.2 Number of first attendances for injuries resulting from trauma, 1983.

(Figures for 1982 in parentheses)

	1983	1982
Traumatic injuries (total)	506	(593)
Arm trauma	144	(161)
Leg trauma	362	(432)

Table 11.3 Reason for providing a prosthesis to non-amputees

	Male	Female	Total	% of total non-amputations*
Trauma	27	7	34	18
Congenital	76	65	141	74.6
+Disease	9	5	14	7.4

(* eg Patella tendon bearing (PTB) brace for non-union of fractured tibia and fibula or flail arm splint)
(+ causing shortening, instability or wasting).

Reasons for amputations

A total of 3,380 (60.3%) of all leg amputations in 1983 were performed for peripheral vascular disease (PVD) (Table 11.4). This compares with 3,455 (62.5%) in 1982. Of all amputations 20.8% were performed for diabetes, mainly because of vascular complications.

Peripheral vascular impairments in general (PVD plus diabetes) still accounts for about 80% of new amputees referred to the Service, a proportion unchanged for several years. There is now some evidence from the USA that the true percentage of diabetes in these PVD amputees is significantly higher than the 20.8% reported. A limited trial to confirm this was started at Roehampton.

If other levels of amputation are excluded, the overall percentage of above knee amputations (including the through knee level) to below knee amputations (including Symes) was 56% : 44%, not significantly different from last year's figures (57% : 43%). It still remains well below the achievement of certain specialist centres where the percentage of below knee amputations is as high as 70% when amputation was performed for PVD.

Table 11.4 Patients seen for the first time at Artificial Limb Centres in England, 1983.

		Male	Female	Total	% of total
(i)	Age distribution				
	Age Range 0–9	87	70	157	2.8
	10–19	108	36	144	2.6
	20–39	259	59	318	5.7
	40–59	681	215	896	16.0
	60–79	2,255	1,051	3,306	59.0
	Over 80	370	415	785	14.0
Total		3,760	1,846	5,606	
(ii)	Reasons for amputations				
	Vascular	2,307	1,073	3,380	60.3
	Metabolic (i) diabetes	735	433	1,168	21.0
	(ii) other	6	4	10	
	Trauma	397	109	506	9.0
	Malignancy	147	97	244	4.5
	Neurogenic deformity				
	(i) Acquired	7	7	14	3.6
	(ii) Congenital	22	27	49	
	Infection (including gas gangrene)	3	2	5	1.5
	Other	51	24	75	

Road traffic accidents (RTAs) — pedestrians, riders or occupants of road vehicles — accounted for 271 attendances (ie amputations and non-amputations) or about 5% of total attendances (Table 11.5). This is comparable with last year's figure of 5.1%. As most (62.4%) are due to two-wheeler accidents, no improvement is seen as a result of the recent seat belt legislation. The ratio of leg to arm amputation from this cause is 5:1 (9:1 in 1982).

Table 11.5 Analysis of main reasons for amputation and details of road accident cases, England, 1983.

		Male	Female	Total	% of total vascular cases
(a)	Breakdown of vascular aetiology (Total 3,380, diabetes not included)				
	Arteriosclerosis	2,064	890	2,954	87.4
	Embolism	133	94	227	6.7
	Thromboangiitis	36	12	48	1.4
	Varicose ulceration	27	42	69	2.0
	Other	47	35	82	2.4
(b)	Breakdown of trauma aetiology (Amputation and non-amputation*) (Total 506)				% of trauma
	Industrial	87	4	91	18.0
	RTA	172	27	199	39.3
	Pedestrian	42	30	72	14.2
	Home	27	27	54	10.7
	Recreation	15	7	22	4.3
	Armed Forces	19	0	19	3.8
	Rail	18	6	24	4.7
	Other	17	8	25	4.9
(c)	Breakdown of RTA and pedestrian cases (Total 271)				Per Cent of RTA
	Pedestrian	42	30	72	26.6
	2-wheeler driver and passenger	152	17	169	62.4
	Other vehicles	20	10	30	11.0

* See footnote to Table 11.3 for explanatory example of non-amputation following road accidents.

The Vehicle Service

An analysis of the motor vehicles and wheelchairs on issue is shown in Table 11.6. More disabled patients are opting for the Mobility Allowance benefit with the result that the number of powered vehicles and private car allowances on issue has continued to decline. In addition, with the introduction of the War Pensioners' Mobility Supplement (WPMS) in November, the War Pensioners' Vehicle Service (WPVS) has also ceased. The Department now no longer issues motor vehicles to any category of patient.

Table 11.6 Analysis of vehicles and chairs on issue in England at 31 December 1983 (Figures for 1982 in parentheses)

(a)	Powered vehicles and private allowances		
	Motor cars	5,691	(6,375)
	Motor propelled three wheelers	7,510	(8,546)
	Electrically propelled three wheelers	149	(214)
	Private car allowances (PCAs)	424*	(1,822)
(b)	Non-powered wheelchairs (including spinal carriages, pedal and hand tricycles)	364,961	(334,051)
(c)	Powered wheelchairs		
	Indoor electric chairs	9,658	(8,794)
	Outdoor electric chairs	7,528	(8,548)
Total		395,921	(368,350)

* The large fall in PCAs is due to many war pensioners transferring to the WPMS which is an enhanced benefit.

The total number of motor vehicles on issue at 31 December 1983 was 13,350.

The Appliance Service

Charged under Royal Warrant with the prescription and supply of orthoses to war pensioners, the Service is responsible for 14,152 pensioners, a decrease of 617 (4.17%) on the number for 1982.

Table 11.7 Patients using the Artificial Limb, Vehicle and Appliance Service in England, 1983. (Figures for 1982 in parentheses)

Artificial Limb Service	66,600	(66,194)
Vehicle Service*	350,064	(350,025)
Appliance Service	14,152	(14,769)

Note: A patient may well receive care from two or even all three services.

* Figures in Table 11.7 refer to patients whereas figures in Table 11.6 refer to numbers of vehicles on issue. A patient may have a motor vehicle or private car allowance, a powered chair and one or more wheelchairs.

MEDICAL MANPOWER AND POSTGRADUATE MEDICAL EDUCATION

Contractual matters

Junior doctors' hours

The initiative to reduce the long hours worked by junior doctors in hospital which began in 1982 was continued through 1983. Following discussions with the profession an Advance Letter MD 3/83[1] was issued in June 1983 prohibiting regular rota commitments more onerous than 1 in 2 from 1 June 1983 save for central approval of exceptional cases where ending such a rota would cause severe service difficulties. Negotiations continue on devising more stringent rules governing the most onerous internal locum working.

The District Working Parties set up to review existing rotas made progress reports in spring and autumn of 1983. They showed that by the autumn the number of juniors on rotas more onerous than 1 in 3 had fallen by about 750 and that a further 200 or so posts were expected to change. Approximately a fifth of all juniors were still expected to be working rotas more onerous than 1 in 3. Central approval was given in a few cases to enable districts to permit regular rotas more onerous than 1 in 2 to continue temporarily. These rotas are being reviewed and it is expected that fewer than 30 will remain. Negotiations will continue with the profession.

Doctors in general practice

There were 24,907 principals in general practice of which 24,719 doctors provided unrestricted general medical services (UPs), an increase of 2.1%, and 188 doctors provided restricted services, a decrease of 9.6%. The number of female UPs increased to 4,294. The decline in the numbers of Designated and Open Practice Areas continued and of 1,569 areas 6 (0.4%) were Designated and 252 (15.1%) were Open.

The average list size again fell and on 1 October 1983 was 2,108, a fall of 1.8%.

There was a further small increase (2.8%) in the number of vocational trainees to 1,769; 655 (37.0%) were female. Throughout the country there were some 215 Vocational Training Schemes with over 700 trainees in post. More than 1,000 trainees made independent arrangements with one of the 2,570 approved trainers in general practice. The Joint Committee on Postgraduate Training for General Practice issued 1,471 certificates of prescribed experience and 258 certificates of equivalent experience during 1983.

Doctors in hospital practice

The number of doctors employed in the hospital service again increased. On 30 September 1983, the total staff in post (excluding para 94 appointments and hospital practitioners) in England and Wales was 37,352 compared with

Table 12.1 Number of unrestricted principals (UPs) in general practice in England and Wales, 1982/83.

UPs Born in:	1982			1983		
	Male	Female	Total	Male	Female	Total
Great Britain	14727	2988	17715	14951	3169	18120
N. Ireland, Irish Republic, Isle of Man, Channel Islands	894	170	1064	851	169	1020
Elsewhere	4504	934	5438	4623	956	5579
UPs entering practice for the first time Born in:						
Great Britain	630	314	944	660	296	956
N. Ireland, Irish Republic, Isle of Man, Channel Islands	18	10	28	16	12	28
Elsewhere	267	53	320	218	47	265

36,633 in 1982, an increase of 719 (2.0%); 29.3% of these staff were overseas born compared with 30.7% at 30 September 1983.

Total consultant numbers increased by 328 (2.5%); 241 men (2.0%) and 87 women (5.6%). The growth was most marked in the following specialties:–

General medicine +15 (1.4%), Geriatric medicine +5 (1.2%), Urology +11 (6.6%), Anaesthetics +72 (4.1%), Mental illness +35 (3.1%), Histopathology +14 (2.5%), and Paediatrics +26 (4.9%).

The Department gave approval for 320 new consultant posts to be advertised in the year 1984/85. The Department had warned health authorities that it might be necessary to restrict approvals in some specialties because of insufficient numbers in the training grades to satisfy demands for new posts. However, in practice it was only necessary to restrict approvals in Mental handicap.

The number of women doctors employed in the hospital service again increased from 7,806 at September 1982 to 8,205 at 30 September 1983, an increase of 5.1%. These figures exclude hospital practitioners and paragraph 94 appointments. The number of doctors from outside the UK and the Irish Republic again fell. There were 10,945 in 1983 compared with 11,243 in 1982, a fall of 2.7%.

Pre-registration house officers

On 30 September 1983, there were 2,988 pre-registration house officers in post; 1,867 men and 1,121 women. The figures for 1982 were 2,874; 1,817 men and 1,057 women.

In the summer of 1983 there was a shortfall of 25 pre-registration posts compared with the number of newly qualified doctors seeking posts. Urgent discussions were initiated to attempt to prevent the problem recurring in future.

Table 12.2 Percentage of doctors born overseas, England and Wales, at 30 September, 1982 and 1983.

	1982	1983
Consultant and SHMO with allowance	17.2	17.5
Associate specialist	42.2	43.9
Senior registrar	22.9	21.4
Registrar	48.9	46.9
Senior house officer (SHO)	43.6	40.6
Pre-registration house officer (PRHO)	13.6	12.0

Part-time training

At present about 18% of women registrars and 32% of women senior registrars (SRs) are training part-time. At 30 September 1983 there were 276 part-time senior registrars in medical specialties in England and Wales out of a total of 2,499 SRs (excluding honoraries).

The national intake of students to medical schools in 1982/83 was 56% men and 44% women. As this percentage reaches equality, by the end of the decade, there will be an increased demand for part-time posts. Agreement has, therefore, been sought from the Joint Consultants Committee (JCC) to examine the present arrangements for part-time senior registrar training under Circular (PM(79)3[2], to see whether the scheme is adequate and whether it will, in its present form, be suitable to deal with an increased number of applicants. As a result of the agreement with the JCC, a Working Party has been set up, the first meeting to be held early in 1984.

Hospital medical staffing structure

The DHSS formed a Working Party with the JCC to examine the hospital career structure. It looked at the problems in the senior registrar grade, particularly in General medicine and General surgery where there is an excess of senior registrar posts in relation to available career grade outlets. As a result, a review of senior registrar posts in these two specialties was started. The Central Manpower Committee is to look at each post that becomes vacant and which the authority wish to refill, and advise as to whether it should be readvertised.

Honorary contracts

A series of meetings was held between the Committee of Vice-Chancellors and Principals, the Medical Research Council (MRC), the JCC and the DHSS. There was further progress in the attempt to extend the planning of the numbers of senior registrar posts to include those posts held in teaching and research at universities. The need for flexibility especially in the research field is recognized by all parties.

Medical manpower planning

The Advisory Committee on Medical Manpower Planning completed its study of the future projections of supply and demand for doctors on a UK basis. It looked at medical student numbers, doctors in training and numbers needed for career grades up to the year 2010.

Medical students

There was an increase in the number of students entering UK medical schools in 1982/83. The total number of entrants was 4,154; 83 more than for the previous year. Of these 2,331 were men and 1,823 were women.

Table 12.3 Intake of medical students and output of doctors, UK, 1981/82 and 1982/83.

Academic year		England	Wales	Scotland	N. Ireland	Total
Intake	1981/82	3,030	150	739	152	4,071
	1982/83	3,082	153	759	160	4,154
Output	1981/82	2,694	143	550	158	3,545
	1982/83	2,890	133	555	164	3,742

University matters

Reductions in finance

In March a survey undertaken by the University Hospitals Association and the National Association of Health Authorities into the effects of the reductions in university finance in 1981/82 was published[3]. The Social Services Committee subsequently asked the Department for comments on the survey.

In response, the Government

a. welcomed the findings of the survey that in virtually all cases there had been no measurable effects on undergraduate teaching or on the NHS commitments of academic staff.

b. acknowledged, however, that in order to maintain service commitments to patients, it had been necessary, in a small number of cases, for health authorities to take up the funding of university posts with a clinical commitment.

c. found encouragement in the evidence that the NHS and the Universities appeared to be co-operating effectively to minimize the effects on patient care.

d. wished to set the loss of academic medical posts with clinical commitments in the context of an increase of 550 whole-time equivalents for doctors working in the service during the year 1981/82.

e. noted the concern that the major impact of reductions in finance might be seen in later years.

The Government was also able to report details of the Medical Research Council's Research Group Scheme to the Social Service Committee. Under the scheme funds can be provided for requirements which traditionally have been regarded as the university's responsibility and which are not available through the Council's existing grant schemes such as minor equipment, supplies, administration, etc. In addition capital contribution can be made to

the cost of alterations or improvements to buildings. The scheme does not, however, cover basic accommodation and services which remain the university's responsibility.

Community medicine

By 30 September, 754 community posts had been established by authorities in England and Wales: this was the same number as in 1982.

Recruitment to the specialty in 1983 was 58 compared with 46 in 1982. On 30 September there were 115 registrars and 59 senior registrars training in the specialty in England and Wales.

Central funding of administrative costs of consortium training in community medicine was started, as a pump-priming measure, in 1974 when the specialty was first established in the NHS. Following a review, it was decided to cease funding to the Thames and Anglia Consortium after the October 1983 entry of registrars had completed their two year course. The timing of the cessation of funding of the two consortia — Midlands/South Western, and Northern — was under review at the end of the year.

Community health service doctors

The Royal College of Physicians is studying the report of the Working Party chaired by Professor Knoweldon which has been considering the supervision of training programmes for community health doctors.

The Department conducted a special survey of community health doctors. This was designed to supplement the statistics routinely collected by the Department on this group of doctors to show, in particular, the extent and nature of work other than child health that these doctors perform. The survey also looked at the contribution that general practitioners make to the service; this is for the most part confined to the fields of child health and family planning.

Council for postgraduate medical education in England and Wales

Information on training posts

A study is being carried out by the Council to examine the feasibility of establishing a national data bank of medical and dental posts for trainees and a clearing house of training posts in NHS hospitals. The study started in October and will last a year.

The Council played an important co-ordinating role in developing proposals for a national scheme of sponsorship for the training of overseas doctors which are under consideration by the profession. Work was still in progress at the year's end.

Continuing education for general medical practitioners

Central funding for the continuing education of general medical practitioners is provided under Section 63 of the Health Services and Public Health Act 1968[4]. In August it became necessary to take action to reduce expenditure because of a substantial anticipated overspend on travelling and

subsistence. A 5% cut in funds for courses was made and a ban was imposed on the zero rating of courses (courses which are educationally approved but not funded from Section 63, for which general medical practitioners can claim travelling and subsistence).

In recognition of the need to seek a longer-term solution to the financial and administrative problems associated with Section 63 courses, a Working Party has been set up whose membership includes professional and academic interests. Arrangements have been made for the Working Party to meet for the first time in early 1984.

The General Medical Council

During the first half of the year the Council and the Department continued to work closely together during the preparation of a Bill to consolidate the Medical Acts. The Bill was considered by the Joint Committee on Consolidations, which has members drawn from both Houses of Parliament, in April and received Royal Assent on 26 July. The Act came into operation on 25 October[5].

The Health and Social Services and Social Security Adjudications Act 1983[6], included a provision which came into effect on 15 August enabling employing authorities to remunerate those practitioners whose registration is suspended by order of the GMC's Health Committee.

During 1983 the Council granted limited registration to 1,129 doctors and full registration to 1,695 overseas qualified doctors and 3,776 doctors qualified in the UK and Republic of Ireland.

In November 1983 the Council approved a document on basic specialist training, and this was sent out to Royal Colleges, faculties and other bodies concerned with medical education. The document sets out the objectives of basic specialist training and the content and suitability of posts.

European Community

Work and discussion continued on matters relating to the implementation of the Medical Directives. The subject of medical demography assumed greater importance during the year particularly the problem of over-production of doctors in some member states and how this might be tackled.

Progress towards submitting acceptable proposals for a draft Directive on specific training for general practice to the Council of Ministers remained slow. The Commission called a meeting of experts in March from which it emerged that the variety of ways in which general medical services were provided in the different member states made it difficult to draw proposals which would be workable in each member state.

The number of doctors from other member states, excluding Eire, who registered in the United Kingdom during 1982 rose by 96 to 327. Of these 137 were Greek and 53 Italian. The Advisory Committee on Training published its Second Report and Recommendations on the Training of specialists in March[7]. The Committee's First Report *'The general problems of specialist training'* was published earlier[8]. The Recommendations in the

Second Report flowed from the provisions of Article 2 of Directive 75/363/EEC[9].

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13

INTERNATIONAL HEALTH

The World Health Organization

The World Health Assembly convened this year for two weeks (normally three weeks) for the second consecutive year thus maintaining the impetus of last year's initiative towards efficiency and economy from the UK and others.

The UK delegation was led by the Minister of State for Health. Addressing the Assembly Mr Clarke reaffirmed the UK support for the WHO's strategy of seeking to achieve Health for All by the year 2000 and commented on the three main elements of the European Regional Strategy as reflected in the Government's health policy. The UK is stimulating action towards a national heart disease prevention programme, emphasizing education for health and the promotion of healthy life-styles, and improving the efficiency and effectiveness of the health service.

The Assembly considered the Programme Budget for the 1984/85 biennium and approved a wide-ranging programme in support of the goal of Health for All. The programme includes cardiovascular diseases and alcohol-related problems. Cardiovascular diseases are the major cause of mortality in the industrial world and are of increasing concern in many developing countries. The Assembly adopted a resolution urging member states to make provision in their health planning for cardiovascular disease prevention. Similarly an increased national and international effort is required to reduce the prevalence of alcohol-related problems which today rank among the world's major public health concerns. Other topics highlighted in the programme review were the difficulties being experienced in many developing countries in controlling tuberculosis; the lack of any tangible improvement in the malaria situation particularly in Africa; and the uneven progress being made in meeting the targets of the 10-year plan to achieve adequate international water supply and sanitation.

The UK delegation called for more action by the WHO in reviewing the role of nursing/midwifery personnel in primary health care and indicated its continuing support for the Extended Programme on Immunization, the Special Programme on Human Reproduction and the programme on Research and Training in Tropical Diseases. These programmes receive financial and other resource contributions from the UK.

Dr H Mahler was reappointed as Director General of the World Health Assembly for a third five-year term starting in 1984.

The WHO European Regional Committee in its thirty-third session considered a draft document outlining proposed Regional health objectives derived from the principles of the Regional strategy. The Committee particularly considered the priorities and also the measures needed for implementation in order to provide guidelines on the health improvements required over the next two decades in Europe. Dominant objectives were

the need to reduce health inequalities among and within countries, the importance of disease prevention and health promotion, an integrated approach to health problems, and the participation by individuals and communities in health matters. The document was subsequently circulated to member states for detailed comment and it is proposed a revised version should be put to the next session of the Regional Committee.

The outstanding question of the selection of member states from the European Region entitled to designate a nominee to sit in the Executive Board of the World Health Organization was finally resolved by adopting a system of selection based on a number of geographical groupings. UK, France and the USSR will continue to be represented on the Executive Board on a three years on and one year off basis.

Seventh Commonwealth Health Ministers meeting

The theme of the meeting was Health Planning and Management. The issues considered included the political dimension in health planning; the allocation of resources among sectors; the restructuring of management systems; the promotion of primary health care and health education; drug supplies, distribution, and management; and a survey of services for the disabled.

In its recommendations the meeting emphasized the need for Governments to improve the administration of health care through planning and management systems that are responsive to local needs, ensure efficient use of resources and manpower and to regard the allocation of resources to health as an investment in economic development. The importance of the multi-disciplinary team approach in primary health care was stressed and it was recognized that the development of primary health care calls for the re-distribution of resources and involves difficult political and professional choices. Other points made were that health education, as the basis of effective primary health care, should be structured as a continuous process with community participation, and should be incorporated into the curricula of schools and teacher training institutions; the development of services for disabled people should be integrated into existing health systems; and the disabled should themselves play a greater part in the planning and implementation of these services.

The Government of Canada offered to undertake with the Commonwealth Secretariat a study on technical co-operation and development assistance among Commonwealth countries in the health field.

Health for All by the year 2000 — measuring progress

When the World Health Assembly adopted the Health for All by the year 2000 strategy it also approved a plan of action for implementing that strategy which, amongst other things, established a system for monitoring and evaluation of progress at national, regional and global levels.

Monitoring was started in 1983 when member states were asked to report to their Regional Offices on the relevance of their health policies to the attainment of the Health for All objective, on the progress being made in implementing them, and on measuring their health situation against a set of

twelve global indicators. Particularly significant indicators were that the policy of Health for All has been endorsed at the highest level; that at least 5% of the gross national product (GNP) is spent on health with a reasonable percentage devoted to primary health care; that primary health care — including essential drugs, vaccines, family planning and health education — are available to the whole population; that the nutritional status of children is within certain parameters; that the infant mortality rate is below 50 per 1000 live births and life expectancy at birth is over 60; and that adult literacy is assured.

The UK assessment was undertaken by an interdepartmental committee chaired by a Deputy Chief Medical Officer of the Department. The main conclusions reached were that the UK health policy was essentially in line with the Health for All strategy; that the UK figures for the health status of the population compare well with other developed countries' averages; and that dramatic changes in health status should not be expected since they are already measured from a sound base-line. The Health for All guidelines recognize that some member states will be continuing an appropriate health strategy rather than moving in an entirely different direction.

The WHO European Region programmes

Cardiovascular and other non-communicable diseases

Cardiovascular diseases are responsible for 30–50% of all deaths in most European countries and many of the remaining health problems are due to other non-communicable diseases.

In 1968 the WHO Regional Office launched a long-term programme on the study and control of cardiovascular diseases. Among earlier studies undertaken was the collaborative trial of clofibrate[1] which was an early attempt at therapeutic primary prevention. The results confirmed the hypothesis that reduction of elevated blood lipid levels even in middle-aged men may prevent some cardiovascular disease but excess overall mortality in the treated group prompted speculation and concern and this trial has now been abandoned. The European collaborative trial in the multifactorial prevention of coronary heart disease[2] using simple methods of community intervention on a few major risk factors (high blood pressure, smoking, high blood cholesterol levels, and overweight) has joined other studies, including notably the multi-risk factor intervention trial in the USA[3] in demonstrating a degree of reduction in the prevalence of risk factors in the study population. However, this has not been matched by reductions in mortality and morbidity. This apparent failure has prompted some observers in the UK to question the relevance of the mass population strategy recommended by the WHO Expert Committee Report on the Prevention of Coronary Heart Disease[4].

New activities include the multinational Monitoring of Trends and Determinants of Cardiovascular diseases in populations (MONICA) project which will investigate changes in cardiovascular diseases mortality with improved medical care and/or decreasing incidence, and the relation of the latter to changes in risk factors, or of behavioural and socio-economic changes in the population. The European Hypertension Research Action Programme

(HYRAP) is concerned with research into the natural history of high blood pressure in different populations; primary prevention of hypertension and its implications for health care; and the management of hypertensive patients.

With the increasing awareness of the influence of the environment and behaviour on health and disease and the identification of common factors that cause or contribute to various chronic diseases the European Regional Office is establishing a new programme for a more unified approach to the prevention and control of chronic diseases in the community.

Accident prevention

Accidents constitute the third major cause of death in Europe, and those due to road traffic form the largest category, especially in the younger age groups, followed by domestic and occupational accidents. Sports and leisure accidents are increasing.

Until 1982 the regional accident prevention programme was mainly concerned with road traffic accidents. The programme has now been extended to include home, leisure, and sports accidents. The main objectives of the programme are to assist countries to develop comprehensive national and local policies through model programmes for the prevention of accidents; develop a basic dataset that recognizes all aspects of the accident/injury process; and encourage epidemiological studies on domestic and leisure accidents. A number of collaborative centres are participating in the implementation of the programme including the Transport and Road Research Laboratory.

An international symposium on accidents in Europe was jointly organized by the City and University of Newcastle and the DHSS. Representatives attended from the health professions, engineers, social scientists, economists, urban designers and planners, and administrators. Topics ranged from road traffic, domestic and sports accidents to the biomechanics of injury and studies in the design for safety. The meeting recommended that there should be a central co-ordinating mechanism for accident prevention in every Member State and supported development of a set of basic data for the determination of the size of the accident problem and the definition of vulnerable groups. It also recommended that there should be further epidemiological studies with particular reference to the effects of alcohol and drugs in accidental causation; more education on safety; comprehensive accident services and the greater involvement of consumer organizations in accident prevention programmes.

Cancer

Since 1981 the Regional Office for Europe has been developing a cancer programme with the aim of applying the existing knowledge on cancer through community-oriented action. Undergraduate and postgraduate education in cancer has been analysed, childhood cancer schemes in Europe studied, and national experience in cervical cancer screening evaluated. Studies have been conducted on the development of comprehensive cancer centres in relation to community cancer control programmes in Europe.

To help formulate national cancer policies and programmes an epidemiological approach has been adopted and guidelines for planning and evaluation of cancer control programmes will be developed. Future activities will include identifying the psychosocial and emotional needs of cancer patients; improving social attitudes towards these patients; promotion of screening for cervical cancer; and development of cost effective methods for the early detection of breast and large bowel cancer.

European Communities

In October 1983 the Council of the European Community approved (Directive 83/570/EEC)[5] changes to the Pharmaceutical Directive governing the marketing of propriety medicinal products, and a Recommendation (83/571/EEC)[6] containing notes for guidance for the evaluation of prospective new products. The Directive introduced a number of detailed technical changes to the requirements for licensing and marketing products including modifications to the procedures which enable pharmaceutical companies to apply for marketing authorization in several member states concurrently. Of particular interest is the introduction of obligatory studies of mutagenic potential in the application for a product licence. Details of the studies required and criteria for evaluation are to be determined in the light of scientific knowledge at the time a licence application is made. Guidance on such studies is expected to be given in a new Council Recommendation which is currently under consideration by the European Commission.

Member states have to comply with the provisions of the Directive by 26 October 1985.

World Health Organization and Council of Europe Fellowships

Arrangements for the administration of the financial and social components of the WHO Fellowship programme were changed radically during 1983. Up to 1981 the British Council had provided these services free of charge while the Fellowship Section of the DHSS administered the academic and technical aspects of the programme. Following the decision of the British Council in 1983 to increase the charges for their services, the WHO entered into agreements with other agencies for financial and social administration. The DHSS Fellowship Section has assumed responsibility for co-ordinating the new arrangements in addition to its involvement in the academic and technical programme. Table 13.1 analyses the number of WHO and Council of Europe Fellowship programmes with which the Department was involved in 1983.

A further 82 requests for programmes were processed but then cancelled by the WHO before the commencement of studies. The number of new Fellowships was 109 fewer than in 1982. This decrease may have been due in part to uncertainty caused by the disruption of the administrative arrangements; in part to the level of fees being charged to overseas postgraduate students by British institutions; and in part to the revision by the WHO of its policy on fellowships which now questions the need to send fellows overseas, using Regional resources wherever possible.

Table 13.1 Fellowship holders from World Health Organization Regions and Council of Europe studying in the UK in 1983

Subject studied	*Europe*	*East Mediterranean*	*Africa*	*South East Asia*	*West Pacific*	*Americas*	*Total*	*Council of Europe Total*
Public health administration	9	16	13	8	8	7	61	3
Environmental health	22	11	2	25	2	7	69	5
Nursing	1	5	1	1	8	0	16	8
Maternal and child health	5	4	1	1	3	2	16	0
Communicable diseases	1	9	1	10	5	3	29	1
Clinical medicine	23	18	9	2	5	3	60	10
Basic sciences and education	6	8	6	9	10	1	40	0
Other health services	6	11	2	19	5	4	47	9
	73	82	35	75	46	27	338*	36

* Fellowships commencing in 1983.
There were in addition 153 Fellowships already in progress at 1 January 1983.

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14

PREVENTIVE MEDICINE

Introduction

It has been decided that, for 1983, there should be a special chapter on prevention, The topics included are cigarette smoking and its health consequences, the prevention of coronary heart disease, health education and health promotion, cervical cytology, and the prevention of genetic and inherited disorders. Many other topics could have been included — for example, immunization and vaccination, family planning, dental health, and virtually all the chapter on environmental health.

Smoking and health

Cigarette smoking remains the country's most serious public health problem. Smoking related disease is responsible not only for considerable mortality (of the order of 100,000 deaths in the United Kingdom annually)[1], a high proportion of which are early deaths, but also considerable and unquantifiable suffering to victims, family and friends. The Royal College of Physicians published its 4th Report in November entitled '*Smoking or Health*'[1] and this provides a comprehensive account of the present position.

The General Household Survey of 1982[2] showed a decline in the prevalence of smoking in both males and females and in all age groups; 38% of men and 33% of women were cigarette smokers in 1982. This decline was true for all socio-economic groups except 'Professionals' whose smoking habits remained at the same low level of 20–21%. The fall in prevalence in the other groups where a significant decline is now apparent was the most encouraging feature. The steepest drop occurred in those with the highest prevalence rates, men and women aged 25–59.

Cigarettes sales at the beginning of 1983 were 7½% lower than a year previously and have fallen 20% in the last few years.

Such evidence indicates the effect of strategies at all levels to control smoking and thereby reduce the prevalence of smoking-related disease. This unfortunately remains at a high level, although there are some encouraging signs, notably a fall in the incidence of lung cancer, particularly in men in the younger age groups.

A new voluntary agreement between the Department and the Tobacco Industry on the advertising of cigarettes took effect from April 1983 and will run until at least 31 March 1986. In this it was agreed that expenditure on poster and cinema advertising should be further reduced; that the space for health warnings on press advertisements and on posters would be increased; and that the clarity of the health warning would be improved. Cigarettes or hand-rolling tobacco advertisements would not be included in video cassettes on sale or hire to the public. A reduction in the upper limit of tar above which cigarette brands would not be advertised or promoted was also agreed.

Later in the year two OPCS surveys commissioned by the Department — *'Smoking attitudes and behaviour'*[3] and *'Smoking among secondary school children'*[4] — were published. The latter survey which found a high level of smoking among secondary school children will be repeated in 1984 in order to obtain a measure of the trend in the smoking habits of school children.

There have been signs that modification of cigarette products leading to lower tar yields has contributed to a fall in the incidence of lung cancer. The Independent Scientific Committee on Smoking and Health (The Froggatt Committee) concerned with the need for product modification, published its 3rd Report[5] during the year. Recommendations were made in relation to tar, carbon monoxide and nicotine yields of cigarettes. The report also sought the co-operation of the tobacco industry in studying the effects on health of certain other injurious substances and proposed the continued monitoring of the consequences of product modification on health. Publication of tables showing the tar and nicotine yields of different brands of cigarettes continued, and on the advice of the Froggatt Committee this was extended during the year to cover carbon monoxide yields also. In view of the substantial reduction in tar yields since the groups in these tables were originally defined, the Committee also recommended that their definition should be reconsidered. The present voluntary agreement with the tobacco industry on product modification expired at the end of 1983. The 3rd Report will provide the framework for discussions on a new agreement.

The prevention of coronary heart disease

There is little to be complacent about in our efforts to reduce the mortality rates of this disease. Death rates from coronary heart disease remain depressingly high although a levelling off in the recent rise is now evident with even perhaps some slight decline.

Progress has been made in reducing the prevalence of cigarette smoking, considered to be a prime factor in the development of coronary heart disease. The extent to which diet plays a part in the cause of this disease is being considered by the panel of experts appointed by the Committee on Medical Aspects of Food Policy (COMA). This panel will advise the Committee on the significance of the relationship between diet and cardiovascular disease and make recommendations. The panel is expected to report its findings about the middle of 1984[6].

A conference on *'Action to Prevent Coronary Heart Disease'* was held at the University of Kent in Canterbury in September[7]. This conference was sponsored by the Department of Health and Social Security, the Health Education Council, the British Cardiac Society and the Coronary Prevention Group and was organized by a Steering Committee, chaired by Professor Geoffrey Rose, on which the Department was represented. The conference was the first occasion on which the prevention of coronary heart disease was examined from every aspect with a view to producing some practical recommendations for the future. The full report is to be published in April 1984[7] and will cover examination of (i) National health policy and planning; (ii) Regional and district policy and planning; (iii) Food and agricultural policy; (iv) Health education; (v) Primary health care; and (vi) The mass media. It is hoped that following the publication of the conference report and the COMA panel report further initiatives will be stimulated at local and national level.

Already some district health authorities are planning and operating activities aimed at the prevention of coronary disease, both on a population basis and in the identification of those most at risk. The Health Education Council has a programme in preparation for a national strategy, which it hopes to start during 1984, and is to pilot a regional strategy in Wales commencing 1984–85.

Education for health: health promotion

During 1983 the Department stimulated the development of a more positive approach to promoting health and preventing illness.

In April the Minister for Health addressed more than 70 chairmen of health authorities at a conference on *'Prevention and Health Education'* held at the King's Fund Centre. He stressed the emphasis that the Government placed on 'prevention' and the importance of a strong working partnership between the Health Education Council and the National Health Service.

The Health Education Council put much effort into strengthening their links with district and regional health authorities and towards the end of the year a joint appointment of a Regional Health Promotion Officer was made with Mersey Regional Health Authority.

The Department organized two seminars for district medical officers during the year. The theme of this series, the third of which was scheduled for March 1984, was *'Preventive Health Care' — the Promotion of Health and Prevention of Illness'*. Some 48 health authorities were represented at these two seminars held at the NHS Training Centre, Harrogate. The first addressed the need to establish some basic principles with reference to responsibilities, roles and priorities, and to produce a model that would illustrate the kind of structure a health authority might need in order to provide effective preventive services. The second examined the problem of putting such policies and plans into action.

Each district health authority received reports of the two seminar proceedings and these provide a reference and guide to the development of the preventive health services.

Prevention of cervical cancer

There has been a national programme to reduce the mortality from cervical cancer since 1966. This programme is based on the finding that in most, but not all cases of cervical cancer, there is a prolonged pre-invasive interval during which the cancerous changes are limited to the most superficial cell layers in the cervical epithelium. The cervical cytological examination is intended to detect these early signs of cervical cancer at a stage where there is no invasion of deeper tissues and treatment by excision or by superficial destruction will be effective in eradicating the disease. The Department is advised on cervical screening policy by the Committee on Gynaecological Cytology, a group of clinicians and scientists working in relevant specialties from outside the Department. At the request of the Department the Committee on Gynaecological Cytology carried out an extensive review of screening during 1980–81, and has more recently updated its advice on the

screening of younger women following the publication, in October 1983, of the research report[8] which suggested an association between prolonged use of oral contraceptives and the subsequent development of cervical cancer. The Department has accepted the Committee's advice that cervical cancer screening should be arranged according to the following schedule:

'Women considered to be at greatest risk from cervical cancer should be screened regularly at 5 year intervals. These are:

(a) women aged 35 years and over;
(b) women who have been pregnant on 3 or more occasions.

Ideally, women in category (a) should be screened at the age of 35 years and at 5 yearly intervals thereafter. However, it may be some years before existing recall procedure can be adjusted so that women in both categories are recalled on an age-related basis. On reaching the age of 65 years further smears need not be taken from those women who have had two consecutive negative routine smears.

The main emphasis in routine cervical screening should be to encourage those women over 35 years of age who have never been screened to come forward for testing, as they are at greater risk.

Screening during pregnancy

A cervical smear should be taken early in the course of care for every pregnancy irrespective of the woman's age or the outcome of the pregnancy.

Screening of younger women

Any woman who is or has been sexually active should have a cervical smear when she first presents for contraceptive advice, and thereafter at ages 20, 25, 30 and 35 years and not at intervening ages. The same screening frequency should be adopted for young women who are or have been sexually active who request a smear but are not seeking contraceptive advice. The only exception should be if pregnancy occurs or if there are clinical reasons for taking a smear.

Prevention of inherited and genetic disorders

There is now a lengthening list of congenital and genetically determined disorders that can be avoided either by the adoption of preventive measures either prior to pregnancy, for example rubella immunization, or during pregnancy, for example the treatment of active syphilis; or by the use of prenatal screening procedures that can identify an affected fetus at a sufficiently early stage of pregnancy for the mother to be offered termination of an affected fetus, for example Down's syndrome or neural tube defects.

Historically the identification and treatment of pregnant women with syphilis was the first antenatal screening procedure that came into widespread use, with the intention of avoiding the anomalies that result from congenital syphilis. Serological tests for syphilis remain a routine part of antenatal care.

The discovery in the 1940s of the link between rubella infection in pregnancy and the abnormalities of the rubella syndrome, initially led pregnant women to attempt to avoid exposure to patients with rubella. There was, at that time, no possibility of immunization. Subsequently passive immunization with gamma-globulin became available for administration to pregnant women thought to be contacts of patients with rubella. In the early 1970s there was a considerable advance when active immunization with rubella vaccine came into general use. The current rubella campaign, which was launched in the autumn of 1983 (see Chapter 4) is the latest in a series of primary preventive measures intended to ensure that as many women as possible are immune from rubella before they reach childbearing age.

Many primary preventive measures are now available and in recent years there have been major advances in the development of both primary prevention and prenatal screening that can be used to identify abnormalities in the fetus *in utero*. As a primary preventive measure, it is possible in some conditions, for example Tay-Sachs' disease or sickle cell anaemia, to identify the carrier state. Where prospective parents are both known to be carriers, pre-pregnancy counselling may be undertaken so that they are aware of the risks they run of procreating an affected child. In some communities where the prevalence of a genetically determined condition is known to be high, and the carrier state can be identified, pre-marital counselling may be undertaken. Similarly pre-pregnancy counselling can be provided for any person with a dominant genetically inherited condition. However, as yet premarital and pre-pregnancy counselling has been more of a theoretical, rather than practical, concept.

Once a pregnancy has occurred there are now a variety of ways available to assess whether the fetus is affected by a genetic condition inherited from its parents, or some other congenital anomaly. Amniocentesis at 16–18 weeks gestation permits the collection of samples of fetal cells, which can then be grown in tissue culture. The chromosomal make-up of the cultured fetal cells can then be examined to see if the fetus has an abnormality such as Down's syndrome. At present women aged 35–40 years and over are generally offered amniocentesis because of the risk of a Down's syndrome infant in this age group of mothers.

Additionally, if there is a history of an inherited metabolic disorder the cultured cells from the fetus may be compared by immunological, biochemical and histochemical methods to see if they behave similarly to established cell lines from individuals who suffer from the suspected condition. There are now over 200 metabolic disorders, mostly rare, that can be identified in this way.

Where a sex-linked inherited disorder such as haemophilia or Duchenne muscular dystrophy is a possibility, chromosomal analysis of the fetal cells can identify male fetuses which will have a 1:2 risk of being affected. Using gene probe techniques it may then be possible to identify those male fetuses with these conditions, from their unaffected brothers.

In some inherited conditions amniocentesis alone is insufficient. In thalassaemia, sickle cell anaemia and other conditions where a diagnosis can be based on a sample of fetal blood, fetoscopy and fetal blood sampling are

possible. In fetoscopy a small instrument is passed into the amniotic cavity and the fetus inspected under direct vision; blood samples can be taken from the umbilical veins. Samples of fetal skin and liver may also be taken. Fetoscopy and fetal blood sampling are used in some centres to diagnose thalassaemia and sickle cell anaemia as well as other congenital disorders that can only be confirmed by laboratory analysis of fetal blood.

The use of serum screening to identify those mothers at increased risk of carrying a child affected by an open neural tube defect was discussed in this Report for 1982 (pages 73–74). Serum alphafeto protein (AFP) is measured at 16–18 weeks gestation and those mothers with an increased level are offered amniocentesis; the level of AFP in the amniotic fluid can then be assessed. A very high level of AFP is associated with anencephaly or open spina bifida. In doubtful cases high resolution ultrasound examination provides an alternative means for indirect visualization of fetal structures and in particular whether anencephaly or spina bifida is present. A few centres use high resolution ultrasound as an alternative to AFP screening but this is not generally considered cost-effective as a primary screening method.

In addition to screening for neural tube defects, high resolution ultrasound can also be used to identify other major structural anomalies such as cardiac abnormalities, renal agenesis, or renal cysts, fetal goitre, limb reduction deformities, defects of the abdominal wall or diaphragm and other major anatomical abnormalities. The use of diagnostic ultrasound in this way is only possible at those centres with special experience in diagnosing fetal abnormalities *in utero*. However, the identification of congenital anomalies is not the only use of high resolution ultrasonic screening in pregnancy. Serial measurements of fetal abdominal circumstances can be used to identify at a very early stage those fetuses suffering from intrauterine growth retardation.

For the future serial ultrasonic assessments of fetal growth may identify with greater accuracy those fetuses experiencing placental insufficiency, they are at increased risk both of intrauterine growth retardation and ultimately death before delivery.

Gene probes

A major breakthrough in the identification of inherited diseases has been the development of genetic techniques which focus on the protein products of aberrant genes and on the analysis of their DNA content and which are now being applied in the identification of inherited diseases. Since the DNA sequence is common to all tissues in an individual the presence of an aberrant gene, particulary one that is the cause of an inherited disorder, can be detected by analysis of whatever cells are obtained from the individual. Reference has already been made to the use of blood cells obtained from the fetus to detect thalassaemia, but it is now becoming possible to undertake prenatal diagnosis for other conditions where a gene probe has been developed. Recent research has identified probes to detect thalassaemia, Duchenne muscular dystrophy, phenylketonuria and Huntington's chorea. Research is progressing on finding similar probes to identify other genetically determined disorders, particularly cystic fibrosis. These probes

depend on the identification of a DNA sequence and, in theory, may be used either on fetal tissue grown in tissue culture following amniocentesis or on fetal cells obtained in some other way. Amniocentesis can only be undertaken at 16–18 weeks gestation. A new technique called chorion biopsy is being investigated in a number of centres; this would permit a small sample of cells, of fetal origin, to be obtained from the implantation site between the 6th and 12th week of pregnancy. The risk that chorion biopsy might provoke a miscarriage is unquantified. However, if it is shown that this method has an acceptably low subsequent miscarriage rate it will then become possible to confirm or exclude certain hereditary conditions on the chorion biopsy sample during the first trimester of pregnancy. If a serious hereditary condition was confirmed the woman could then be offered pregnancy termination at a much earlier stage of gestation, thus avoiding the physical and psychological disadvantages that are known to follow pregnancy termination at more than 16 weeks gestation. It has been reported that chorion biopsy samples can also be used to identify the chromosomal make-up of the fetus. However, further work is required to evaluate the scope, method and risks of chorion biopsy before it has an assured place in prenatal prevention of inherited disorders.

Alcohol in pregnancy

In recent years there has been concern as to the effect of alcohol on intrauterine development. While there is now no doubt that heavy drinking during pregnancy can harm the fetus, and should be avoided, opinion remains divided about the extent to which lesser intakes of alcohol are harmful, and whether there is a threshold below which it is safe to drink. During the year the Department received advice on this subject from the Royal College of Obstetricians and Gynaecologists and the British Paediatric Association. In the light of this the Department has advised women to keep alcohol consumption during pregnancy as low as possible. However, it is also recognized that pregnant women who find it impossible to cut out alcohol altogether could suffer from unjustified and possibly harmful feelings of guilt and anxiety. This will be taken into account by the Health Education Council in forthcoming publications on alcohol and on pregnancy.

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15

SPECIAL SUBJECTS

a. Organization and Management in the NHS

NHS management inquiry

A consistent element in the Government's policy for the promotion of health in recent years has been the search for better methods of managing the very large volume of resources (getting on for £13 billion in 1983) devoted to the National Health Service in England. Following the administrative restructuring[1,2] implemented in 1982 this programme of management improvement continued with the setting up of regional accountability reviews and the development of comparative performance indicators[3].

The process was carried a step further with the setting up in February 1983 of an Inquiry into the effective use and management of manpower and related resources in the NHS. The Government's purpose was to seek advice from professional managers with experience in other large organizations and with this view the Secretary of State invited Mr Roy Griffiths, Deputy Chairman and Managing Director of Sainsbury's, to lead a team whose other members were Mr Michael Bett, the Board Member for Personnel of British Telecom, Mr Jim Blyth, the Group Finance Director of United Biscuits, and Sir Brian Bailey, formerly Chairman of the South Western Regional Health Authority.

The team met a large number of doctors and other health workers from all parts of the country and became convinced, quite early in the course of their enquiries, that closer involvement of clinicians in the management process would prove a vital ingredient for the success of any further steps which might be taken in pursuit of better management. They therefore commissioned small scale studies in six hospitals on the problems attendant upon the involvement of clinicians in management, looking for example, at the organization of out-patient clinics, of waiting lists and of in-patient arrangements. Problems experienced by both doctors and patients were discussed with those responsible for the management of the hospital and subsequently with the health authorities concerned, with the aim of exploring the reasons for the problems encountered and the scope for further involvement of medical staff in the management process.

Financial control and accountability were central features of that process and therefore of the clinicians involvement in it. The Team felt that the development of management budgets was such a vital management tool that, in advance of reporting, it proposed the establishment of demonstration projects in four districts — to which the Department agreed. Two firms of management consultants were engaged in September 1983: Arthur Young McLelland Moores to work with North Tees and Southmead Health Districts and Coopers Lybrand to work with Basingstoke and Ealing Districts. These districts were selected to give geographical spread and to

provide examples of three districts which had already introduced specialty costing and one which had not in order to test whether the pre-existence of specialty costing facilitated the introduction of management budgets. The Department set up a small Steering Committee to supervise the programme.

The Team finally reported on its Inquiry in October 1983 in a letter to the Secretary of State. Underlining again the primary purpose of the NHS was the delivery of service to patients; it called for a new approach to management, ensuring that responsibility is pushed as far down the line as possible within the Service. Its detailed recommendations included:–

(i) the creation within the Department of a Health Services Supervisory Board, chaired by the Secretary of State, and of a subordinate multi-professional NHS Management Board, under a Chairman with considerable experience in effecting change in a large service-orientated organization — the whole intended to strengthen existing arrangements for supporting the Secretary of State in his management role;

(ii) the extension of the accountability review process[2] through to unit level;

(iii) the creation of a clearly defined general management function through all levels of the NHS, by the identification of a general manager at regional, district and unit level, who could be a doctor, a nurse, a treasurer or from another discipline — the criterion to be the best person for the job;

(iv) the implementation of plans for all day-to-day decisions to be taken in the main hospitals and other units of management unless there were clear reasons why they should be taken at a higher level;

(v) the closer involvement of clinicians in the management process, consistent with clinical freedom for clinical practice — emphasizing the need for proper administrative support for clinicians, together with strictly relevant management information, and a fully developed management budget approach.

No changes were recommended in the statutory responsibilities of the Secretary of State or of Health Authorities, nor in their relationships with the Department and its officers; the Team stressing that all the measures suggested could be introduced, if desired, without legislation.

On 25 October 1983 the Secretary of State made a statement to the House of Commons in which he welcomed the general thrust of the Report and the advice it contained, and announced a time-table for consultation on the recommendations. He also announced the establishment of the Health Services Supervisory Board, which had its first meeting before the end of the year, by which time work was under way in the Department to bring together those of its functions concerned with NHS management, in anticipation of the establishment of the NHS Management Board.

Performance indicators

Following the work of the previous year on performance indicators[3] there were two major developments during 1983. The first of these was the establishment of a Joint NHS/DHSS Group on Performance Indicators,

which met initially on 27 July 1983, with terms of reference to advise on the future development, publication and use of performance indicators for NHS management, and to report to the Secretary of State. At its second meeting the Joint Group decided to establish eight working groups to carry forward the detailed development of performance indicators in a number of areas: services for children; services for the elderly; services for the mentally handicapped; services for the mentally ill; acute services (including accident and emergency services, obstetrics and regional specialties); support services (ambulance services, hotel services, medical records, pathology, pharmacy and x-ray services); estate management; and, manpower. Two other important initiatives by the Joint Group were the commissioning of a literature search and the canvassing of a wide range of organizations for 'good ideas' as to how their task might be carried forward.

Meanwhile, a series of performance indicators for every health district in England were published in September 1983 under cover of Circular NH(83)25[4]. These indicators were based on 1981 data, the latest then available collectively, and covered clinical activity, finance, manpower, ambulance services and estate management. In presenting the indicators it was made clear that the objective was to enable managers locally to gain an overall picture of a district's deployment of resources as compared with that in other districts. The indicators used do little more than point out unusual patterns which may need further investigation. At the same time as this publication, the Department made available to the National Health Service a suite of computer programmes which could be used to display and analyse selected items of performance indicator data.

Health services information

The NHS/DHSS Health Services Information Steering Group continued in its work under the Chairmanship of Mrs Edith Körner, making available for comment during the course of 1983 interim reports covering: activity data on paramedical and similar services[5]; the development of a new approach to information about health services to, and patient care in the community[6]; improved information to assist financial management[7]; data on a miscellaneous group of services not covered in other reports[8]; data necessary to manage patient transport services[9]. On the last of these topics, following consultation the Steering Group was able to submit to the Secretary of State a final report before the end of the year and it is anticipated that final versions on the other topics will be submitted during the early part of 1984. Thereafter, a programme will be agreed for introducing some or all of the recommendations in the Reports.

Manpower exercises in the health service

The National Health Service is labour intensive and its effective management must involve a proper oversight of its manpower. The overall number of staff has risen steadily, and between 1960 and 1981 the number of directly employed staff rose by 83%. In 1983 there were about 827,000 whole-time directly employed staff in all categories.

Until recently the main control on the numbers employed has been the amount of money available to the authority concerned. Increasingly, the Department has become concerned to ensure efficient control and use of manpower, and in 1982 authorities were asked to incorporate manpower control as an integral part of their planning procedures. Because progress was unsatisfactory this was supplemented in 1983 by the manpower targets exercise. In consultation with authorities manpower targets were settled for each regional and special health authority, to be implemented by March 1984. Two regions were to increase numbers slightly, but there would be a small reduction in numbers overall. No individual staff group targets were set, but regions were asked to continue the existing trend of increasing the proportion of the total workforce providing direct patient care.

Manpower control is now an explicit feature of planning, the policy being to ensure that services develop faster than the growth in revenue, by increasing efficiency, and that the money spent should increase more rapidly than the numbers of staff employed. Strategic planning requires the reconciliation of service plans with the estate, the revenue and the manpower available. As an essential component of plans to improve health services, manpower will continue to be monitored carefully.

Universities and the health service

Since the inception of the National Health Service there has been close collaboration between it and the Medical Schools. Not only does the service rely on the Universities for its future supply of doctors, but academic staff are themselves substantial providers of services to patients. The Medical Schools in turn rely upon the Health Service to provide the clinical basis for their academic work. Traditionally this has been a friendly partnership based on uncosted mutual assistance, or 'knock-for-knock' as it is commonly known. It is generally accepted that it is difficult to make a precise apportionment of costs within a university hospital into those which are academic and those which are service in nature. The effect of economic stringency, affecting the university system first and then the National Health Service, led to fears that the knock-for-knock system might be overstrained. It is pleasing to record that common interests, and common sense have prevailed in a situation which has undoubtedly sometimes been difficult. In general a spirit of partnership has prevailed in the face of common difficulties. The need to ensure that partnership remains a feature of University/Health Service relations is apparent in the discussions of bodies like the Academic Forum, chaired by the Chief Medical Officer. Officers of the Department and members of the academic community both find helpful opportunities to consider problems jointly, even though problems may not be instantly soluble. The key role of the Universities and their medical faculties in maintaining excellence in all fields of health service activity will undoubtedly remain as important in the future as it has been in the past.

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Non-steroidal anti-inflammatory drugs

Non-steroidal anti-inflammatory drugs (NSAIDs) are used to treat a range of conditions from headaches to severely disabling arthritis. Some of them, for example aspirin, are available on general sale in packages of 25 tablets provided they are in child-proof containers; a few, 'Ibuprofen' is one example, can be bought in pharmacies; but most are used to treat severely disabling conditions and can only be supplied on prescription. NSAIDs can be of considerable therapeutic benefit but they can also cause severe adverse effects in a small percentage of patients. For this reason, the Committee on Safety of Medicines (CSM) began, early in 1983, a review of products in this class and is continuing to monitor closely the safety of individual products.

Three NSAIDs were withdrawn from the market in 1983 on grounds of safety.

Zomepirac sodium (*'Zomax'*) was withdrawn from the UK market by the manufacturer in 1983. *'Zomax'* had earlier been withdrawn from the market in the USA where it had been associated with 5 deaths from severe allergic reactions. At the time of withdrawal 512 adverse reactions reports had been received by the CSM. These included 5 deaths, though none of these were due to severe allergic reactions. The future licensing of the drug is to be considered by the CSM in 1984.

'Osmosin' (a sustained release formulation of the non-steroidal anti-inflammatory drug, indomethacin) was first marketed in the UK in December 1982. By June 1983, the number of adverse reaction reports received by the Committee was giving rise to concern. The types of adverse reaction reported were those expected with indomethacin, predominantly headache and gastro-intestinal problems, but there were also two reports which associated the drug with perforations in the lower bowel, an unusual site for damage by a non-steroidal anti-inflammatory drug. The CSM drew the reported adverse reactions to the attention of doctors, with particular reference to the lower bowel perforations, in the August 1983 edition of *Current Problems*. This report lead to an increase in reports of adverse reactions to the product. By late August 1983, 13 deaths in the UK had been reported, leading to the withdrawal of the product from the world market in September 1983. The UK product licence was surrendered in January 1984.

Indoprofen (*'Flosint'*) was first marketed in the UK in September 1982. Late in 1983, the Company marketing the product in the UK made available to the Licensing Authority the results of a post-marketing study which gave concern about serious and fatal toxic effects, particularly gastro-intestinal events. The CSM had received 217 reports of adverse reactions associated with *'Flosint'*, including 7 cases where the patients had died. On the basis of these reports, the product licence for *'Flosint'* was suspended in December 1983 and the CSM was asked to consider whether the licence should be revoked. The Committee will consider this in 1984.

'Depo-Provera'

'Depo-Provera' which is manufactured by Upjohn Limited, is an injectable form of the drug medroxyprogesterone acetate licensed in the UK for short-term contraception and for the treatment of certain cancers. In 1982 the CSM considered an application for a product licence to market the drug for long-term contraception and advised the licensing authority that a licence should be granted on condition 'that it (*'Depo-Provera'*) is recommended for use only in women for whom other contraceptives are contra-indicated or have caused unacceptable side effects or are otherwise unsatisfactory'. The CSM also recommended that a number of warnings should appear in the product literature.

After careful consideration of the safety, quality and efficacy of the product the licensing authority decided that it should refuse the application. The Company appealed against this decision under Section 21(5) of the Medicines Act 1968 and a panel was appointed by the licensing authority to hear their case. The Chairman of the Panel was Professor Rosalinde Hurley and the members were Professor Asscher, Professor Jacobs, Professor Kennedy and Dr Leonard. The hearing was in two sessions. The first took place on 8 and 9 November 1982 and dealt mainly with procedural matters. Dr Leonard then resigned from the Panel for personal reasons and Professor Langley was appointed to replace him. The second session of the hearing was held in public between 25 and 29 April 1983. The Panel had previously considered data provided by Upjohn Limited and, at the hearing, heard and questioned 24 witnesses brought by the Company. With the agreement of the Company the Panel also accepted written evidence from other interested groups.

Post-coital contraception

There was much debate on post-coital contraception in 1983. On 13 May 1983 the Minister for Health, Mr Kenneth Clarke, in the light of some public concern about the safety of the oral contraceptive tablets used for post-coital contraception announced that 'there is already considerable evidence to suggest that, used in accordance with a doctor's instruction post-coital contraception presents no serious hazard — either to the women herself or to the fetus, should she nevertheless become pregnant. But, in order to allay any doubts about the safety of the contraceptive pill when used in this way, I have decided to seek the advice of the CSM 'on the risks and benefits involved'.

The Committee considered the 4 methods of hormonal post-coital contraception which are currently used in the United Kingdom and issued the following advice:

a. Combined oral contraceptive tablets

The tablets used contain 0.25 mg levonorgestrel (progestogen) and 0.05 mg ethinyloestradiol (oestrogen). The dosage is 2 tablets within 72 hours of unprotected intercourse, followed by 2 further tablets 12 hours after the first dose, the CSM considered that this combination oral contraceptive tablet when used in this way is acceptably safe for occasional emergency use only, but its efficacy falls far short of conventional hormonal contraception. The published evidence on other combination oral contraceptives used as post-coital contraception is very limited.

b. Oestrogen alone post-coital contraception

The dosage is either 5 mg of ethinyloestradiol taken daily for 5 days or 50 mg of stilboestrol taken daily for 5 days. The CSM understood that these methods were used infrequently in the United Kingdom. On the basis of the limited evidence available the methods would appear to offer a similar level of efficacy to the combined oral contraceptive but possibly caused more adverse reactions. The combined oral contraceptive also had a shorter treatment regimen and was therefore likely to be more acceptable to patients.

c. Progestogen only post-coital contraception.

The Committee felt that there was not enough suitable data on the use of progestogens on their own for post-coital contraception to give a judgement on the risks and benefits involved. The CSM would therefore not recommend their use for this purpose.

d. Danazol ('Danol')

This is a semi-synthetic steroid which is still at an early stage of evaluation. The CSM considered that no judgement could be made on it as a post-coital contraceptive.

The Committee's advice, which was conveyed to interested medical bodies, was that, where emergency hormonal post-coital contraception was needed, the most suitable method was the combined oral contraceptive tablet.

Other aspects of post-coital contraception are discussed in Chapter 7.

c. Scientific services and biotechnology

Cost effectiveness of diagnostic services

The introduction of new technologies, improvements in the quality and reliability of diagnostic information and the extension of the range of investigations and tests offered to clinicians results in increased demand on all the scientific services. Health authorities have been asked to look into the efficiency of services and the Department has started discussions with the professions and regional officers on ways in which the diagnostic services can be made more cost effective and at the same time take maximum advantage of developing technology to maintain and improve standards.

There are a number of interrelated avenues to explore, the first of these being the variation in revenue costs of the services provided. Comparisons of regional or district costs can be made only if there is some national standard for measuring not only quantity but also quality of output. Activity indicators or performance indicators are being developed; their successful application depends critically on the accuracy of the statistical information on staffing, workload and expenditure that is reported to health authorities.

New equipment and techniques tend to add to rather than replace existing techniques, with consequent increase of revenue cost per patient.

There is a need to extend the evaluation of the technical performance of new equipment and techniques to establish clinical benefits and assess cost effectiveness. The Department has started discussions to develop protocols and priorities for this wider appraisal of health technology.

The existing services are demand-led and are accessible to most clinicians virtually without limit. There is concern that some of the tests carried out are of doubtful clinical value. Both those who use and those who provide the service are being encouraged to review their present workloads and demands. It should also be possible to make more efficient use of expensive diagnostic equipment and highly trained staff as a consequence of the reviews of organization and manpower in the diagnostic services now taking place.

Advisory Committee on Dangerous Pathogens

The Advisory Committee on Dangerous Pathogens was set up in 1981 to advise Government Departments and the Health and Safety Commission on a number of broad issues relating to work with infectious micro-organisms. The Committee's first task was to produce recommendations on the '*Categorisation of Pathogens According to Hazards and Categories of Containment*'. A report was submitted to ministers and the Commission late in 1983 and will be published in 1984[1].

Four hazard groups were defined along with four related containment levels in the form of model codes of practice applicable to laboratory and animal work involving any of the categorized organisms. The report also includes a number of useful appendices on specialized topics.

The report provides a common set of national standards based on the hazard ratings of the various organisms and the recommendations apply to laboratories in teaching, production, research and clinical establishments. Some sections of the 'Howie Code'[2] are modified or amended as a consequence of this report.

The Committee is also developing advice on the means of inactivating specimens which may contain haemorrhagic fever viruses prior to examination, a standard for flexible film isolators and the provision of interim guidelines for staff handling specimens from patients with AIDS.

The Laser Safety Working Party

Since the invention of the laser in 1960 its use in medical practice has expanded rapidly. The final collimated laser beam can be used to photocoagulate; to seal bleeding vessels; or to vaporize tissue. The beam, however, can injure both patients and staff. Damage to the eye is the greatest risk.

In 1981 the Department set up a Working Party comprising medical and scientific personnel from the NHS, the Health and Safety Executive and the National Radiological Protection Board. The terms of reference were to recommend the technical requirements for equipment and the operational procedures needed to protect patients and staff against radiation used in medical practice. The Working Party reported in October 1982.

In 1983 Health Authorities and professional bodies were consulted on the report which recommended general administrative arrangements, environmental and equipment safety features and precautions for users. The guidance, based on the revised British Standard (BS 4803: 1983)[3] and advice from the Health and Safety Executive will be published shortly under the title *'Guidance on the Safe Use of Lasers in Medical Practice'*.[4]

Bone marrow transplantation

Following the publication of the Black Report on bone marrow transplantation in 1982, which recommended the setting-up of bone marrow transplant services on a supra-regional basis[5], Ministers asked a new group, the Supra-Regional Advisory Group, then being established to consider services of national importance, to consider these recommendations.

The Supra-Regional Advisory Group found that in the short interval since the review by the Black Working Group there had been considerable development both in terms of potential demand for bone marrow transplantation and the spread of clinical expertise in providing the service. In addition to six London centres three of the 10 Regions outside London had each established a centre and were providing a limited number of bone marrow transplants. Three further Regions were actively planning to develop a service with support in principal for the proposals and two other Regions were expressing interest in developing a service. A further consideration was that bone marrow transplantation both allogeneic and autologous was proving a useful treatment for other malignancies as well as leukaemia and this might cause further expansion in demand for a service which a limited number of centres could not accommodate. In view of this

the Advisory Group concluded that regional development was more appropriate to bone marrow transplant services rather than imposing on the already expanded service a limited number of centres. Ministers accepted the Advisory Group's conclusion.

The Government agreed to allocate additional resources (£150,000 in 1983/84 and £500,000 in the following year) to the centres in London to enable them to expand their services. It was expected that this would help to relieve any waiting list pressures on the London centres during the period when units outside London were building up their bone marrow transplant capacity. The extra funding was divided equally between the 6 London centres after an allocation to be divided appropriately between the two Regional Transfusion Centres who provide the units with the necessary blood products required for transplant patients.

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d. Tinnitus

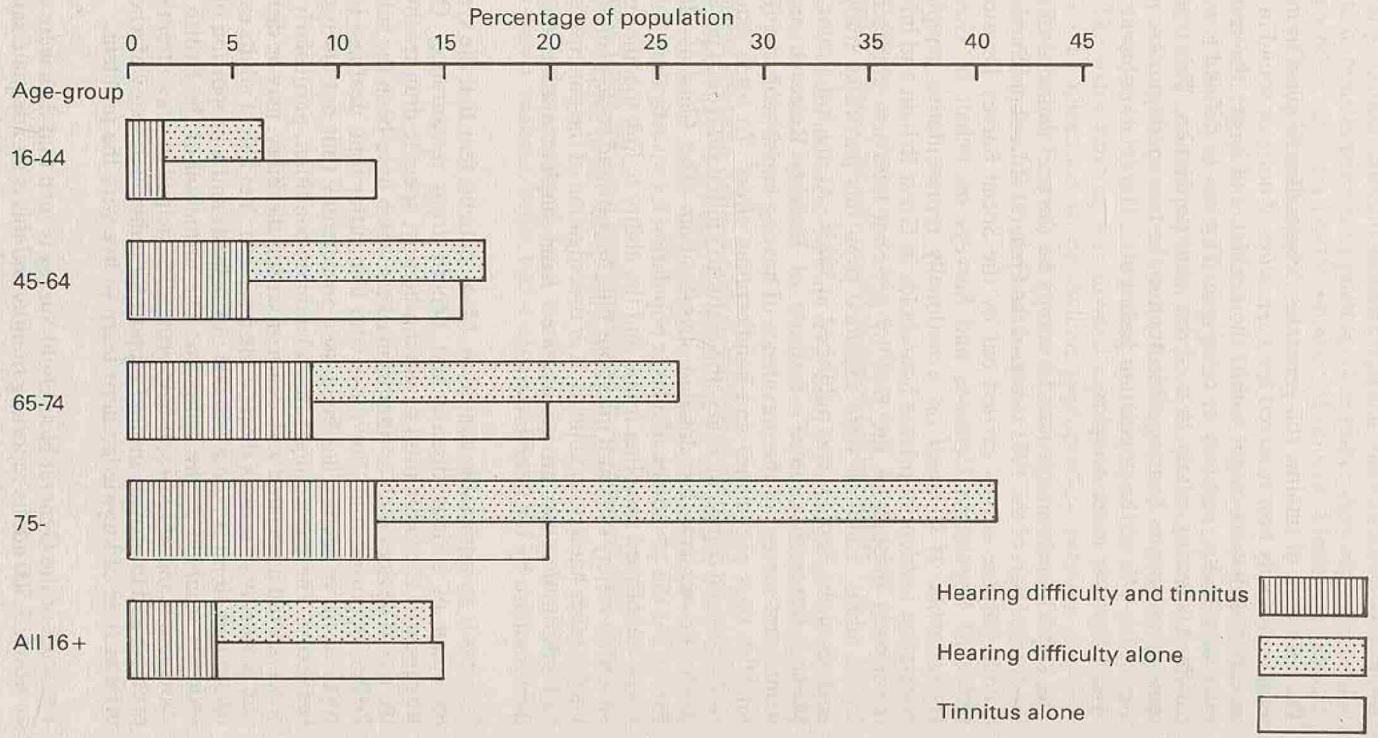
The definition of tinnitus still generates debate after 50 years or more. The term is probably best reserved for a *sensation* of noise or sound in the head or ears that has its origin within the cochlea and is not the result of an external stimulus, auditory or otherwise. Tinnitus as defined is a common condition affecting nearly 15% of the adult population. This is about the same prevalence as hearing difficulty and the two conditions are related in that nearly 5% of the population have both. The relationship at different ages is however more complex.

The Department commissioned a survey on the prevalence of tinnitus and this formed part of the 1981 sweep of the General Household Survey. This is a multi-purpose survey carried out by the Social Survey Division of the Office of Population Censuses and Surveys on behalf of Government Departments. It is based on a nationally representative sample of the population resident in private households in Great Britain and information is collected throughout the year by personal interview embracing some 23,000 adults. Children were excluded from this particular study and an analysis of the findings was published in 1983[1]. At much the same time the Medical Research Council's Institute of Hearing Research mounted a multicentre survey[2] of the prevalence of hearing impairment and tinnitus to establish their prevalence and handicapping effect. To some extent these studies proved complementary, the Institute's initial sift from a postal survey producing subjects for detailed investigation. The General Household Survey has the advantage of a large population for investigation based upon a well-established sampling frame and the ability to link together responses on a wide variety of health questions plus background socio-economic data. On the other hand no examination or investigation of the patients is possible and information has to be obtained from implementation of a single questionnaire by lay interviewers.

Tinnitus is an intractable condition. Many patients fear that the symptom is an omen of serious disease and benefit from reassurance. Otherwise treatment is a combination of psychotherapy, specific drug treatment and the use of devices such as tinnitus maskers which have been the subject of a DHSS supported trial. For those who also suffer total deafness in an ear, cochlear nerve section has been used successfully (but not always so) as a last resort. There is a danger that a common condition, particularly one that is not in itself associated with death or serious disability, may be dismissed as one unworthy of serious therapeutic attention. Yet 2% of adults experience continuous tinnitus (some 800,000 in England) and a proportion of these is seriously troubled by the symptom. The formation of the British Tinnitus Association and of local self-help groups has helped to draw attention to the problem and to provide mutual support for individuals many of whom in the present state of knowledge must learn to live with the problem.

The scale of the General Household Survey is such that data were collected on nearly 3,500 adults reporting tinnitus and this is an adequate sample size to permit disaggregation by socio-economic group and age to investigate associated factors. Figure 15.1 shows the prevalence of self-reported hearing difficulty and that of tinnitus by age-group. Self-reported hearing difficulty is

Figure 15.1:
Percentage of the population reporting hearing difficulty, tinnitus or both by age-group (General household survey 1981)



not the same as an objective measurement of hearing impairment which it probably under-estimates. Hearing difficulty is highly age-dependent, tinnitus much less so with this particular survey suggesting a plateau above the age of 65 years. However at all ages tinnitus is found in around one-third of those reporting hearing difficulty with the result that the rise in the prevalence of tinnitus with increasing age is entirely due to an increase in the number of individuals with *both* conditions. The prevalence of tinnitus alone (ie without hearing difficulty) does not increase with age, and this survey suggests that it decreases slightly. It is to be hoped that the combination of epidemiological studies with laboratory investigation will produce a better understanding of this condition and advances in its therapy.

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[1] Office of Population Censuses and Surveys. Social Survey Division. *General household survey 1981.* London: HMSO, 1983. £11.70.

[2] Medical Research Council. Institute of Hearing Research. *Epidemiology of Tinnitus.* In: Evered D, Lawrenson G, eds. Symposium on Tinnitus held at the CIBA Foundation, London 13–15 January 1981. London: Pitman, 1981. (CIBA Foundation symposium: no 85).

e. Heart transplants and reorganization of the transplant advisory panel (TAP)

Heart transplants

The present programme of heart transplantation in England started at Papworth Hospital in January 1979. Their first patient never fully recovered consciousness and died soon after the operation but the second is still alive and very well now some 4½ years after the operation. The programme at Harefield Hospital started in 1980. By the end of 1983 Harefield had carried out 83 transplants on 80 patients with 46 survivors and Papworth 62 operations on 61 patients with 38 survivors. Figure 15.2 taken from the Evaluation Team's Interim Report shows the cumulative survival curves up to July 1983 for the two units; they are not statistically significantly different. In numerical terms, for the combined units, this means a 59% one year survival, 47% two years and 42% three year survival. In the last two years with the introduction of cyclosporin A, the new immunosuppressive drug, there has been an improvement in survival (the latest one-year actual survival is 75%) as well as a marked reduction in the length of stay in hospital.

At the beginning of 1982 the Department funded an evaluation team to:-

Analyse the resource costs within Papworth and Harefield Hospitals associated with their respective transplantation programmes.

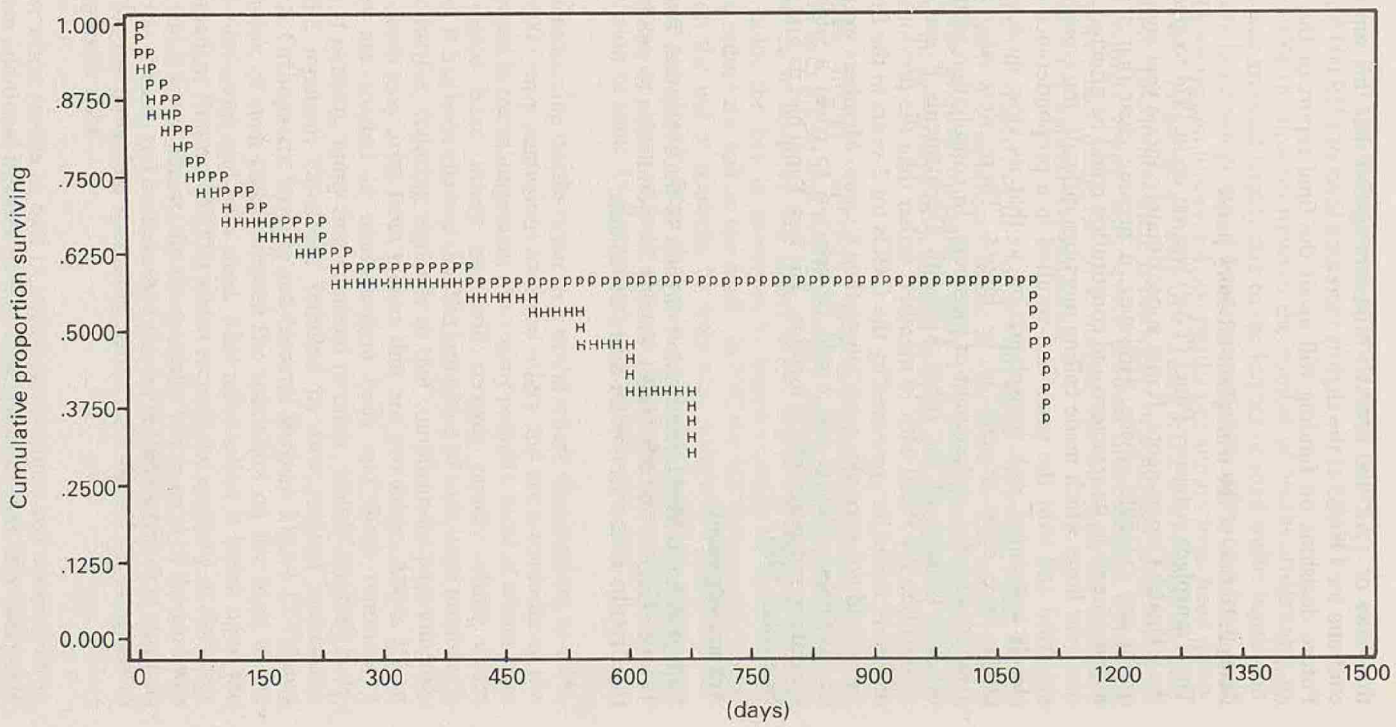
Identify and analyse extra NHS costs and other public sector costs incurred outside the 2 centres by patients involved in the transplantation programme and their selection procedures.

Measure benefits in terms of basic outcome data.

The final report on the study is expected at the beginning of 1985. However, a most useful Interim Report (unpublished) was produced in October 1983, which discusses methodology and presents preliminary results. Its authors emphasize that firm conclusions should not be drawn from their work until the final report is available. The Interim Report was considered by the Transplant Advisory Panel (TAP) and the Standing Medical Advisory Committee (SMAC), and both commended the scientific value of the report and of the programme in general. They recommended that the existing two programmes should continue at least at their present level, until the final report was available. They also considered a report from the British Cardiac Society which had recommended a major expansion of heart transplantation including the setting up of a third unit, probably in the North of England. Both TAP and SMAC felt that such an expansion was premature and should not be considered until the final report of the evaluation team was available.

In the early years most of the financial support for the two programmes came from charitable sources, though the Department had found £50,000 capital, for improvements to the intensive care unit and operating theatres, and £100,000 revenue support for Papworth Hospital. The main source of the charitable support terminated at the end of 1982 and the Department then made available £200,000 for each unit for the financial year 1983/84 to enable the programme to continue. After considering the interim report and

Figure 15.2:
Heart transplatations: the cumulative survival survey for Harefield (H) and Papworth (P) Hospitals up to 31st July 1983



the views of TAP and SMAC, Ministers agreed that this support should continue for 1984/85 at the slightly increased level of £218,000 for each unit. Future decisions on funding will await the final report of the evaluation team.

Reorganization of the transplant advisory panel

The Transplant Advisory Panel (TAP) was set up in 1974 to give advice to the 4 Health Departments. It met approximately once a year and gave much useful and valuable advice. However, it became clear that a number of improvements in its structure and constitution could be effected. The Panel was over large which made calling meetings difficult, the composition was not fixed and over the years had resulted in a preponderance of persons closely associated with transplantation so that its view on some matters might have been thought to be biased. There were also no formal arrangements for replacement of members. In consultation with the Chief Medical Officers of the other 3 Health Departments it was agreed to reconstitute the Panel with 18 members rather than the previous 27, These members would be appointed by the CMOs for 3 years in the first instance and would not normally serve longer than 6 years. Members would serve in an individual capacity but would be selected to cover a wide range of specialties and geographical location. The new Panel had its first meeting in November 1983.

Acknowledgements

I am grateful to Mr Martin Buxton director of the evaluation Team and Mr Terence English and Mr Magdi Yacoub for permission to publish some of their results in the section on heart transplants.

f. The management of acute head injury

By the late 1960s the upward trend of the number of deaths attributable to head injury was arrested largely due to the impact of road traffic legislation upon the very large sub-group of head injury deaths that arose from road accidents. There remain however 4,500 deaths per annum from head injury in England with a mean age at death of 44 years and a loss of some 28 years of expected life. In addition there is the legacy of a further 1,500 survivors per annum, equally young, with severe residual brain damage rendering them dependent and incapable of a normal life but with an expected life-span that is not appreciably reduced.

Although the full tragedy of this toll is most apparent in the effect on the young, age itself is a significant factor in the cause of the injury and in determining the eventual outcome. Figure 15.3 shows the relative population rates for all age-groups of death and of hospital admission for the year 1979.

Of the deaths, around 2,000 occur from extreme brain damage that is incompatible with life so that death normally intervenes before the patient can be admitted to hospital. For these, in our highly mechanized society, prevention holds the key in measures to improve safety at work and in particular to reduce the toll on the roads. In 1983 we saw the introduction of legislation on the use of seatbelts by front-seat occupants of cars and the value of these has already been shown in a reduced death toll and a large reduction in the incidence of facial injuries. The latter alone previously led to the admission of some 14,000 victims to hospital every year.

Most of the remaining deaths occur in hospital where they amount to 1.4% of the 135,000 yearly admissions for head injury and are a reminder of the challenge posed in the management of so many patients, most of whom have relatively minor head injury and will recover rapidly whilst under observation. It has been claimed that the admission of such large numbers is counter-productive, reducing vigilance so that complications pass unrecognized and death may arise from factors that are avoidable. About 5% of these cases are treated in neurosurgical beds and these represent a distillation of patients, many first admitted to other, mainly surgical, beds. Most of the inpatient cases are handled by two surgical specialties. Traumatic & Orthopaedic Surgery and General Surgery. Figure 15.4 shows the distribution of such cases between the specialties on the basis of the number of admissions and beds used. This information is based upon the Hospital Inpatient Enquiry (HIPE) which records the specialty of *discharge* (or death) which is not necessarily the specialty where most of the care was given. For this reason, and because the rules for recording transfers may bias the totals for the individual specialties, some care should be exercised in interpreting these data.

Head injury often results as part of widespread trauma and some of these patients have additional injuries such as limb fractures that may determine the admitting specialty but for most it appears that the only condition requiring *inpatient* care is the head injury itself. It is therefore open to debate which specialties should shoulder the burden of providing this care.

Figure 15.3:
Registered death rates from head injury (ICD 800-804, 850-854) and hospital admission rates, relative values by age-group (mean death rate 92 per million population, mean admission rate 2.8 per thousand), England and Wales 1979.

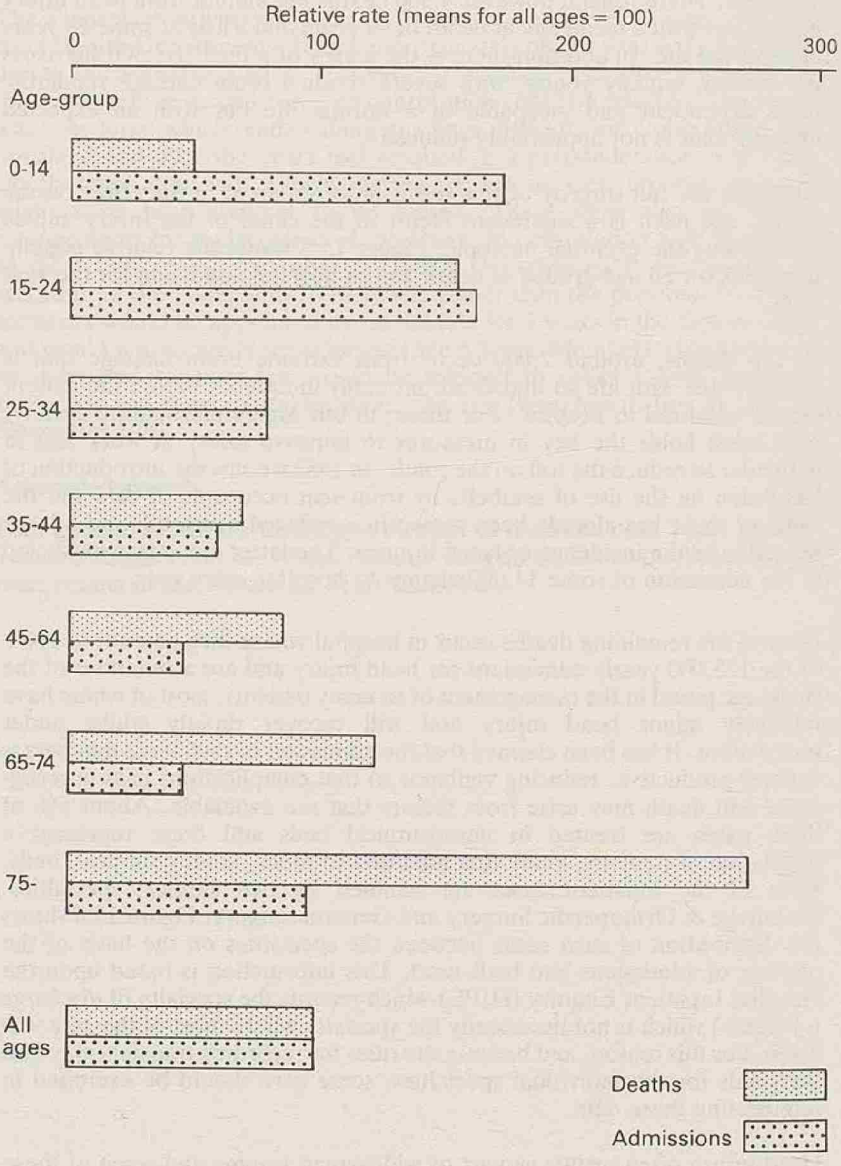
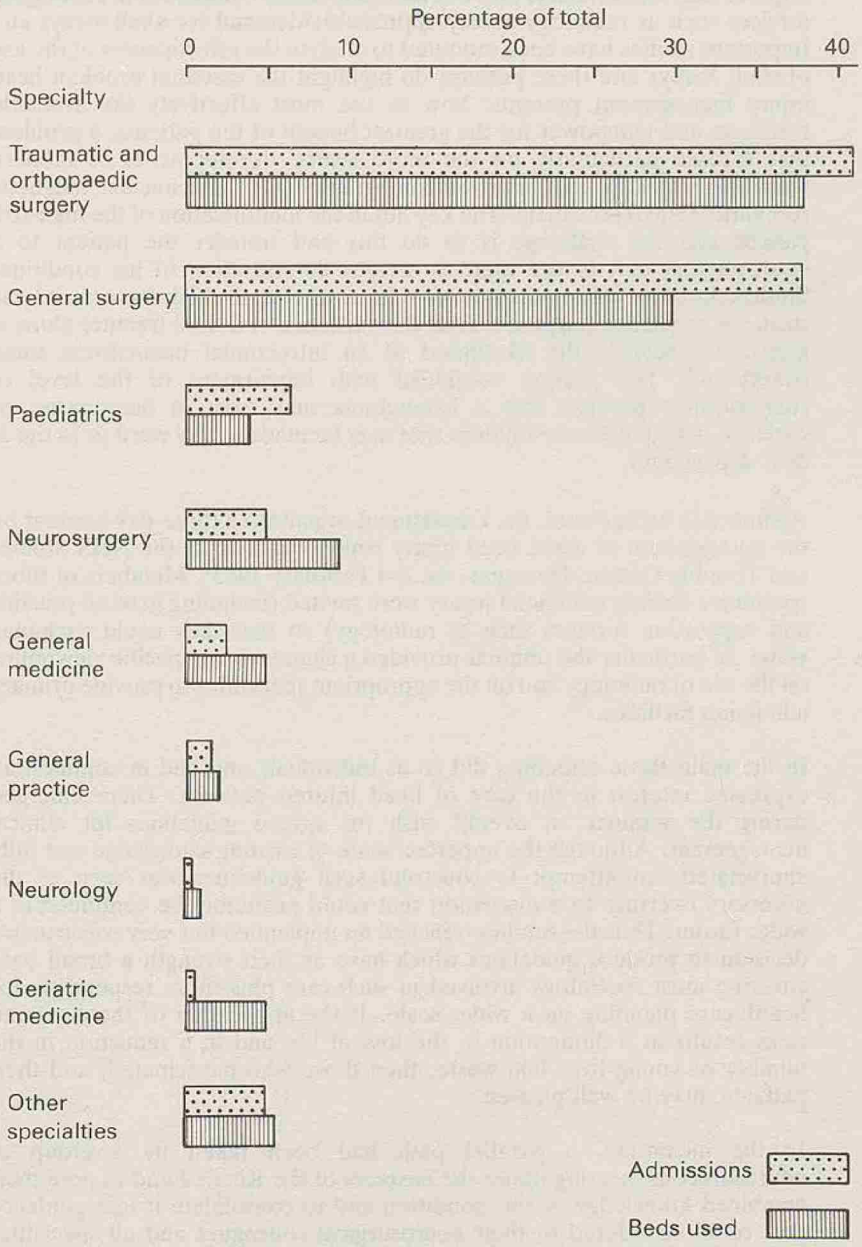


Figure 15.4:
Main specialties admitting head injury showing the proportion of the admissions and the proportion of the hospital beds provided by each, England and Wales, 1979



The burden is by no means limited to the admitting specialty. The large number of patients attending Accident & Emergency departments has to be examined and investigated to permit a safe answer to the very difficult question Is this patient fit enough to return home?. Such decisions may require the use of observation beds and always impose on supporting services such as radiology a very appreciable demand for skull x-rays etc. Important studies have been mounted to analyse the effectiveness of the use of skull X-rays and these perhaps do highlight the essential problem head injury management presents: how to use most effectively the available resources and manpower for the greatest benefit of the patients, a problem that focuses particularly on the more scarce developments of modern technology such as computerized tomography (CT) and nuclear magnetic resonance (NMR) scanners. The key lies in the identification of the high-risk patient and the challenge is to do this and transfer the patient to a neurosurgical unit *before* there is serious deterioration in his condition. Studies on large data-bases now enable us to quantify risk factors and use them for predictive purposes. Thus the existence of a skull fracture alone is known to increase the likelihood of an intracranial haematoma some twenty-fold. This feature combined with impairment of the level of consciousness predicts that a haematoma may exist in one-quarter of patients — and these are findings that may be made in any ward or in the A & E department.

Against this background, the Department organized a three-day seminar on the management of acute head injury which was held at the NHS Studies and Training Centre, Harrogate on 2–4 February 1983[1]. Members of those specialties dealing with head injury were invited (including general practice and supporting services such as radiology) so that they could exchange views. In particular the seminar provided a chance to air specific viewpoints on the use of radiology and on the appropriate specialties to provide primary admission facilities.

In the main those attending did so as individuals and had in common an expressed interest in the care of head injured patients. There emerged during the seminar an overall wish for agreed guidelines for clinical management. Although the imperfect state of existing knowledge was fully appreciated, an attempt to construct such guidelines was seen as the necessary overture to a discussion that could profitably be continued in a wider forum. Thus the seminar reached an unplanned but very constructive decision to produce guidelines which have as their strength a broad base covering most specialties involved in such care plus those responsible for health-care planning on a wider scale. If the application of these ground rules results in a diminution in the loss of life and in a reduction in the number of young lives laid waste, then those who participated, and their patients, may be well pleased.

In the meantime, a parallel path had been taken by a group of neurosurgeons meeting under the auspices of the King's Fund to pool their combined knowledge of this condition and to consolidate it into guidance that could be offered to their neurosurgical colleagues and all specialties involved with primary referral of cases. The result of their deliberations has been published[2].

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[2] Briggs M, et al. *Guidelines for initial management after head injury in adults: suggestions from a group of neurosurgeons. Br Med J* 1984; **288:** 983–5.

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