DEPARTMENT OF HEALTH AND SOCIAL SECURITY

On the State of THE PUBLIC HEALTH for the year 1984

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DEPARTMENT OF HEALTH AND SOCIAL SECURITY

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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 1984

> 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 1984.

These reports cover a period of 129 years. The first was written by Dr. (later Sir) John Simon and dealt with the year of his appointment as Medical Officer to the Privy Council (1856). Since Sir John there have been 12 holders of the office of Chief Medical Officer (CMO). Each CMO has every year commented upon unsolved problems in public health. The exercise of this privilege has revealed over the years not only how but also why changes in the nation's health have come about.

For the report for 1984 I have looked at the nature and scope of the work on which we are currently engaged and selected new titles for the main chapters — vital statistics, public health, developments in the NHS and in medical sciences and services, international health and social security. This introduction contains a commentary on some of the happenings recorded under those headings. It does not purport to be a summary of the Report.

VITAL STATISTICS

A rather different approach has been followed this year for the chapter on Vital Statistics, with extension of the range of sources of data and their presentation in graphical form where this is appropriate.

Two new sections present limited material from the Hospital In-Patient Enquiry (HIPE), and from the General Household Survey (GHS). The discharge statistics indicate the main causes of hospitalization by sex and over the age range, whilst the data from the GHS indicate the degree of contact in the health service with NHS general practitioners, attendance at out-patients and in-patient care. Recently, the Office of Population, Censuses and Surveys (OPCS) introduced into its weekly monitor a graph showing the trend of notifications for infectious diseases (different diseases being selected week by week on an eight week cycle). An example of such a graph is included. It compares the trend for dysentery in the past year with the highest and lowest weekly figures over the preceding ten years.

Use of some of the statistics available to OPCS creates difficulty in presenting material for the same calendar period, and for England only. Limitations in data retrieval have meant that some of the material relates to England, some England and Wales, and some Great Britain. The text draws attention to sets of data that differ in geographical coverage. Each section indicates the primary source of the statistics and where more detailed data can be obtained.

A table sets out the commonest causes of death for males and females for different age groups. In addition a new table is provided on the Future Years of Life Lost — this indicates the different contributions to the toll from mortality when one bears in mind the expectation of life at the age of death.

International mortality from malignant disease discussed. This is the first of a cycle of such contributions, with different major causes of death being selected each year. Space limitations permitted presentation of data on two particular cancers only — lung cancer in males, and breast cancer in females. These are cancers where the long-term trends of mortality in this country are relatively unfavourable compared with those in other countries for whom equivalent data are available.

PUBLIC HEALTH

Communicable diseases

Aids

A major step forward in unravelling the cause of the acquired immune deficiency syndrome (AIDS) was the discovery almost simultaneously in France and in the USA of a retrovirus known as LAV/HTL VIII respectively in the lymphocytes of sufferers from the disease and the persistent generalized lymphadenopathy which often precedes it. The identification of a causal agent enabled studies of the seroprevalence of antibodies to it and furthered hopes that eventually a vaccine against the disease would be produced. The increase in the number of cases reported to the Communicable Disease Surveillance Centre (CDSC), the evidence of the widespread nature of the infection through seroepidemiological studies and the rapid increase in numbers of cases in the USA where the disease was first identified emphasized the implications for the public health and the need for the control of the spread of infection to be regarded as an issue of prime importance to the future of the nation.

Tuberculosis

Tuberculosis is now both curable and preventable. In the past X-ray screening of certain occupational groups and of those admitted to this country for long-stay or settlement, sometimes combined with tuberculin skin-testing, has helped identify those with evidence of current or past infection. But the benefits of occupational screening and of vaccination have diminished as the overall incidence of infection and of disease has fallen. In recognition of this and the need to reduce exposure to radiation, it has been agreed that routine chest X-ray for certain occupational groups (particularly those working with children) will only be required when there are specific medical reasons.

The Joint Committee on Vaccination and Immunization has carefully considered the future of the present comprehensive BCG immunization programme. It now recommends that BCG vaccination of school children should continue for a few more years with the intention of changing to a more selective scheme before 1990, unless a further survey of tuberculosis notification shows that the downward trend is not maintained. In the meantime plans should be developed to ensure that BCG vaccination will continue to be offered to those at special risk. This is not an indication that the problem of tuberculosis has vanished but recognition of the need to concentrate preventive methods where they are likely to be most effective. In the meantime great benefit has accrued in the younger population of whom at least 75% are protected by immunization, a legacy that will yield benefit for many years to come.

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Food poisoning

Over the last three years there has been a steady rise in the number of cases of food poisoning notified to OPCS and in the number of laboratory reports to CDSC. Part of the increase in laboratory reports was probably due to increased laboratory facilities and investigation and to better reporting. However, the fact that the recent trend in laboratory reports matches that in notifications suggests that part of the increase was real. Most of the food poisoning was due to salmonellosis and laboratory reports of incidents of salmonellosis therefore showed the same trends as were shown by all food poisoning. A large peak occurred at week 37 (see Figure 1.6 page 29) in the number of food poisoning notifications. This coincided with the outbreak of salmonellosis at Stanley Royd Hospital in which 19 deaths were believed to be caused by salmonella infection. At the time of writing the hearings of the public enquiry into the outbreak have taken place, but the report has not yet been completed. This was one of the largest outbreaks of salmonellosis in hospital reported in England. Although the number of such outbreaks in hospital rose at the same time as the overall increase in salmonellosis in the late 1960's and early 1970's, there was a decrease by more than half between 1979 and 1983, despite the continuing rise in salmonellosis outside hospital.

Pâté was the vehicle in three outbreaks of salmonella food poisoning in 1984. In the two which were due to imported pâté, the gelatine coating/topping contained more organisms than the pâté itself. In another outbreak associated with airline catering the gelatine/aspic coating of the hors d'oeuvres was the vehicle. The need for vigilance in maintaining good hygienic practice in producing any type of cooked meat product is also emphasized in the outbreaks of salmonellosis in Essex and Humberside which were due to cross contamination of cooked meat from raw meat and inadequate temperature control.

Other common causes of bacterial food poisoning are *Clostridium perfringens* and enterotoxin - producing strains of *Staphylococcus aureus*, but these are much less frequent than salmonellosis. Pasta is an unusual vehicle for *Staphylococcus aureus* enterotoxin. It is likely that the use of unpasteurized egg was one of the factors in the contamination at the factory which produced the lasagne responsible for the outbreak described on page 48.

Most food poisoning arises from meals in catering establishments, in the home and at special functions, usually involving meat or meat products contaminated with pathogenic organisms either not eliminated or introduced during the preparation stage. Proper regard to the need to keep raw meat separate from cooked meat, to thaw and then cook frozen meat (particularly poultry meat) thoroughly, to keep cooked meat either chilled or at a high temperature, to cook thoroughly when reheating meat dishes, and to observe good hygienic practices would undoubtedly reduce the extent of the problem. This is the message which, with the help of the Health Education Council, we take every opportunity to put across.

The use of unpasteurized milk continues to be a hazard to health. Publicity following the incident reported on page 49 caused the demand for raw milk to drop and enquiries for the installation of on-farm pasteurization to increase and it is hoped that sales of untreated milk will drop further after November 1985 when amending regulations take effect.

Environmental health

Radiation

Both members of the public and the Government are paying increasing attention to suggestions that adverse health effects may arise from exposure to low levels of environmental radiation.

In November 1983 the Government set up an independent inquiry to look into the recently published claims of an increased incidence of cancer in the vicinity of the British Nuclear Fuels plc site at Sellafield. This inquiry was chaired by Sir Douglas Black. The report of the inquiry was published in July 1984, and gave a qualified reassurance to the people who were concerned about a possible health hazard in the neighbourhood of Sellafield. The report also stressed the uncertainties with regard to both the available epidemiological data and the estimation of radiation dose. The Group made ten recommendations for further work, all of which were accepted by Government and are being implemented as rapidly as possible.

This highlighted a particular problem: the difficulty in interpreting epidemiological data when they relate to relatively small numbers of people, because of the real possibility of fairly wide fluctuations in rates due to chance alone. There can also be problems with estimation of likely exposures. The Department is at present considering ways of improving risk assessment in this area.

Fluoridation of drinking water

Dental decay remains a serious health problem despite the welcome general reduction in prevalence in recent years. The 1983 Children's Dental Health Survey has shown that, among 15-year-olds in England, an average of 5.6 teeth were decayed, filled or extracted due to past decay. In other parts of the United Kingdom, the figure is even higher.

The use of fluoride supplements administered individually, in particular as fluoride toothpaste, has certainly contributed markedly to the general reduction in dental decay. Unfortunately, despite dental health education for the community, many children do not receive such fluoride supplementation, which must depend on conscious effort by parents or guardians. Only fluoridation of drinking water has the advantage of reaching the whole of a community. Numerous studies in the United Kingdom and throughout the world have shown not only that water fluoridation makes a significant contribution to the general decline in dental decay, additional to that achieved by the other forms of fluoride supplementation, but also that it is of particular benefit to the more socially deprived parts of the population.

Successive Governments have endorsed the fluoridation of drinking water since schemes were first introduced in the United Kingdom thirty years ago, following an assessment of the benefits seen in the United States; yet even now, only 10% of the population of the United Kingdom receives fluoridated water. Undoubtedly, fuller implementation has been impeded by allegations that fluoridated water is harmful to health. It is claimed that fluoridated water causes allergy, arthritis, cancer, diabetes, renal and thyroid disorders, and a wide variety of other diseases. After many investigations in the form of official committees of enquiry, and by bodies such as the Royal College of Physicians and the World Health Organization, (WHO) such claims remain unsubstantiated. Some of the allegations were aired once again during the

course of the recent lengthy court case in Scotland. In his judgement, Lord Jauncey upheld the efficacy and safety of water fluoridation.

The Department has assessed reports relating to the effects of fluoride ever since the fluoridation of water was first considered. Where appropriate, it has commissioned research and published appraisals. During 1984, particular attention was paid to the allegations that water fluoridation could cause cancer or genetic damage in man. The facts were examined carefully and thoroughly, and no basis for these allegations was found.

At the time of writing, the Water (Fluoridation) Bill was entering its final Parliamentary stages. The Bill seeks to give specific legal powers for the implementation of fluoridation schemes. Fluoridation of water is safe, and is the most effective measure available to improve the future dental health of the whole community. There is every reason for the nation's children to have the benefits of water fluoridation which are, at present, available only to the minority.

Prevention

The problems of cigarette smoking among young children

The reduction in cigarette consumption noted in this Report for 1983 (page 123) continued during 1984 with a reported fall of 2.7%. While encouraging, this decline is smaller than the annual fall in recent years and leaves no grounds for complacency regarding the level of tobacco consumption and the morbidity and mortality associated with it. For while the number of adults who smoke continues to decline large numbers of young people are taking up the habit. Children experiment with cigarettes from a very early age but it is not until adolescence that smoking becomes a regular[†] rather than an experimental practice. Figures from several surveys have shown that the prevalence of smoking among adolescents rises steadily during their secondary school years. The Derbyshire Smoking Study found that the prevalence of regular smoking among boys rose from 6% at 11-12 years to 25% at 15-16 years to 33% at 18-19 years. Among girls the respective prevalences were 3%, 19% and 30%. So about a third of all young people are already smoking regularly when they are 19 years of age. It is important therefore, that studies should continue in order to throw light upon the social and other influences motivating young people to take up regular smoking and to take appropriate and effective steps to discourage them. In 1984, therefore, we asked OPCS to repeat a national survey of smoking prevalence among secondary school children. The results underline the need to intensify our efforts in this area. The 1984 survey showed no decline in teenage smoking since 1982, and for certain age groups e.g. 16-year-old girls, a slight increase. A range of new positive measures are being instituted to tackle the problem, including a £1m. pilot media campaign aimed at young people which is being tested in two regions, and a new detailed study to examine why children smoke.

Early in the year a meeting took place between the Parliamentary Secretary for Health and the tobacco retail organizations to discuss the problem of illegal sale of cigarettes to children under 16 years of age and to inform the trade of the Department's intention to issue guidelines on the subject to retailers. As a result, guidelines were subsequently issued to retailers on steps they should take to prevent illegal sales of

[†] Regular is here defined as smoking one or more cigarettes per week.

cigarettes to children and posters were produced for them to display in shops. The Home Secretary announced in May that the maximum penalty for illegal sale of cigarettes to children under 16 years of age would be doubled to £400.

The major emphasis in this field must continue to be placed on health education. An extra $\pm^{1/2}$ million was granted to the Health Education Council specifically to boost their anti-smoking campaigns — in April a leaflet was issued to schools setting out the recent research facts about teenage smoking to act as a simple basic fact sheet for use by teachers, parents and teenagers themselves.

An innovation in the Government's approach to the problem of smoking among teenagers began in June when a private sector advertising agency, Waldron, Allen, Henry and Thompson Ltd was commissioned to carry out a special enquiry into the reasons why young people smoke with a view to developing a media campaign specifically targetted at this age-group. Initial results from the research phase were encouraging. A lot of new material about young people's beliefs and attitudes came to light. It turned out that, while discounting much of what they were told by ''authority figures'' of the adult world, members of their own age group who have been smokers but subsequently given up, are held in particularly high esteem by teenagers. Further work, designed to build upon these findings is continuing.

While the emphasis must remain on discouraging the young from taking up smoking and on persuading smokers to quit entirely, further action to reduce the enormous toll of morbidity and mortality from smoking-related diseases is centred on the development and use of ''less harmful'' cigarettes for those who continue to smoke. Further impetus to this programme was given by a provision in the 1984 Voluntary Agreement on Product Modification to re-structure the tar-bands so that all cigarettes yielding 18 mg or more of tar are designated ''High Tar''. If earlier patterns are followed, this range may gradually disappear from the market. It must be recognized, however, that the benefits of tar reductions are probably limited to the prevention of lung cancer.

Diet and coronary heart disease

Death rates from coronary heart disease have remained high although the most recent mortality statistics are moderately encouraging in that they show a downward trend in mortality in both women and men. In several countries with a high incidence of coronary heart disease mortality has fallen sharply, but in others it has increased. These trends have in a few instances been related to changes in prevalence of the major risk factors — raised blood pressure, raised blood cholesterol and smoking — and changes in diet may also have been important.

In July 1984 a report from an expert Panel of the Committee on Medical Aspects of Food Policy (COMA) was published. This report set dietary recommendations in the context of the need to deal with other risk factors such as smoking and lack of exercise.

The evidence relating cardiovascular disease to diet, although extensive, is incomplete. Nevertheless the COMA Panel concluded there was sufficient consistency in the evidence to make it more likely than not that the incidence of coronary heart disease in the United Kingdom would be reduced, or its age of onset delayed, if consumption of saturated fatty acids and total fat were reduced. All of the advice for dietary change is moderate and in accord with generally accepted principles and good practice in nutrition and dietetics. The Government has accepted the

findings of the Panel and steps are being taken to implement its recommendations.

One of the conclusions of the expert panel is that the subject of diet and cardiovascular disease is of sufficient importance to merit an ongoing review. In the past this subject has been reviewed by COMA only infrequently and as a special exercise. The advantages of an ongoing review are considered to include continuity, evolution of a coherent policy as opposed to periodic recommendations, and greater public awareness of its importance. An evolving policy could also facilitiate education and change on the part of the food and catering industries. Our recent experience in this area would endorse this advice, and we shall be looking into how arrangements for an ongoing review might be set up. As far as possible, these could include monitoring public response to health education, changes made by food manufacturers and caterers, and trends in mortality from cardiovascular disease and all causes.

Drug misuse

The Government has developed and co-ordinated a comprehensive strategy to tackle drug misuse. The objective is to attack the problem on five main fronts by reducing supplies abroad, tightening controls on drugs produced and prescribed here, making policing even more effective, strengthening deterrent measures and improving prevention, treatment and rehabilitation.

The role of health education, the kind of information that should be made available and how it should be disseminated has been reviewed. The major problem centres around the use of the media and whether a shock and scare approach or a more low key campaign was likely to be the more effective. Market research was undertaken in order to plan a campaign for early 1985. The public's perception of drug misuse certainly needs changing but information alone is not enough to influence and change behaviour.

Doctors should play an active part in early intervention and support of young people and their families. The Advisory Council on the Misuse of Drugs, aware of the wide differences in medical treatment offered to drug misusers and the uncertainty of many doctors, often with little previous experience about the treatment they should offer, recommend that a committee of medical experts should be invited to draw up guidelines of good clinical practice in the treatment of drug dependence. This was agreed by a representative meeting of the profession at a conference convened by the Secretary of State in January 1983.

The committee completed its report in 1984 in which they recommended that all doctors have a responsibility to provide care for drug misusers. Copies of their report were sent to every hospital doctor and general medical practitioner.

Drug misuse is discussed in more detail in Chapter 2 (d).

Developments in medical sciences and services

Toxicology and environmental protection

The present level of economic development in this country is largely the result of applying advances in technology to all sectors of economic activity, and future growth will involve continued application of new technological innovation. The use of new technology, new materials and new processes inevitably involves the use or generation of new chemical compounds to which the public may be exposed, and an

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important part of preventive medicine consists of the assessment of such new chemicals for possible effects on human health, together with a continuing assessment of existing chemicals in the light of advances in scientific knowledge. Such safety assessment requires the evaluation of toxicological information on a compound, which may be obtained from laboratory studies, tests in animals, or the monitoring of human populations, especially if substantial exposure to the compound occurs. In addition it is necessary to consider levels of exposure to these chemicals — this information being provided by other Government Departments such as the Department of the Environment or the Ministry of Agriculture, Fisheries and Food.

In the early 19th century the public health consequences of industrial or even preindustrial technology were unknown, but in the last 150 years there has been increasing assessment and control of chemicals in the environment. The DHSS, the Ministry of Agriculture, Fisheries and Food and the Health and Safety Executive continued that work by concentrating on four main objectives.

First, there is the refinement of existing methods of toxicology testing so that results have more predictive value for man. Secondly, there is an emphasis on replacing existing whole animal tests with alternative methods using, for example, cellular organelles, whole cells, tissues and organs in isolation. Thirdly, there is now greater acceptance that less precise estimates of certain end points in toxicity are adequate for safety assessment particularly as applied to acute toxicity testing, and that such tests are generally only necessary for chemicals such as pesticides and industrial chemicals to which there may be accidental exposure in high concentrations. Finally, there is increasing research to assess the effect of chemicals in areas not previously investigated, such as the immune system and behaviour patterns.

This work has been helped by increasing international recognition that regulations need to be adapted to meet scientific advances, and that international agreement on methods of toxicity testing will result in easier, cheaper evaluation of chemicals.

An additional step forward was the completion in October of arrangements for a comprehensive and permanent scheme for Good Laboratory Practice (GLP) monitoring in the United Kingdom along the guidelines recommended by the Organization for Economic Co-operation and Development. Under these new arrangements GLP monitoring is extended to cover all laboratories producing toxicological data for regulatory assessment purposes on any chemical.

Developments in the NHS

Primary Care

During the year there have been several developments in primary health care which are referred to later in this report. At the same time there has been a growing interest amongst the profession and public in the development of primary health care for the future, to make it more effective, efficient and patient responsive. The British primary care system is unique and has much to be proud of. Whilst recognizing it is important not to jeopardize the existing achievements it may now be desirable to consider further developments. The establishment of the National Health Service (NHS) in 1948 and the changes following the doctors' charter negotiations in the mid-60s were major milestones in primary care. Many believe the time has come for further initiatives.

In order to build upon the strength of the system it is necessary to reflect upon and review the progress of primary health care so far to identify the nature of the problems faced. Only then is it possible to discuss the way forward. The development of ideas and the achievement of consensus is often a slow and halting process which cannot always be hurried. However certain trends are emerging which will require careful consideration.

The first is that of quality care. At present there is a wide diversity in the standard of care patients receive and there is little incentive other than professional pride for general practitioners to strive for the highest standards of care. This problem has been highlighted by the recent "quality initiative" of the Royal College of General Practitioners.

There is also general acceptance that the NHS must demonstrate that society is receiving value for money from each one of the many services. These and other important issues will continue to be discussed throughout the coming year for there is little doubt that we are at the beginning of a period in which ideas will be developed that will shape the future pattern of primary health care.

Organization and management

Implementation of the NHS Management Inquiry Report

In the latter part of the year the first appointments of General Managers, to Regional and District Health Authorities were made, and it was announced that Mr. Victor Paige would take up the post of Chairman of the NHS Management Board in January 1985. These appointments followed the recommendation of the NHS Management Inquiry Team led by Roy Griffiths, and are the first steps in a process which is aimed to produce a fundamental improvement in the management of the NHS.

Since the end of 1984 individual districts have been drawing up plans for their management arrangements, and have embarked upon the process of appointing managers at unit level. The impact of the changes will be judged by the experiences of individual patients as they receive care and treatment in the various units — the functional level at which face to face contact is made. The selection of managers at this level who have a sound understanding of health needs and care will be a crucial factor for success.

International health

The Member States of the European Region of WHO have agreed a set of 38 targets aimed at improving health in Europe by the year 2000. Seven of these targets are concerned with reduction in mortality and relate to increased life expectancy or decreased overall mortality (infant and maternal mortality), or to mortality from specific causes (diseases of the circulatory system, cancer, accidents and suicide).

On page 112 the mortality rates for some of the outcome targets for the European Community (EC) and Scandinavian countries are compared using data supplied by the WHO European Regional Office. The trends in England and Wales over the past

decade for all but two of the indicators have shown a decrease in mortality. The two exceptions are cancer of the cervix and suicide.

Acknowledgements

My colleagues have prepared most of this Report and I am grateful to them for this and for their support during the year. As, always, the staff of the Office of Population, Censuses and Surveys has provided us with the Vital Statistics chapter and with other material needed to make a sensible appraisal of the nation's health.

I wish also to record that the work of the Department has to respond to the challenges of clinical practice. It can only do this if we are able to call upon the help of expert advisers who carry the confidence of their colleagues in the various health professions. Many experts devote much time and labour to collaborate with Government in dealing with multiplicity of problems (often behind the scenes). The extent and value of this work may not be fully appreciated within the profession. What these experts achieve is of as much benefit to the profession as it is to government.

International exchanges are becoming increasingly important. Useful contacts result from formal occasions such as meetings of the World Health Organization, the Chief Medical Officers of the European Community and the Council of Europe as well as the tripartite meetings at the highest medical level with Canada and the United States.

It is a pleasure to record my thanks for the collaboration received from other Government Departments and the Medical Research Council.

I am, Sir Your obedient servant,

E D Acheson October, 1985

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VITAL STATISTICS

Population size (England)

The population resident in England on 30 June 1984 is estimated to have been 46,956,000 some 110,000 higher than a year earlier (Table 1.1). This was the biggest annual increase in population since 1973 when natural change (the difference between numbers of births and deaths) accounted for almost all of the increase. In the year ending mid-1984 only about one-half of the population increase was due to natural change — a result of the number of deaths falling while the number of births remained steady. The remainder of the increase in population was due to net civilian migration, a component of population change which has tended to fluctuate in recent years. It is unusual for there to be a net inflow of migrants into England, although smaller gains due to net migration occurred in 1978-1979 and 1979-1980. The 1983-1984 net inflow is explained by a marked drop in the number of British citizens emigrating while the number of immigrants stay at much the same level as a year earlier.

Table 1.1: Components of population change, England (thousands)

Mid-year to mid-year	Population at start	Components of population change (mid-year to mid-year)							
	orpenou	Births	Deaths	Natural change	Net civilian migration	Other changes*	Total change		
1974-75	46,683	590	554	+36	-56	+12	- 9		
1975-76	46,674	561	563	- 2	-22	+10	- 14		
1976-77	46,660	536	544	- 9	-17	+ 6	- 20		
1977-78	46,640	544	548	- 4	-22	+25	- 2		
1978-79	46,638	591	554	+36	+13	+11	+ 60		
1979-80	46,698	610	543	+67	+18	+ 3	+ 89		
1980-81	46,787	606	542	+65	-47	+16	+ 34		
1981-82	46,821	592	552	+41	-61	- 5	- 26		
1982-83	46,795	593	545	+49	- 2	+ 4	+ 51		
1983-84	46,846	591	540	+52	+59	0	+110		
1984-85	46 956								

*This category represents changes in numbers of armed forces (both UK and foreign) plus adjustments to reconcile population change between mid-year estimates of natural change and net civilain migration. These adjustments take into acount 1981 Census data which suggest that the net migration loss may have been overestimated during 1971-80.

Age and sex structure of the resident population (England)

The estimated age and sex structure of the mid-1984 resident population of England is shown in Table 1.2. The age composition of the population is determined by past fluctuations and trends in fertility, mortality and migration. For example, the 4% increase in the number of pre-school children between 1981 and 1984 reflects the proportionately higher number of births during this period compared to the number of births in 1976-1980.

The population of school age (5-15 years) fell by almost 9% between 1981 and 1984 again this is a reflection of past birth trends, and the size of this population can be expected to continue falling for the next five years. The most striking change since 1981 is the increase in the number of very old people, that is those aged 75 years and over; this group as a whole has increased by over 8%. However within this age-group the number of men aged 75-84 has increased by nearly 11%, compared to just over 6% for women of the same age; and for those aged 85 and over the increases are around 8-9% for both sexes.

Table 1.2: Population age and sex structure at	30 June 1984, England
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(thousands)

Age group	Number	s (000s)	d Films	Percenta distribut	ge ion		% Change between mid-1981 and mid-1984			
	Persons	Males	Females	Persons	Males	Females	Persons	Males	Females	
0-4	2,955	1,514	1,440	6	7	6	+ 4.3	+ 4.1	+ 4.4	
5-15	6,808	3,498	3,310	14	15	14	- 8.6	- 8.6	- 8.7	
16-29	10,236	5,202	5,034	22	23	21	+ 3.8	+ 4.0	+ 3.7	
30-44	9,411	4,735	4,676	20	21	19	+ 2.6	+ 2.4	+ 2.7	
45-64/59*	9,074	5,169	3,904	19	22	16	- 0.3	+ 1.5	- 2.6	
60/65-74**	5,488	1,775	3,713	12	8	15	- 2.7	- 6.7	- 0.7	
75-84	2,428	861	1,567	5	4	6	+ 7.9	+10.8	+ 6.4	
85+	558	129	429	1	1	2	+ 9.2	+ 8.4	+ 9.4	
Allages	46,956	22,883	24,073	100	100	100	+ 0.3	+ 0.4	+ 0.2	

* 45 to 64 for males, 45 to 59 for females.

**65 to 74 for males, 60 to 74 for females.

The proportion of people of pensionable age as a whole (that is, men aged 65 and over and women aged 60 and over) did not change significantly between 1981 and 1984. In 1984 the proportion stood at 18% of the total population (Table 1.3); this compares with 19% in Wales and 14% in Northern Ireland. The figures in Great Britain are among the highest in the EC countries. Thus, with the EC the corresponding proportion varies from 13% in the Republic of Ireland to 18% in West Germany.

Table 1.3: Proportion of population of pensionable age (selected countries)

Country	Percentage of population of pensionable age*	Reference
UNITED KINGDOM		304
England	18	10 AL
Wales	19	> 1984
Scotland	17	and the second se
Northern Ireland	14	and a framework of the
EC COUNTRIES		
West Germany	the 18 second which share the	1982
France	16	1982
Italy	16	1981
Netherlands	14 methoday loui is read	1982
Belgium	16	1981
Luxembourg	inedia 16 des fundados encorres	1981
Republic of Ireland	13 - 13 - in the second second second	1981
Denmark	17	1982
Greece	16	1981
OTHER SELECTED COUNT	RIES	
Australia	12	1983
Chile	7	1983
Japan	12	1983
USA	14	1982

* Defined for comparison purposes as males aged 65 and over, females aged 60 and over.

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Birth statistics — aspects of relevance for health care

Teenage conceptions

A new series of statistics covering all conceptions leading to maternities and abortions under the 1967 Act was published by OPCS during 1984 (OPCS Monitor, FM1 84/6) and has subsequently been up-dated.¹ The figures do not include conceptions leading to spontaneous abortions but otherwise they provide full coverage of the outcome of pregnancies according to the age of the women at conception. In Table 1.4 the numbers of girls getting pregnant at ages under 16, and at ages under 20, per 1,000 girls in respective age groups are compared for the years 1972 and 1982. For girls under 16 the overall conception rate fell by 16% over the period; there was a particularly steep decline in the rate of girls getting pregnant at age 15 who married before the baby was born. At ages under 20 the conception rate fell by 29%. The rates of conceptions both inside and outside marriage fell although for those inside marriage the decline was much more marked. Teenage girls who became pregnant in 1982 were much less likely to marry before the birth of the child than in 1972.

First births to women aged 30 and over

First births to women aged 30 and over are of medical interest in view of the greater likelihood of obstetric problems with a first pregnancy at these older ages. Table 1.5 shows that during 1984 there were more first births to women in this age group than in 1964, when total numbers of births were at a post-war peak, and that the numbers have increased by over 50% during the 10 years since 1974. Increases were particularly sharp for women aged 30 to 34 and in 1984 over 1 in 50 married women of this age had a first birth within marriage. It should be noted that some of these women may have had a previous illegitimate birth but such events are not directly identifiable from birth registrations.

Sex ratio of births and multiple births

Table 1.6 shows that there were relatively fewer live male births per 1,000 live female births in 1984 than either 10 or 20 years earlier; nevertheless, numbers of male live births were still about 5% greater. The proportion of male to female births varied little for mothers of different ages.

The proportion of maternities with multiple births was about 1 in 100 during 1984, slightly lower than in 1964 and about the same as in 1974. There was a sharp upward gradient in the proportion according to mother's age. Whereas only about 1 in 200 maternities to teenage women involved multiple births, for women aged 35 and over the proportion was almost 1 in 60.

Seasonal variation in numbers of births

Table 1.7 shows that in 1984 the average number of live births per day was highest in September (5% above the annual mean) and lowest in December (6% below the annual mean). Over the 20 year period from 1964 births occurring during the summer and autumn (June to November) became relatively more frequent whereas the reverse

		Conceptio	ns outside marriage		Conceptions inside marriage				
Age at conception	All conceptions	Total	Illegitimate sole*	Maternities joint*	Legitimate† maternities	Abortions Under 1967 Act	Total	Maternities	Abortions under 1967 Act
Under 16									
1972	9.2	9.2	2.8	1.0	1.6	3.8		지도는 것 같아.	
1982	7.8	7.8	1.9	1.2	0.3	4.4	- T		
Under 20									
1972	79.2	53.0	10.4	4.7	21.7	16,3	26.2	25.6	0.6
1982	56.4	44.5	8.7	9.8	8.1	17.8	11.9	11.5	0.5

Table 1.4: Teenage conception rates 1972, 1982 Rates per 1,000 girls

Notes:

Rates for the under 16 and under 20 age-groups are based upon the populations of girls aged 13-15 and 15-19 respectively.

† Conceptions outside marriage leading to legitimate births occurring less than 8 months after marriage.

* Illegitimate births may be registered by the mother alone (sole) or by both mother and father (joint).

England and Wales

was the case for births occurring during the winter and early spring (December to April); these changes were particularly pronounced during the period from 1974 to 1984.

Table 1 5.	First legitimate	births to women	aged 30 or over	1964 1974 1984
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Age of	Number o	f births (000s)		England a Rates per	women		
mother	1964	1974	1984	1964	1974	1984	1.0
All ages							
30 and over	33.4	23.3	35.8	8.1	6.2	8.8	
30-34	23.5	18.1	28.3	18.6	13.8	20.6	
35-39	8.1	4.3	6.7	6.1	3.4	4.7	
40-44	1.7	0.9	0.7	1.2	0.7	0.6	
45 and over	0.1	0.1	0.0	0.1	0.0	0.0	

Note:

Rates for women of age 30 and over and 45 and over are based on the populations of married women aged 30 to 44 and 45 to 49 respectively.

Table 1.6: Sex ratio of live births and maternities with m	ultiple births: 1964, 1974, 1984
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Age of mother	Male live l 1,000 fem	births per ale live births		England a Materniti births per	ies of the state of the	
	1964	1974	1984	1964	1974	1984
All ages	1,062	1,061	1,049	11.6	9.7	10.1
Under 20	1,068	1,061	1,049	6.3	5.9	5.2
20-24	1,060	1,059	1,044	9.2	8.0	8.3
25-29	1,065	1,061	1,052	11.8	10.3	10.5
30-34	1,059	1,069	1,047	15.5	13.1	12.5
35 and over	1,055	1,056	1,061	16.2	14.1	15.2

Daily av	Daily average* number of births as proportions of annual average												
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	
1964	0.98	1.03	1.07	1.03	1.02	1.01	1.01	0.97	1.01	0.96	0.93	0.95	
1974	0.98	1.02	1.06	1.02	1.03	1.02	1.02	0.99	1.02	0.97	0.94	0.93	
1984	0.97	0.99	1.01	1.01	1.02	1.03	1.03	1.01	1.05	0.99	0.96	0.94	

*Adjusted for variations in proportions of births occurring on different days of the week.

Place of confinement

Table 1.8 shows that in 1984 the place of confinement for almost all maternities was a NHS hospital with no GP beds. The proportion of confinements at the mother's own home fell from more than 1 in 4 in 1964 to only 1 in 100 in 1984. The proportion of confinements in maternity homes and in NHS hospitals with GP maternity beds also declined sharply.

Table 1.8:	Place of confinement:	1964, 1974, 198	4		
Year	Year maternities (000s)	NHS hospitals	Non-NHS hospitals and maternity homes	En At home	gland and Wales Elsewhere*
1964	890.5	67.1	2.9	28.4	1.5
1974	640.8	94.0	1.7	4.1	0.2
1984	634.0	97.8	1.1	1.0	0.1

*Elsewhere includes homes for unmarried mothers, psychiatric hospitals, remand homes, reception centres and private homes (other than mother's usual residence).

Mortality and morbidity statistics

1. Mortality

1984 was a year of limited spread of influenza, and no extremes of temperature. The overall level of mortality was therefore lower than the previous year - with a total of 531,314 deaths, and a crude mortality rate of 11.3 per thousand population. The analyses by sex, cause, and age are set out in Table 1.9. This presents the five commonest causes of death in each of the age and sex sub-groups of the population, together with data by sex for all ages. When examining a table like this it must be remembered that the cause list utilized has a major influence on the ranking of the individual causes. For example, the fourth commonest cause of death at all ages is malignant neoplasms of the digestive organs and peritoneum; if a finer split of the cause of death had been used, such that oesophageal, stomach, colon, and rectal cancer had been separately examined this would have removed the broader cause from the fourth rank. The table has been based on aggregations of causes of death to the level recommended in the World Health Organization Basic Tabulation List. The youngest sub-group included is 1-14, excluding deaths under the age of 1, because of the very different profile of cause of death in the neonate. The following sub-section comments on infant mortality. In children aged 1-14 the toll from road accidents is the first ranked cause in both males and females; other injury and poisoning also figure high in the lists, with the third cause being congenital malformation in males but the second in females. The relatively high fatality from neoplasms of the lymphatic and haematopoietic system (predominantly Hodgkin's disease, non-Hodgkin's lymphoma, and leukaemia) is reflected by the appearance of the cause in the fifth rank for both males and females. Road vehicle accidents and other causes of injury and poisoning again ranked as first causes of death in both males and females aged 15-34, with suicide and self-inflicted injury being the third in male and the fourth in female.

By the age of 35-54 ischaemic heart disease has risen to the first rank in males, whilst breast cancer is responsible for a group of neoplasms appearing in rank one for females. Ischaemic heart disease then remains the commonest cause of death in both males and females at the two older age-groups tabulated. The overall toll from cardiovascular disease is shown by the three leading causes in both males and females, which add cerebrovascular and other circulatory diseases to the top ranked ischaemic heart disease in the oldest age group. Respiratory disease then appears in the fourth rank for both males and females. The final row in the table shows the numbers of deaths from all causes; it must be remembered that only about 0.5% of all deaths in the age group 1-14, with the main contribution in the age group 55-74 for males, and 75+ for females. Nearly two-thirds of all deaths in females occur after the age of 75.

Stillbirths and infant mortality

Table 1.10 shows the live births, stillbirths and infant mortality in England for the period 1960 to 1984. In 1984 the stillbirth rate remained at the 1983 level, but all the other rates shown in the table continued the decline seen over the period to reach the lowest rates ever recorded.

Low birthweight babies

It can be seen in Table 1.11 that the proportion of low birthweight babies (2500g and under) has changed little in recent years. However Table 1.11 also shows that during the period 1977-1984 the perinatal mortality rates for these low weight births have fallen in a remarkable manner. Thus, for all low birth weight babies the fall was 42.2% while for babies weighing 1,001 to 1,500g the fall was 52.1%.

A detailed analysis of international trends in perinatal and infant mortality is in preparation and an abstract of this will be presented in next year's report.

Future years of life lost

One alternative way of presenting data on mortality in a population involves consideration of the "Future Years of Life Lost" for each particular death. For example, for a boy aged 15 killed in a road accident, one can postulate that such a death involves a considerable number of "expected years of life lost". The calculation for future years of life lost assumes an expected life for each death up until the age of 85 (which is arbitrarily chosen partly to exclude deaths in the very elderly from ill defined conditions, but also to have an acceptable span of life). An alternative statistic is an estimate of the years of working life lost, which counts the loss in years between the ages of 15 and 64 for each death. (This ignores the variation in the age of retirement and the age of commencing work in sub-groups of the population). Using age and sex specific mortality rates by cause for 1984, Table 1.12 has been produced. This shows the proportion of all Future Years of Life Lost and Future Years of Working Life Lost for various causes of death, and contrasts this with the proportion of numbers of deaths for these same causes. The table presents material for sixteen causes of death; it can be seen that the ranking varies depending on the statistic that is examined. This is because the calculation of years of life lost weights the numbers of deaths by the age at death.

	A	III ages		1-14		15-34		35-54		55-74	75	and over
RANK	Males %	Females %	Males %	Females %	Males %	Females %	Males %	Females %	Males %	Females %	Males %	Females %
	Ischaemic heart disease	Ischaemic heart disease	Road vehicle accidents	Road vehicle accidents	Road vehicle accidents	Road vehicle accidents	Ischaemic heart disease	M.N. of bone connective tissue; skin and breast	Ischaemic heart disease	Ischaemic heart disease	Ischaemic heart disease	Ischaemic heart disease
	31	24	21	16	29	15	35					
	M.N. of respiratory and intrathoracic organs 10	Cerebro- vascular disease	Other causes of injury and poisoning 19	Congenital anomalies	Other causes of injury and poisoning 18	Other causes of injury and poisoning 11	M.N. of digestive organs and peritoneum 9	M.N. of genito- urinary organs	M.N. of respiratory and intrathoracic organs 12	Cerebro- vascular disease	Cerebro- vascular disease	Cerebro- vascular disease
3	Cerebro- vascular disease	Other diseases of the circulatory system	Congenital anomalies	Other causes of injury and poisoning	Suicide and self- inflicted injury	M.N. of bone connective tissue, skin and breast	M.N. of respiratory and intra- thoracic organs	Ischaemic heart disease	M.N. of digestive organs and peritoneum	M.N. of digestive organs and peritoneum	Other diseases of the circulatory system	Other diseases of the circulatory system
	10	10	13	13	13	9	9	10	- 9	9		- 13
4	M.N. of digestive organs and peritoneum 8	M.N. of digestive organs and peritoneum	Diseases of the nervous system and sense organs 9	Diseases of the nervous system and sense organs 10	Diesases of the nervous system and sense organs 5	Suicide and self- inflicted injury 7	Suicide and self- inflicted injury 5	M.N. of digestive organs and peritoneum 8	Cerbro- vascular disease 8	M.N. of bone connective tissue, skin and breast 8	Chronic obstructive pulmonary disease and allied conditions 8	8
5	Other diseases of the circulatory system	Pneumonia	M.N. of lymphatic and haemato- poietic	M.N. of lymphatic and haemato- poietic ticsue	M.N. of lymphatic and haemato- poietic tissue	Diseases of nervous system and sense organs	Cerebro- vascular disease	Cerebro- vascular disease	Chronic obstructive pulmonary disease and allied conditions	M.N. of respiratory and intra- thoracic organs	M.N. of respiratory and intra- thoracic organs	M.N. of respiratory and intra- thoracic organs
	7	5	8	6	5	7	5	6	6	7	7	6
Remainder	34	38	30	40	30	51	37	44	28	39	35	29
All causes	264,182	267,182	1,332	916 100	5,792	2,656	19,181 100	12,091 100	121,836 100	80,006 100	112,802 100	169,030 100

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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 l 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
1984	600.573	3,425	5.7	2,640	4.4	10.0	3.9	9.4

Table 1.10: Live births, still births and infant mortality, England, 1960-84

* Per 1,000 live and still births

† Per 1,000 live births

Detailed analysis of stillbirth and infant mortality are published annually by OPCS.

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Table 1.11:	Low birthy	veight babi	es (2500g	and under),	England, 1	977-1984	a			
Year	Low birthweight as a percentage of all birthweights		Perinatal mortality rates (stillbirths plus deaths under 1 week per 1,000 live and stillbirths) for low birthweight group							
	Liveborn	Live and stillborn	under 1,001g	1,001g- 1,500g	1,501g- 2,000g	2,001g- 2,250g	2,251g- 2,500g	all under 2,501g		
1977	6.5	7.0	811	499	187	71	38	154		
1978	6.6	7.1	792	437	173	64	31	142		
1979	6.5	7.2	772	415	152	56	30	132		
1980	6.9	7.3	742	362	144	51	27	121		
1981	6.8	7.2	679	298	120	46	24	105		
1982	6.9	7.2	649	280	109	44	22	99		
1983	6.8	7.1	601	254	103	44	21	93		
1984	6.8	7.1	570	239	87	42	21	89		

Table 1.12 has been produced. This shows the proportion of all Future Years of Life Lost and Future Years of Working Life Lost for various causes of death, and contrasts this with the proportion of numbers of deaths for these same causes. The table presents material for sixteen causes of death; it can be seen that the ranking varies depending on the statistic that is examined. This is because the calculation of years of life lost weights the numbers of deaths by the age at death.

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2. Discharges from hospital

OPCS processes a 10% sample of discharges from non-psychiatric hospitals in England, and a separate set of statistics for maternity patients. Figures 1.1 and 1.2 show the distribution of discharges by age and sex, for the six commonest causes of discharge in males and seven in females and all other causes (excluding the maternity patients). These are very broad causes of discharge, and the data for females are particularly influenced in the age group 15-34 by the hospitalization of women with gynaecological conditions. As far as the males are concerned, there are fewer discharges for the age group 55-64 and then a secondary rise. It must be remembered that these statistics are of discharges rather than discharge rates, and that the age groups vary in number of years span. The decline at the oldest age group is a reflection of the smaller numbers of population at risk of discharge. There is a contrast between the discharges for males and the females over 75 years of age; there are larger numbers of females at advanced ages, and there may also be increased likelihood of hospitalization for a given health problem because of the proportion without support of a spouse to care for them during illness.

Extensive data on the number of discharges and discharge rates for detailed causes, and age, sex, and marital status are published in the annual statistics on the Hospital In-patient Enquiry (Series MB4).

3. Contacts with the health care services

The Social Survey Division of OPCS carries out the General Household Survey (GHS), which is a continuous survey based on a sample of the general population resident in private (that is non-institutional) households in Great Britain. The survey has been runnign since 1971, and collects data on six main subjects; population, housing, employment, education, health and income. Some results from the 1982 GHS health section are presented in Figure 1.3. These are based on questions about consultations with an NHS general practitioner in the 14 days before interview, visits to out-patient departments of hospitals in the previous three months, and spells of inpatient care in hospital in the preceding year. The data have been reworked to estimate average contacts per person per year for these three forms of contact with the health service. The data are presented for six age groups and separately for males and females. It can be seen that consultation rates with general practitioners are highest in the youngest and oldest age groups. There is also appreciable difference in the rates for contact with the general practitioner in males and females aged 16-44, with less disparity between the sexes at the other age groups. As is obvious from the figure, there is much more frequent contact with the general practitioner than attendance at out-patients, and relatively low admission rates to hospital in comparision with such attendances. The intention of this figure is to draw attention to the relative degree of contact with these branches of the health service, and the differences between the sexes and the age groups. No other source of data provides equivalent material. More detail is provided in the annual reports from the GHS.

4. The prevalence of various forms of cancer

With the collaboration of the NHS, OPCS collects statistics on registrations from malignant disease for England and Wales. The latest available data from the regions for the whole of the country are for 1981. Figure 1.4 shows the cumulative percentages of registrations for all forms of malignancy, and then selected broad groups. These statistics are based on the age and sex specific incidence rates, applied



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to the appropriate life table for the whole of the population. (The method is explained in Cancer Statistics, Registrations 1981, Series MB1 No 13). They suggest that approximately one-third of males and females may develop malignant disease at some stage in their life. The commonest specific site is male lung cancer, and nearly a tenth of all males may develop such malignancy during their life. Again, the data depend on the breadth of the site of malignancy used to prepare the graphs, and one set of curves relate to digestive organs and peritoneum. This appears a relatively common cancer, approximating to the statistics for lung cancer in males — but it is made up of the major components oesophagus, stomach, colon, and rectum together with a number of other less common malignancies. The figure also shows the data for genitourinary cancer (which would be particularly affected by prostrate cancer in males and uterus and ovary cancer in females, in addition to bladder and kidney for both sexes). A much less common cancer are those involving the lymphatic and haematopoietic tissue, which occurs in less than 2% of the population throughout their life.

Because the same horizontal axis is used for all the separate segments of the figure, one can identify variation in the age distribution of malignancy; for example, the lymphatic and haematopoietic curves rise slowly and steadily throughout the age range, whilst the genito-urinary curve in males rises relatively late and rapidly.

5. Congenital malformations

Each District is responsible for collating data every month on notifications of congenital malformation recognized at birth or in the first week of life and for forwarding statistical particulars for each affected baby to OPCS. The material is examined at monthly intervals in order to monitor for local or national increases for a specific malformation or a variety of malformations. In the data year 1984 there were no markedly aberrant results.

Figure 1.5 shows the notification rates per thosand total births (stillbirth plus live birth) for spina bifida in the 14 health regions in England, and in Wales. In broad terms, there seem to be higher rates in the North and West, with East Anglia showing a rather different level compared with its adjacent regions. It is generally considered that spina bifida is the product of both genetic and environmental influences.^{2,3} No single aetiological factor explains the distribution in this country. It has been pointed out that the availability of diagnostic facilities and the proportion of terminations carried out may also affect the regional variation.⁴

6. Infectious diseases

Following the outbreak of whooping cough in 1982, and that of measles in 1983, the number of notifications of these diseases in 1984 were the lowest annual figures since 1976 and 1981 respectively. In contrast, the number of notifications of food poisoning was the highest since figures were first collected centrally for this condition in 1950, and the number of notifications of dysentery was the highest for nine years. Figure 1.6 shows weekly notifications of dysentery in England and Wales in 1984, compared with the highest and lowest number received each week between 1974 and 1983. It illustrates the contribution made to the annual total by a large outbreak between March and June; during this period 53% of cases notified in England and Wales were reported from the Yorkshire and Humberside region.









7. Prevalence of long-standing illness

The GHS asks about the presence of long-standing illness or disability for the subjects involved in the survey. In addition a question is asked about the presence of long-standing illness that gives rise to limitation of activity. Table 1.13 presents data on the prevalence of reported long-standing illness by sex and age. It must be emphasized that this is the informants' essentially subjective assessment of their own health, which may be influenced by changes in the subjects' expectation of quality of health and their knowledge of health matters — as well as by underlying changes in the duration and prevalence of illness in the community. The statistics indicate that by the age range 16-44 about one fifth of both males and females in Great Britain report the presence of long-standing illness.

By the age range 45-64 the prevalence has doubled, and it rises again in the age range 65-74. However, for males aged 75 and over there is a drop which is not statistically significant, whilst the females show a slight further rise. The highest figure is 58% for males and 67% for females. It must be emphasized that some of these percentages are based on small samples of respondents. In the age group 75 and over, the mean age of the women is higher than that for men. It is not clear whether there are differences in the subjects' perception of long-standing illness in these age groups. There may be a different expectation of fitness in the oldest age group. Between 1972 and 1982 the highest prevalence of long-standing illness is in the oldest age group of both males and females, but it does not rise inexorably as it does for mortality with advancing age, or frequency of hospitalization.

All persons	A. 1. 1.				0	Great Britain: 1982	
Age	Males	14/10	Female	S	Total		
$1 \ge 1$	%	Base = 100%	%	Base = 100%	%	Base = 100%	
0-4	8	871	7	820	7	1691	
5-15	15	2178	13	2162	14	4340	
16-44	21	5210	23	5329	22	10539	
45-64	41	2930	42	3151	42	6081	
65-74	58	1112	58	1433	58	2545	
75 and over	57	534	67	995	64	1529	
Total	28	12835	31	13890	30	26725	

Table 1.13: Chronic sickness: prevalence of reported long-standing illness by sex and age

Source: General Household Survey, 1982, Table 8.2.

8. International statistics

In past annual reports a brief table has been inserted on international comparisons of mortality. This material has been of limited value, partly because of some of the difficulties in international comparisons, and the limited material that could be examined in a single table. In this subsection consideration is given to some international comparisons of the mortality from malignant disease. This was selected as the first of a sequence of mini reviews of international comparisons of various major diseases. In the space available the treatment is relatively limited, though more extensive material had been examined than is presented here.
Data have been abstracted and examined for mortality from 13 sites of malignancy (Buccal Cavity, Oesophagus, Stomach, Colon, Rectum, Lung, Breast in females, Skin, Prostate, Uterus, Bladder, Hodgkin's Disease, and Leukaemia). The basic data are age adjusted mortality indices for males and females for 31 countries, for the time span 1901-80. Whether the full time span could be examined depended on the availability of published data for the different countries. A technique of indirect age standardization was used for the material, partly because of the absence of age specific data in publications for many of the countries for the earlier part of this century but also because this facilitated presentation of material in a single index for any site of malignancy for each country and for each sex. To examine age specific trends in mortality rates is a more searching probe of the material, but has the disadvantage of the mass of material that has to be retrieved and examined (ie when using five year age groups about 20 times as much material as using an age-standardized index).

As far as all malignant neoplasms are concerned, for the 31 countries that were examined (predominantly European with developed countries from Asia, America, and Australasia), England and Wales ranked sixth for males, and twelfth for females. However, the ranking varied from site to site, though generally if males were relatively high in the international ranking for a particular site, so were females. There was no site for which England and Wales headed the rank order of the countries, but both male and female came second for malignant neoplasms of the lung, with Scotland at the head of the list; females were second in the rank order for breast cancer, with Netherlands heading the list. These two sites have been chosen for the figures that follow.

The trends vary from site to site, with some sites showing appreciable decrease during the century and others appreciable increase. For example, deaths from buccal cavity malignancy and skin malignancy have steadily declined. There has been a reduction in mortality from some of the alimentary tract neoplasms, particularly stomach and rectum. The commonest cause of deaths from cancer has already been identified lung cancer, and this has shown rapid rise in all countries during this century; the rise began earlier in some countries including England and Wales, and in males rather than females. However, the general pattern is similar, and this rise is accounted for by the well-known causative link with cigarette smoking. Other sites to show appreciable increases in mortality have been the neoplasms of the haematopoietic and recticuloendothelial system - Hodgkin's Disease, non-Hodgkin's lymphoma, multiple myleloma, and leukaemia. Again the increase has involved all the countries studied, and mortality for males and females. Diagnostic improvement may have had an appreciable impact on the statistics for these neoplasms. Another site to have shown appreciable increase in males earlier than females is pancreatic cancer. In addition to improved diagnosis, smoking is likely to have been an influence here.

Figure 1.7 shows the mortality trends for lung cancer for seven countries for males for the period 1936-80. The value 10 on the chart can be converted to an age adjusted mortaity rate of about 70 deaths per 100,000 males. The seven countries have been selected from the original list of 31 for clarity in the figure. They illustrate a range of geographical and cultural backgrounds, and countries at different stages of development during the present century. The figure shows, bearing in mind the use of a log scale, that England and Wales has had a considerably greater mortality in males throughout the period examined in comparison with other countries. The other countries show a similar increase (approximate parallelism of the slopes for each of the countries). The USA appears in second position throughout the period whilst the





countries with the lowest mortality are Chile and Japan. It is usually argued that smoking is responsible for about 90% of the deaths from lung cancer; if this is so the experience of England and Wales raises questions about differences in the smoking habits in the different countries, or perhaps different characteristics of smoking, or even the influence of other factors in England and Wales that have not existed in some of the other countries.

Figure 1.8 shows the trends in mortality for the same seven countries for women with breast cancer. In this figure, the value of 10 approximates to an age adjusted mortality rate of about 50 deaths per 100,000 females. Again the same time span has been selected. The general pattern of results is very different, with relatively limited change in the force of mortality for the four countries with the greatest hazard. However, France, Chile and Japan show increases in mortality; in particular the ageadjusted mortality in France has nearly reached the fairly stable levels existing in the top four countries. Throughout the period the curve for England and Wales is in the first or second place, switching for a limited period with the values for Denmark which have risen to a greater extent during the past 50 years then the figures for England and Wales. Obviously one must consider the impact of various processes in determining the mortality rate, assuming the statistics on mortality to be reliable. There may be variation in the influence of aetiological factors altering the incidence of the disease, there may be changes in development of early detection of premalignancy or early malignancy, whilst innovations in treatment may alter the prognosis of subjects. For England and Wales and the other countries with an appreciable problem from breast cancer, there is no sign of a clear impact of prevention or treatment of this condition. Unlike smoking, there has been no specific environmental factor identified that is responsible for this disease, though research has indicated a number of risk factors (eg a familial tendency, an association with age at first pregnancy and suggestions that diet may play a part).⁵ Though recent reports have indicated the importance of early diagnosis⁶ and the impact of advances in treatment,⁷ there is no sign as yet of the influence of these on trends.

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PUBLIC HEALTH

2

(a) Communicable Diseases

Introduction

Despite considerable advances in methods of treatment, certain communicable diseases still remain a danger to the public health and consume a large amount of resources when they are not fully contained. In parallel with this improvement in treatment, more sophisticated tools have become available to the epidemiologist who seeks to pinpoint the source of an outbreak but this ability has itself identified "new" disease and the challenge is as great as ever.

While the scourge of smallpox has gone and diphtheria and poliomyelitis are at present under control other conditions such as legionellosis and the Acquired Immune Deficiency Syndrome (AIDS) have emerged. The control of the virus infection (HTLV III) which is the causative agent underlying AIDS is undoubtedly the greatest challenge in the field of communicable disease for many decades.

This chapter presents information on the more notable events which took place during 1984 in the field of communicable disease. Many of these, although relatively rare, still pose a potential danger to life and well-being and it would be a mistake to conclude that modern curative medicine will always make good inadequate preventive medicine. Other diseases, particularly those that are sexually transmitted, continue to absorb an increasing proportion of available resources.

The problems of microbial contaraination of food and food poisoning are world-wide and, as we shall see, the UK is not immune to this category of illness.

Material in this chapter is collated from various sources, in particular from reports prepared by Public Health Laboratory Service (PHLS), Communicable Disease Surveillance Centre (CDSC), from data collected by the Office of Populations, Censuses and Surveys (OPCS) and from returns made to this Department.

Acquired immune deficiency syndrome (AIDS) and HTLV III infection

The number of new cases of AIDS reported in the UK between 1 January and 31 December 1984 was 77. Previously 31 cases had been reported between December 1981 (the first reported case in the UK) and 31 December 1983. The CDSC set up a national reporting system in 1982 which relies on reports on AIDS collected on a voluntary basis from clinicians, laboratory reports of opportunistic infection and scrutiny of death certificates.

By the end of 1984, 108 cases had been reported to the CDSC which fulfilled the criteria for AIDS as defined by the Centers for Disease Control (CDC), Atlanta, USA. Of the 108 cases, 93 were in homosexuals, 3 in haemophiliacs, 1 in a heterosexual contact and 11 were not in any risk group. Six of these 11 were either African or had an association with Africa. The number of patients with Kaposi's sarcoma, *pneumocystis carinii* pneumonia, other opportunistic infection, cerebral lymphoma and the deaths in each group is shown in Table 2.1.

Table 2.1: The total number of cases of AIDS and deaths reported to the Communicable Disease Surveillance Centre up to 31 December 1984.

the second s	Cases	Deaths
Kaposi sarcoma	34	9
Pneumocystis carinii pneumonia	40	20
Kaposi sarcoma + Pneumocystis carinii pneumonia	8	3
Other opportunist infections	24	12
Cerebral lymphoma	2	2
Total	108	46

Human T-cell Lymphotropic Virus Type III (HTLV III)

Reports of a retrovirus isolated from patients with AIDS and at risk of AIDS in France and in the USA appeared in the scientific press early in 1984. The French isolate was named lymphadenopathy associated virus (LAV) and that in the USA human T-cell virus Type III (HTLV III). These viruses are thought to be identical and to be causally related to AIDS. This virus which is referred to as HTLV III in this publication has been isolated from lymphocytes in blood, semen and saliva of patients with AIDS and may be found in the blood in the presence of antibody to HTVL III. Antibody to HLTV III is a marker of infection with the virus. For practical purposes persons who are HTLV III positive should be assumed to be infectious although much remains to be learned about the relationship of the presence of the antibody to infectivity. Furthermore, the virus has been isolated from certain seronegative individuals possibly in an early state of infection who have not yet developed antibody.

Diversity of disease due to HTLV III

Like many illnesses caused by a virus the clinical spectrum varies widely. There are many asymptomatic individuals, but some have lymphadenopathy and a minority have developed AIDS. The majority of individuals with antibodies to HTLV III have no symptoms or have minor illnesses although some of these will develop AIDS at a later date. The fact that many infected persons are infectious but unaware that they have been infected creates serious problems for control of spread of infection.

The spread of AIDS and HTLV III

The spread of HTLV III appears to be principally by sexual intercourse particularly but not exclusively between male homosexuals. It is also transmitted through blood as in the shared use of needles etc. amongst drug abusers and through the therapeutic use of blood and blood products.

Transmission of HTLV III by blood and blood products in the UK

During 1984 three recipients were known to have become HTLV III antibody positive following blood donations from one donor who subsequently developed AIDS. The plasma from one of his donations also contaminated a batch of Factor VIII, During 1984 there were no cases of AIDS arising from this or other blood transfusions. Three haemophiliacs developed AIDS and two died; they had all received imported commercial Factor VIII.

Measures Taken to Control the Spread of Aids

The Expert Advisory Group on AIDS (EAGA)

At the end of 1984 steps were taken to establish the Expert Advisory Group on AIDS (EAGA). The EAGA met early in 1985 and will give advice on all measures required to control the spread of AIDS.

AIDS — Interim, guidelines by the Advisory Committee on Dangerous Pathogens (ADCP)

At the request of the Health Departments and the Health and Safety Executive, the ACDP drew up interim guidelines¹ to safeguard the health of medical and nursing staff and others who may come into contact with AIDS patients and specimens taken from them. These guidelines will be reviewed by the ACDP during 1985 in the light of scientific developments in the field.

Health Education Council

Leaflets have been produced by the Health Education Council² to promote greater awareness of the risks of the disease. They have been made available in large numbers to individuals in groups especially at risk such as male homosexuals and drug abusers, and to the public generally.

The Blood Transfusion Service

A working group of the Advisory Committee on the National Blood Tranfusion Service recommended that screening tests for HTLV III antibody should be introduced into Regional Transfusion Centres to screen all blood donations. The development of reliable tests suitable for use in transfusion centres has been regarded as a priority both in the UK and the USA and in 1984 the evaluation of a number of tests was being undertaken with the expectation of their introduction in 1985 to increase the safety of blood transfusion. In the meantime the leaflet *AIDS and how it concerns Blood Donors* asking those in high risk groups to exclude themselves from donating blood was amended and updated and arrangements made for individual distribution to blood donors.

Heat-treated Factor VIII is believed to reduce the risk of transmission of the virus to haemophiliacs. Commercial firms marketing Factor VIII were invited by the Committee on Safety of Medicines to submit applications for licences to enable heat-treated Factor VIII to be readily available for prescription. Arrangements were put in hand to ensure all Factor VIII produced at the Blood Products Laboratory, Elstree could undergo heat treatment.

The necessary expansion of the Blood Products Laboratory to enable the manufacture of blood products to ensure self-sufficiency in the UK has proceeded on course.

UK and overseas collaboration on research into AIDS

The Working Party on AIDS set up by the Medical Research Council (MRC) continues to review relevant scientific information and research world-wide, whilst collaborating with research workers overseas. The MRC Working Party provides information to the Department concerning European and World Health Organization research initiatives.

The Department is in regular contact with the World Health Organization AIDS Reference Centre in Paris which collates AIDS data from European countries.

There is UK membership of the Comité de la Récherche Médicale (CRM) Working Group on AIDS which is responsible for European Community medical and public health research on the disease.

The Department is also in regular contact with officials of the Government of the United States of America, and staff of the Public Health Service and Communicable Disease Centers, to keep up-to-date with the measures being taken in that country to combat AIDS.

Tuberculosis

The conquest of tuberculosis is a significant part of the medical and social history of the twentieth century (Figure 2.1). In 1919 when the Chief Medical Officer produced the first annual report from the newly-formed Ministry of Health, he recorded 77,511 new cases of tuberculosis in England & Wales for the year and 46,312 registered deaths from the disease, almost 60% of the new cases. In 1984 there were, in contrast, 5,877 new cases notified in England and 698 deaths, representing a proportion of 12% of the new cases. (Comparable figures for 1983 were new cases 6,685, deaths 701 (10.5%); and for 1982 new cases 7,226, deaths 692 (9.6%)).

Although deaths as a proportion of new cases have not shown a consistent downward trend in the last decade, these figures conceal a most important change: by 1984 tuberculosis had almost ceased to be a killer of the young. The deaths in the main affect the older age groups and are a legacy of the past. Deaths from tuberculosis in those under the age of 45 years in the post-war period in England & Wales have shown a downward trend far greater than that seen for the older age groups (Table 2.2).

We are still however dealing with a serious disease, a disease that is especially serious for vulnerable ethnic groups. Those living here from the Indian sub-continent have been shown to have incidence rates that are 25 times greater than in the indigenous population of the UK.³

Modern antibiotics have made much less formidable the problem of the infectious patient who nowadays may be rendered non-infectious in a matter of weeks. However treatment regimens are still long and require diligent supervision for many months particularly when there is migration, possibly across national boundaries. Although such developments in medicine and surgery have played an important part in these changes, there is no denying the considerable impact of preventive medicine combined with social changes throughout this century. Early detection of new cases and effective surveillance of contacts will continue to be a mainstay in the eradication of this disease.

Table 2.2: Deaths from tuberculosis, 1954, 1964, 1974, 1984

Year	Deaths fr	om tuberculosis
	All ages	Below 45 (% of total)
1954	7,797	2,655 (34.1%)
1964	2,484	326(13.1%)
1974	1,261	107 (8.5%)
1984	745	37 (5.0%)

BCG vaccination

The BCG vaccination programme has spanned 33 years and is aimed at the 13-year old population of school children. Normal recommended practice require a skin test for tuberculin sensitivity (the Mantoux or Heaf test) followed by BCG vaccination for those with a negative result, grade I reactors being treated as negative. Parental agreement is normally obtained both for the skin test and subsequent BCG, if indicated, and nearly all children available for the reading of a negative result receive BCG vaccine.



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The overall acceptance rate for BCG vaccine in the school programme in 1984 was 71% and the short-fall (from 100 per cent) has several components:-

- (i) Not all non-State schools provide facilities for the test and vaccination.
- (ii) Natural absentee rates of the order of 5% are compounded, some children missing the skin testing, others missing the reading and vaccinating session.
- (iii) Refusal of permission by the parents of the child, although in some cases permission is withheld simply because the child is already known to have received BCG vaccine.
- (iv) Around 7% of all skin tests read are positive (Heaf grade II or greater) and therefore not eligible for vaccination.

With the increasing use of neonatal vaccination, especially in ethnic groups of high susceptibility to tuberculosis, overall acceptance rates must be higher than that shown for the school programme as it is not at present possible to link the records for the two schemes. In 1984 31,876 neonatal vaccinations were carried out in addition to the 507,909 performed during the school programme (Table 2.5). Parental evidence on past BCG vaccination is not always accurate nor is it always possible to confirm such vaccination on the evidence of an appropriate scar. Thus, many children previously vaccinated receive a skin test and the outcome of that test determines whether vaccine is administered.

Although the use of jet injectors for intradermal BCG vaccination has proved popular and acceptable in many cases, evidence suggests that predictable results free of adverse local reaction are not always obtained, probably from some undetected fault in the instrument or in its application. The fact that local abscesses may develop after a considerable interval (see Figure 2.2) may result in a disturbing number of local abscesses occurring before the faulty practice is recognized. For this reason, the Joint Committee on Vaccination and Immunization (JCVI) has recommended that the jet injector should not be used for BCG vaccination. It is however recognized that the recommended needle and syringe method requires careful training of operators, so that they consistently produce accurate intradermal injection, and has a penalty in time and cost of materials. In spite of this the JVCI does not recommend further use of the jet injector in the light of accumulated evidence.

If ascertainment of a high proportion of local reactions is to be achieved, good quality record keeping is essential. Not only must the batch numbers of test material and vaccine be recorded, but also the name of the operator performing the skin test, the observer reading that test and the vaccinator. The incident that provided material for Figure 2.2 was well-documented and provided early evidence that the initial cluster of abscesses was associated with one doctor and/or jet injectors that he used. When the school programme was re-started using the needle and syringe, a further cluster of abscesses occurred and this was readily traced to one vaccinator whose intradermal injection technique was unreliable. The incident emphasizes the importance of using a limited number of operators who have all been well-trained in the technique of intradermal injection.

A survey of the efficacy of BCG vaccine carried out by the MRC Biostatistics Unit in 1983 has confirmed a current efficacy of 74% in those aged 15-19 years, the same value as that found in the 1979 survey.



Creutzfeldt-Jakob disease

Following the issue of the report of an Advisory Group on the Management of Patients with Spongiform Encephalopathy (Creutzfeldt-Jakob Disease) in 1981, continuous review has been maintained of the recommendations therein and particularly of those that deal with disinfection and sterilization because of the particularly resistant nature of the organism. The Department's Microbiology Advisory Committee has considered recent research that suggested that the sterilization procedures in the Appendix of that Report may not be effective. The original recommendations had been put forward as an interim measure and the new advice advocated autoclaving at 136-138°C at 30 lbs psi either for a single cycle of 18 minutes duration or for six separate cycles of three minutes.⁴ This disease leads to terminal dementia and may have an incidence of 1 per million population though ascertainment of cases is difficult and most studies therefore yield an incidence that is probably lower than the true value. It is now generally accepted that operations upon the central nervous system may in certain circumstances pose a risk of transmission of the virus from infected patients to others because of the high resistance of the organism to normal sterilizing procedures. Transmission has also occurred as a result of corneal grafting from an infected person.

Diphtheria

In January 1984 a 52-year-old man attended the Accident and Emergency Department of a hospital with a six day history of sore throat that had not responded to oxytetracycline. A throat swab taken on clinical suspicion of diphtheria proved positive for *Corynebacterium diphtheriae var mitis*. A total of 52 contacts were identified of which 8 were hospital staff and 25 hospital patients. In all 50 of these contacts were traced and throat swabs were taken from them all, none of which yielded a positive culture for *C. diphtheriae*.

Contacts with nasopharyngeal symptoms were treated with erythromycin. One nonhospital contact developed a sore throat with a membranous exudate and was admitted to an infectious disease unit. The index case had not been abroad in the previous year and the source of his infection has not been identified. However antibiotic courses had been started before swabs were taken in three of the contacts and it is possible that one of these was an unidentified carrier.

The only other case in 1984 occurred in a 6-year-old girl where *C. diphtheriae* was isolated from a throat swab although she had only a transient illness and recovered without any toxic symptoms. Contacts were traced and offered appropriate prophylaxis.

Influenza

As in other winters since 1977 the prevalence of influenza remained low throughout the winter of 1983-84 (November 1983 — June 1984). From January onwards sporadic outbreaks were reported from services establishments, schools, factories and geriatric units. During March the indices used in surveillance suggested an increase in influenza activity and for a time in April these rose but subsided again quickly.

Influenza A subtype H_1N_1 (48%) and influenza B (42%) were much more commonly identified than influenza A subtype H_3N_2 (10%).

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Legionellosis

In England and Wales, 29 cases of Legionnaire's disease were reported in 1977 and 73 in 1978. Thereafter the annual number of reports ranged from 129 to 181. In 1984, 151 confirmed cases were reported, comprising 119 male and 32 female patients. Of these 15 died. Fifty-five infections appear to have been acquired abroad. Two widely publicized outbreaks were reported during the year. Legionella pneumonia was reported in 15 cases during the winter of 1983/84 and all occurred in one city where the dates of onset suggested a point source of infection. Epidemiological investigation failed to find any connection with visiting a single premises such as a hotel, hospital, shop or office. It was concluded that airborne spread from a cooling tower was the most likely explanation for this outbreak. The other episode was associated with a hotel in a seaside resort. Illnesses recognized at the time and active case finding led to the identification of 27 cases together with 8 cases of Pontiac fever (non-pneumonic legionellosis), all associated with the same hotel. Apart from being the first report of Pontiac fever in the UK, this episode was of particular interest in that epidemiological and microbiological studies suggested that the infection was associated with two whirlpools⁵ but no further cases of legionellosis were reported following the implementation of suitable control measures.

Malaria

During 1984 there was a downward trend until April/May, followed by a rapid increase in June. This higher plateau was maintained until November, when the number of cases began to fall and this reflects the increased number of travellers going to malarious areas from this country during the summer and autumn months. Cases of malaria by month in 1984 and cases and deaths from malaria during the last 10 years are shown in Table 2.3. After a peak of 2053 cases in 1979 there was a decline to 1471 in 1982, but there is now an upward trend (1711 cases in 1983 and 1934 cases in 1984).

Total monthly 1984	cases	Tota	Total annual cases and deaths 1975-84			
Alway Man		Year	Cases	Deaths		
January	88	1975	749	5		
February	88	1976	1220	3		
March	96	1977	1529	7		
April	78	1978	1909	10		
May	133	1979	2053	5		
June	248	1980	1670	9		
July	269	1981	1576	2		
August	268	1982	1471	10		
September	249	1983	1711	7		
October	218	1984	1934	6		
November	99					
December	131					

Table 2.3: Malaria: Total monthly cases (1984) and total annual cases and deaths, 1975-84 (UK).

Source, PHLS Malaria Reference Laboratory

Two of the cases reported to the Communicable Disease Surveillance Centre during the year were:

- (i) A 44-year old man died form *Plasmodium falciparum* malaria in July. He had worked in Africa for many years. A week after returning to England he developed a feverish illness, and subsequently died of cerebral malaria. There is little doubt that he had taken regular anti-malarial prophylaxis. This illustrates the real need to think of malaria as a diagnosis in all patients with pyrexia who have recently returned from malarious areas.
- (ii) At the beginning of August, a 15-year old boy attended hospital as a day case for possible hormonal abnormalities. About eight days later he developed an illness subsequently diagnosed as *Plasmodium vivax* malaria; he had not been abroad in previous months. An Asian boy admitted to the unit on the same day was found to have *P. vivax* infection. Despite detailed enquiries it is still not known how the former patient acquired malaria. It remains the only case in 1984 where there was the possibility of transmission within the UK.

Measles

The annual number of notifications of measles in England and Wales for the years 1981-1983 were 52,979, 94,195, 103,700 with 62,000 cases in 1984 which has proved to be a year of relatively low prevalence. A campaign was launched in July 1984 asking Health Authorities to intensify their immunization programmes.^{6,7} In order to increase the uptake of vaccination it was suggested that special attention be paid to children entering playgroups, nursery school and pre-school in addition to children in their second year of life. Health Authorities were also asked to ensure that immunization status was reviewed at entry to school. It was the intention that the campaign should be renewed each year to encourage increased immunization activity that would coincide with the autumn school term.

Poliomyelitis

During the year three cases of paralytic poliomyelitis were reported to the Department. Two of these patients were recipient vaccine-associated poliomyelitis occurring in infants receiving their first dose of oral poliovaccine. One of these children was found dead in her pram one month after the original illness following vaccination; autopsy revealed evidence of poliomyelitis of the interior horn cells. The third case was a 24-year old man who developed a flaccid paralysis of both legs and trunk, which was subsequently diagnosed as paralytic poliomyelitis. The patient, an unmarried man, lived alone; he had not been abroad nor received oral poliomyelitis vaccine recently.

Rubella

Reports from the Royal College of General Practitioners indicate a cycle in which 1981 and 1982 were years of low incidence followed by two years of higher incidence; the level of reporting peaked in April 1984 and the overall incidence was similar to that of the previous year.

The National Rubella Campaign, which was launched in 1983, was probably responsible for the rise in pre-vaccination screening of adult women that occurred in 1984. Since the launch of the Campaign regional conferences which included

N. Ireland have been held. These were well attended. Promotion of rubella immunization in connection with ethnic minorities has now been included in the Asian Mother and Baby Campaign.

Viral haemorrhagic fever

A male British geologist returned from Sierra Leone in May having spent some time camping up-country. At the time he had not felt well for several days but arrived in the UK by scheduled airline. He was met by a relative and taken by private car to the casualty department of a London hospital from which he was eventually transferred to a High Security Infectious Disease Unit (HSIDUs), where he was nursed in a Trexler isolator. A diagnosis of Lassa fever was subsequently confirmed and the PHLS CDSC arranged surveillance of the contacts in his immediate family and in the hospitals he had attended. It was not considered necessary to follow-up contacts on the flight to the UK as the patient had no respiratory symptoms. Surveillance of contacts was uneventful and the patient recovered although the full isolation procedure was maintained for three weeks whilst the virus continued to be isolated from blood or urine specimens.

This was the ninth known importation of a viral haemorrhagic fever into Britain. There has never been a secondary case and facilities offered by the HSIDUs established in the mid-1970s have been demonstrated to be effective. The full value of such units however also depends on the number of cases they admit where there is a *high* suspicion of viral haemorrhagic fever but where the eventual diagnosis proves to be something else. Patients arriving in this country from endemic areas (mainly Africa) with unexplained fever can pose considerable diagnostic difficulty and the facilities of the HSIDUs provide full protection to public health whilst a diagnosis is established. For every true case of viral haemorrhagic fever, there are several patients admitted on high suspicion where the diagnosis is eventually shown not to be a viral haemorrhagic fever.

Viral hepatitis

Notifications of infective jaundice numbered 5,801 in 1984, showing a further fall from the 6,316 cases in 1983 and 10,605 cases in 1982. Laboratory reports to the CDSC of viral hepatitis A and acute hepatitis B totalled 4,824 in 1984, representing an increase from 3,880 in 1983 but a decrease from 6,162 in 1982. Within these laboratory figures however, there was a 62% increase in reports of acute hepatitis B to 1,997 cases in 1984 compared with an annual average of 1,230 for the years 1981-1983. Observations suggested that this rise may be associated with intravenous drug abuse, because the increase was greatest in the 15-24 age group, and the number of cases with a history of drug abuse was almost double that recorded in each of the previous 3 years. Home Office data show that the number of new addicts in the UK rose from 1,600 in 1980 to 4,186 in 1983.

Whooping cough

1984 was an inter-epidemic year when 5,500 cases were notified in England and Wales compared with 19,000 cases notified in 1983. This was the lowest annual number of cases reported since 1976 which was the last inter-epidemic year before the resurgence of whooping cough. It is expected that a further resurgence will commence in the latter part of 1985.

Gastro-intestinal infections

Bacillary dysentery

Notifications of bacillary dysentery to OPCS increased from 5,004 in 1983 to 7,157 (provisional) in 1984 and laboratory reports of *Shigella sonnei* have followed a similar trend. Although notifications and laboratory reports have increased nationally, the greatest rises have been in Northern England, particularly the Yorkshire NHS region. The sex distribution of notifications and laboratory reports has not changed but the age distribution shows that most of the rise took place in preschool and primary school children. Detailed local investigations did not demonstrate any association with overseas travel or immigration.

Cholera

Two cases of imported cholera occurred during the year. A woman aged 36 years had one reported isolation from faeces of *Vibrio cholera el tor 01 inaba* following a flight from Perth, Australia to Heathrow with one hour stopover in Bombay. A 32-year old schoolmaster had *V cholera el tor 01 ogawa* and *Shigella sonnei* isolated on his return from an extensive tour of Pakistan.

Illness Abroad — Portugal

There were reports of illness occurring in visitors to Albufeira, Algarve, Portugal during the summer of 1984 particularly during late July and August. The Portuguese Health Authorities invited assistance from CDSC who sent 3 investigators to the area together with Professor R Y Cartwright, St Luke's Hospital, Guildford. The report that they prepared concluded that the high incidence of gastro-intestinal disease was due to a number of different organisms that were isolated from returning holidaymakers. The vehicle of infection was thought to be sewage or sewage polluted water. The methods of exposure appeared to be unchlorinated tap water and sewage polluting bathing beaches and watercourses. The Portuguese Health Authorities began measures in early September 1984 to improve the standard of the drinking water and work on the sewage system should improve conditions for the summer of 1985.

Typhoid

The number of cases (excretors and carriers) known to CDSC of typhoid fever decreased from 209 in 1983 to 170 in 1984. The JCVI has recently recommended that vaccination against typhoid is not now normally required for travellers to European countries which border the Mediterranean.

Food poisoning and microbiological contamination of food

The professional staff of the Food and Environmental Hygiene Branch consists of two Environmental Health Officers (EHOs), a Medical Officer and a Senior Medical Officer. Their role is the surveillance of food hygiene problems and the epidemiology of foodborne diseases, advice to colleagues and other Government Departments, liaison with and advice to local authority Environmental Health Officers (EHOs) and Medical Officers of Environmental Health (MOsEH) and collaborating in national action to control suspect food. Data about hygiene problems and the occurrence of illness associated with manufactured food are now held on micro-computer, in order to facilitate the early identification of conditions which lead to a hazard to the consumer.

In 1984 frequent liaison visits continued to be made to local authorities, especially by the EHOs. The members of the branch participated in the organization and teaching of courses on food microbiology and hygiene and environmental medicine and public health. The medical officers and environmental health officers represented DHSS at numerous national and international meetings, including the annual conferences of the Institution of Environmental Health Officers, the Royal Institute of Public Health and Hygiene and the Association of Sea and Airport Health Authorities, the FAO/WHO Codex Alimentarius Committees on Fish, on Meat products and, on General Food Hygiene, and a WHO conference on Hygiene in Institutional Catering.

Food poisoning statistics

As mentioned in this Report for 1983 (page 55), the Department's former annual return of food poisoning data from local authorities (Form SBL640) was discontinued after 1982 in favour of the more comprehensive central data collection systems now operated by the OPCS and the CDSC.

Notifications and cases ascertained by other means reported to OPCS in England and Wales are included in weekly, quarterly and annual OPCS publications.⁸ Table 2.4 gives extracts, relating to England only, from the OPCS's collations for 1982, 1983 and 1984. The total increased by 25.4% in 1983 and by 7.2% in 1984. However, there are many factors which influence these statistics and no particular inference should be drawn from apparent trends.

	Year	Formally notified	Ascertained by other means	Totals
Presumed contracted abroad	1984	1,062	685	1,747
	1983	1,006	559	1,605
No Best Har ment swall	1982	866	421	1,287
Presumed contracted in GB	1984	9,607	5,403	15,010
	1983	8,651	3,803	12,454
and the second second second	1982	7,022	3,085	10,107
Not known where contracted	1984	1,776	1,211	2,987
	1983	1,954	1,008	2,962
	1982	1,468	714	2,182
Totals	1984	12,445	7,299	19,744
	1983	11,611	5,410	17,021
and the second	1982	9,356	4,220	13,576

Table 2.4: Food poisoning cases in England 1982-84 corrected notifications to OPCS

The CDSC carries out annual reviews of food poisoning and salmonellosis, based on OPCS data and on reports to the CDSC by laboratories and MOSEH in England and Wales and including a small number of reports from Ireland. Summaries of the review for 1982 and 1983 were published.^{9,10} The CDSC also conducts reviews of food poisoning data relating to particular foods (eg milk, shellfish) and the results are published from time to time.^{11,12,13,14}

Incidents of special interest

In February a report was received from the EEC Commission Brussels of an outbreak of staphylococcal food poisoning in Luxembourg associated with the consumption of "Braibanti" brand Italian lasagne. At the request of Food and Environmental Hygiene branch, local authorities and Public Health Laboratories immediately started an investigation of stocks of lasagne. CDSC was alerted. Before the microbiological results were available, CDSC had received reports of staphylococcal food poisoning which were identified as being associated with consumption of this lasagne.¹⁵ After urgent discussion with the trade and the PHLS the Department issued a public warning.16 At the same time the trade withdrew all stocks of the suspect lasagne from sale. Microbiological examination of other types of lasagne from the same manufacturer also showed high levels of staphylococcal contamination and similar action was taken. The Italian authorities were informed and all production at the factory was stopped. They then undertook a thorough investigation with the assistance of the manufacturers and the British importers and retailers. A Medical Officer from the Food and Environmental Hygiene branch, accompanied by a microbiologist from PHLS, visited Italy to talk to the Italian health officials and to inspect their laboratories and some lasagne factories, in order to ensure that appropriate standards of hygiene are maintained so as to minimize the risk of a repeat of this incident. The health warning was withdrawn 5 months after the outbreak, ¹⁷ and a report is to be published.18

In June the CDSC noticed an increase in the number of isolations of Salmonella goldcoast which is normally a relatively rare serotype in Britain.¹⁹ Investigation by local authorities, assisted by CDSC, showed that the source was a Normandy type of pâté from a factory in France. By the time this was reported to DHSS, the British importers had already stopped distribution of all products from that factory and had alerted the retailers who had removed the Normandy type of pâté from sale. Subsequent investigations showed that other products from that factory were also contaminated and these were also removed from sale. The importers and the manufacturer immediately started investigations at the factory and as soon as possible they met DHSS officials and presented all the information that was available. The immediate source of the contamination appeared to be the equipment used to decorate with aspic those meat products intended for the United Kingdom market. It is not certain how this had become contaminated but once contamination had occurred the inadequate cleaning routines permitted the infection to persist within the apparatus. In addition to this the layout of the factory and practices followed by the employees appeared to permit other routes by which contamination could be carried to the finished cooked product, despite supervision by French Government veterinarians as requested under EC Meat Products Legislation. Before imports to the UK were resumed, a full report was obtained from the French authorities indicating the means taken to prevent any recurrence.

In October, *Salmonella isangi* another relatively rare serotype in Britain was isolated from samples taken by certain Port Health Officers of different types of pâtés produced from a factory in Belgium. An increasing number of isolations of *S. isangi* had been reported to CDSC and some persons had eaten the affected pâté.²⁰ As the pâté had been distributed widely, the Department, after discussion with the trade and PHLS, issued a public health warning.²¹ At the same time the trade withdrew all stocks of the suspect pâté from sale and distribution. The Meat Hygiene Division of the Ministry of Agriculture, Fisheries and Food, requested the Belgium authorities to investigate the factory. The manufacturers had identified contamination of one of the

machines applying gelatine to the pâté. Before imports to the UK were resumed a full report was obtained from the Belgian authorities and certain labelling changes were made. The public warning was then withdrawn.

These three incidents illustrate the co-ordinating role of the Department in determining the need for and issuing a food hazard warning. Other outbreaks which came to the Department's notice were as follows. A third and larger outbreak relating to pâté involved contamination of chicken liver pâté by *Salmonella hadar* produced locally was reported in Bristol.²² Two large outbreaks of *Salmonellosis* occurred in Essex and in Humberside, ^{23,24,25,26} and in both the source was identified as a different meat products manufacturer where poor hygiene permitted cross contamination of cooked meat from raw meat followed by inadequate temperature control, allowing prolific multiplication of the contaminating salmonella. Assistance was given to the local authorities by EHOs of the branch and by staff at CDSC in identifying the source and in preventing further outbreaks. It was of interest that the establishment in Humberside had been visited some years ago by a Medical Officer and EHO from the branch who had commented at that time on food handling practices likely to lead to cross-contamination. In the Essex outbreak the causative organism was *Salmonella virchow*, and in the north *S. typhimurium*, the commonest salmonella serotypes affecting man.

A notable *outbreak of Salmonellosis* which occasioned national publicity, occurred in August in a *large hospital*.^{27,28} Over 350 patients and 50 staff were affected at the Stanley Royd psychiatric hospital in Wakefield, between 26 August and the middle of September 1984; 27 patients died during the outbreak, although not all of the deaths were associated with salmonellosis. The Secretary of State set up a Public Enquiry (Chairman Mr J Hugill, members Professor Rosalinde Hurley and Mr J Salmon) which met in Wakefield during March and May 1985. The report of the Enquiry is expected to be published. This was one of the largest hospital outbreaks of salmonellosis ever reported in England.

An unusual infection associated with the consumption of unpasteurized milk was reported in West Yorkshire between March and June 1984.²⁹ *Streptococcus zooepidemicus* (Lancefield group C) was isolated from 11 patients by blood culture, in CSF and mycotic aneurysm. Seven patients died, although the infection was not necessarily primarily responsible for all the deaths, 9 of whom were over 70 years. All had drunk unpasteurized green-top bottled milk found to come from two farms. Following press publicity of the incident there was a 10-30% drop in the demand for raw milk and a number of queries concerning the installation of on-farm pasteurization plant.

Amendment Regulations have been made under the Food Act 1984 to prohibit sales of untreated milk to outlets such as shops, schools, hotels and other catering establishments and institutions with effect form 1 November 1985.

Sexually transmitted disease

The total number of new cases reported by the clinics in England in 1983 was 547,437 (309,040 males and 238,397 females), an increase of 6% over 1982 (Tables 2.5 to 2.8). Those diseases which continued to show an upward trend were non-specific genital infection, candidiasis, herpes simplex, genital warts and molluscum contagiosum. A summary of the trends in incidence between 1973 and 1983 is given in the DHSS Statistical Bulletin 3/85.

The number of gonococcal infections due to ß-lactamase-producing strains was virtually unchanged. The AIDS problem has added a great and increasing burden to already stressed clinics in North West London and will undoubtedly do so before long in many other clinics which have a large proportion of homosexual patients.

Acquired immune deficiency syndrome (AIDS)

In the USA a cumulative total of 7,691 cases of AIDS with 3,661 deaths had been reported by the end of 1984. In the UK the cumulative total by the end of 1984 was 108 cases with 46 deaths (Table 2.1); 81 (75%) were reported from London. Homosexuals accounted for 86% of the cases. An appreciable number is known to be already infected by HTLV-III, particularly in London. It is uncertain how many of them will develop AIDS but it seems certain to be at least 10%. AIDS is discussed in more detail on pages 35 to 37 of this Report.

Gonorrhoea

There was a decrease in incidence of 8% for males and 6% for females. Cases in males aged 25 years and over (the age group of males most affected by AIDS) showed a very significant decline between 1981 and 1983, which may have resulted from a reduction in promiscuous behaviour among homosexual males following health education about AIDS. The number of infections with β-lactamase (penicillinase) producing *Neisseria gonorrhoeae* reported from laboratories in the UK in 1984 was almost unchanged at 1,227 compared with 1,223 in 1983. Of the 918 in 1984 in which the source of infection was stated, 30.5% were acquired abroad compared with 27% in 1983.

Syphilis

The incidence of early acquired syphilis continued to fall during the year under review. There was a decrease of 14% for primary and secondary syphilis, 12% for males and 27% for females. There was only a very slight increase in the total number of cases of late syphilis, but the number of cases of cardiovascular syphilis increased from 39 in 1982 to 45 in 1983 and of neurosyphilis from 89 to 133. The number of cases of congenital syphilis decreased from 126 in 1982 to 80 in 1983 and only one of the cases was an early infection (i.e. a-child under 2 years of age). The very low incidence of early congenital syphilis in the past 25 years is a reflection of the fall in incidence of acquired syphilis in females and the success of antenatal screening.

Chancroid

There was a reversal of the increase of recent years. Considerably fewer cases were reported from the particular area which had accounted for the rise of recent years.

Non-specific genital infection

Unlike gonorrhoea non-specific genital infection continues to increase, with a 4% increase in males and 6% in females. Because of the difficulty in diagnosing non-specific genital infection in females many of these cases are treated epidemiologically and included by several clinics in the category "other conditions requiring treatment" rather than as cases of non-specific genital infection. Testing for *Chlamydia trachomatis* is becoming more widely available now that simplified methods of diagnosis using monoclonal antibodies have been developed.

Trichomoniasis and candidiasis

The number of cases of trichomoniasis declined by 19% in males and 9% in females. In contrast candidiasis increased by 7% in males and 11% in females.

Genital herpes

The total number of cases rose by 21% to 16,534. The increase in males was 14% and in females 31%. Greater public awareness in recent years has probably resulted in relatively more patients with recurrent herpes attending clinics for advice;¹ because the clinic returns include some recurrent as well as primary cases the true size of the increase is uncertain. A more detailed method of reporting cases of herpes will be required to determine this.

Genital warts

As in the previous year there was a substantial increase in cases of genital warts. The total rose by 14% to 37,899.

Other conditions

"Other conditions requiring treatment" increased by 22% in females and 8.5% in males whereas the increase in "other conditions not requiring treatment" was only 3% in females and 5% in males. Since 1980 the increase in females of other conditions requiring treatment was 84%, but it was only 12% in other conditions not requiring treatment. These differences may be largely due to the inclusion in the category "other conditions requiring treatment" of women treated for bacterial vaginosis (anaerobic vaginosis) which has received increased recognition in recent years.

The clinics

The medical staff of clinics in England and Wales at 30 September 1984 was 418 (250.4 whole-time equivalents) (WTE) compared with 415 (244.7 WTE) in September 1983. The figures for 1984 included 121 (113.6 WTE) consultants, 30 (28.7 WTE) senior registrars, 41 (38.8 WTE) registrars and 23 (22.1 WTE) senior house officers, compared with 115 (109.7 WTE) consultants, 30 (27.7 WTE) senior registrars, 38 (36.3 WTE) registrars and 22 (21.0 WTE) senior house officers in September 1983. At 30 September 1984 there were 22 (5.6 WTE) hospital practitioners and 170 (35.3) part-time medical officers (clinical assistants).

Table 2.5: Cases of syphilis, gonorrhoea and chancroid reported in England for the year ended 31 December 1983 with the figures for the year ended 31 December 1982 in parentheses (for the incidence rate per 100,000 population see Table 5.3).

	Total		Male		Female
Syphillis					distant for the second second
Early	1,934 (2,145)	1,721	(1,804)	213 (341)
Primary and secondary only	1,149 (1,337)	1,039	(1,187)	110 (150)
Late	1,313 (1,293)	902	(877)	411 (416)
Congenital	80 (126)	39	(58)	41 (68)
Gonorrhoea					
All forms	48,393 (52,156)	30,464	(33,058)	17,929 (19,098)
Post-pubertal gonorrhoea					
Allages	48,367 (52,132)	30,455	(33,049)	17,912 (19,083)
Under 16 years	280 (429)	81	(115)	199 (314)
16-19 years	10,285 (10,449)	4,438	(4,469)	5,847 (5,980)
20-24 years	17,989 (18,532)	10,963	(11,382)	7,026 (7,150)
25-34 years	13,957 (15,534)	10,120	(11,149)	3,837 (4,385)
35-44 years	4,302 (5,347)	3,529	(4,386)	773 (961)
45 years and over	1,554 (1,841)	1,324	(1,548)	230 (293)
Chancroid	80 (125)	56	(88)	24 (37)

Table 2.6: Other sexually transmitted diseases reported in England in year ended 31 December 1983 together with the figures for year ended 31 December 1982 in parentheses (for incidence per 100,000 population see Table 5.4).

Section in 198	Total	Male	i no produ	Female
Lymphogranuloma venereum	36 (30) 27 ((19)	9 (11)
Granuloma inguinale	21 (15) 14 ((13)	7 (2)
Non-specific genital				
infection (NSGI)	134,079 (128,	197) 97,673	(93,983)	36,406 (34,214)
NSGI with arthritis	462 (501) 443 ((476)	19 (25)
Trichomoniasis	18,274 (20,	162) 1,317 ((1,620)	16,957 (18,542)
Candidiasis	57,876 (52,	404) 11,101	(10,328)	46,775 (42,076)
Scabies	2,192 (2,	044) 1,818	(1,652)	374 (392)
Pediculosis pubis	9,093 (9,	799) 6,194 ((6,620)	2,899 (3,179)
Genital herpes	16,534 (13,	653) 8,882	(7,810)	7,652 (5,843)
Genital warts	37,899 (33,	343) 23,319	(20,639)	14,580 (12,704)
Genital molluscum	1,574 (1,	378) 977	(887)	597 (491)
Other treponemal diseases	745 (833) 467 ((532)	278 (301)
Other conditions requiring				
treatment in a centre	90,817 (79,	019) 44,370	(40,883)	46,447 (38,136)
Other conditions not requiring				and a second second
treatment in a centre	121,900 (117,	127) 77,026	(73,506)	44,874 (43,621)
Other conditions referred				in the second of
elsewhere	4,135 (3,	318) 2,230	(1,822)	1,905 (1,496)

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		1979			1980			1861			1982			1983	
	Male	Temale	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	
Early syphilis All arres	9.45	1 48	5.36	9.41	1.60	5.41	8.50	1.44	4.90	7.92	1.42	4.58	7.54	0.89	
Primary & secondary only	5.88	0.80	3.28	5.92	0.87	3.33	5.53	0.80	3.10	5.21	0.62	2.86	4.55	0.46	
Under 16 vears	1	0.04*	0.02*		*90.0	0.03*	*90.0	l	0.03*	0.04*	0.08*	*90.0	1.	1	
16-19 years	4.87	3.38	4.14	4.06	3.78	3.91	4.40	2.99	3.71	3.04	1.96	2.52	3.45	1.44	
20-24 years	14.12	2.76	8.56	14.83	3.47	9.27	15.27	3.52	9.48	13.34	2.51	7.99	11.94	2.01	
25 years and over	7.29	0.60	3.77	7.29	0.58	3.75	6.48	0.56	3.35	6.29	0.45	3.21	5.33	0.32	
Late syphilis All ages	4.22	1.8.1	2.98	4.16	2.04	3.07	4.26	1.78	2.98	3.85	1.73	2.76	3.95	1.71	
Congenital syphilis							200		00.0	30.0	00.0	20 0	LI 0	LI 0	1
Allages	0.19	0.35	0.28	0.27	0.24	0.26	0.20	15.0	67.0	C7-0	0.20	17.0	0.17	n.17	-
Gonorrhea (post pubertal)					10.00				:	10 20 .		00.111	07 001	14 P.L.	01
Allages	154.75	84.22	18.59	150.49	85.26	117.04	140.90	11.94	11.22	00.041	04.4/	30.1	07.021	+C.+/	3
Under 16 years	1.50	5.86	3.62	c/.1	66.0	3.81	1.82	00.0	70.6	77.7	0.40	4.5	KC-1	C1.4	0
16-19 years	284.80 4	12.83 3	347.31	276.65	120.00	345.53	277.54	393.83	334.44	277.65	390.93	332.84	2/3.26	80.185	32
20-24 years	654.29 4	49.88 5	54.23	650.23	454.13	01.19	8/ 070	11.024	77 67	11.610	07.665	10.01C	10.460	30.55	4 4
25 years and over	10.661	41.2/	81.18	70.101	00.40	07-00	+0-171	11 .cc	10.11	00.021	71.00	10.01	17.001		2
Chancroid															
All ages	0.16	0.02*	0.09	0.17	0.07	0.12	0.28	0.11	0.19	0.39	0.15	0.27	0.25	0.10	

123.55 4.68 19.41 35.29 80.90 3.36 1.59 8.83 0.08 0.04 0.99 39.01 193.86 186.74 260.21 286.21 Total --- new cases per 100,000 population at all ages seen at hospital clinics in England, 1979-1983 151.50 0.08 70.56 194.65 1.56 12.06 31.84 60.67 2.48 7.93 0.04 0.03 193.28 Female 1983 $\begin{array}{c} 1.94\\ 5.77\\ 5.77\\ 48.66\\ 7.97\\ 7.97\\ 38.93\\ 38.93\\ 38.93\\ 102.21\\ 4.28\\ 2.05\end{array}$ 0.12 0.06 428.10 Male 194.47 *TT.* 9 337.61 168.85 0.06 0.03 273.93 $\begin{array}{c} 1.07\\ 43.08\\ 111.98\\ 4.37\\ 2.0.94\\ 220.94\\ 711.25\\ 711.25\\ 2.94\\ 1.78\end{array}$ 250.28 7.09 Total 0.05 0.01* 2.09 0.10 7.11 77.21 45.33 175.20 7.25 1.63 29.06 13.24 34.28 24.33 90.59 52.90 3.89 2.04 2.34 1.25 Male Female 332.63 181.64 6.23 1982 412.51 142.47 179.44 158.80 0.08 66°L 305.84 173.97 238.12 0.85 256.53 $\begin{array}{c} 1.25\\ 43.23\\ 100.34\\ 4.58\\ 18.63\\ 23.83\\ 63.49\\ 2.60\\ 1.88\end{array}$ Total 145.01 6.27 127.17 0.04 0.06 124.65 0.15 77.26 155.88 1.65 1.65 11.44 18.80 45.36 2.01 2.01 Female 5.75 1981 Rates based on fewer than 10 events and consequently their reliability as a measure may be affected Male 0.13 0.04 395.74 $\begin{array}{c} 2.40\\ 7.30\\ 7.68\\ 7.68\\ 26.22\\ 29.13\\ 82.63\\ 3.21\\ 3.21\\ 2.44\end{array}$ 163.83 6.81 0.06 0.04 245.98 1.17 44.42 95.98 4.92 17.14 21.61 60.63 129.04 Total 2.48 230.52 5.71 0.03* 0.02* 115.02 Male Female 0.13 78.62 148.53 2.05 10.53 16.34 43.00 1.69 295.54 168.75 1980 4.94 153.48 105.81 0.10 0.07 383.82 2.27 8.42 8.42 40.68 7.95 24.10 227.16 3.32 3.32 2.52 6.52 Table 2.8: Other sexually transmitted diseases and other conditions -0.06 0.06 220.67 0.98 42.05 85.56 4.47 16.12 19.08 52.78 2.09 2.34 215.11 106.80 4.83 Total 91.41 0.08 75.33 133.03 1.70 9.60 14.25 36.94 84.49 159.18 3.75 Male Female 0.04 0.05 1.43 1979 0.09 0.08 356.67 1.93 7.03 35.61 7.39 222.97 224.16 69.45 69.45 2.77 3.23 130.27 273.97 5.97 Warts (condylomata acuminata) Other conditions not requiring Lymphogranuloma venereum Non-specific genital infection Non-specific genital infection Pubic lice (pediculosis pubis) Other conditions requiring Other treponemal diseases Other conditions referred Molluscum contagiosum treatment in a centre treatment in a centre Granuloma inguinale Trichomoniasis with arthritis Herpes simplex elsewhere Candidiasis Scables

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Vaccination and immunization

Table 2.9 shows the number and percentage of children completing primary courses of vaccination over the last 10 years.

Table 2.9: Numbers of children completing primary courses of vaccination (with the percentage of eligible children vaccinated before three years of age shown in parentheses, but for BCG this percentage is of the estimated school population age 13 years), England, 1975-1984.

	Year	Diphtheria	Whooping cough	Tetanus	Polio- myelitis	Measles	BCG
ł	1975	478,960(81)	247,900(78)	499,200 (82)	481,500(81)	310,200 (55)	522,507 (70)
	1976	487,830(77)	240,600(61)	510,230(77)	495,600(77)	323,650 (50)	564,447 (74)
	1977	490,928(78)	191,899 (39)	513,116(78)	515,575(77)	304,885(51)	590,104 (76)
	1978	505,987(80)	199,389(41)	524,403 (80)	518,829(80)	302,075 (52)	576,635(73)
	1979	528,568(81)	250,250(31)	543,712(81)	533,616(81)	331,700(51)	563,922(73)
	1980	545,855(82)	285,561 (35)	560,194 (82)	549,729 (82)	351,618(54)	617,925(81)
	1981	552,198 (83)	320,496(42)	564,362(83)	554,481 (83)	368,512(55)	575,099(78)
	1982	558,139(85)	384,827 (47)	572,692(85)	562,826(84)	390,715 (57)	547,073 (75)
	1983	527,099 (86)	405,744 (55)	536,835 (86)	530,137 (86)	392,011(61)	538,118(76)
	1984	531,868 (86)	391,669(60)	539,973 (86)	553,802(85)	435,434(63)	507,909(71)

Yellow fever vaccination

Those travelling to countries where yellow fever is endemic, or travelling from such a country to one that harbours the *aedes* mosquito but where the disease is not endemic, may be required to produce evidence of vaccination against yellow fever in the form of a valid International Certificate of Vaccination. Under the provisions of the International Health Regulations, yellow fever vaccination certificates are only valid if they have been issued by a vaccination centre designated by the health administration for the territory in which it is situated, — for England the Department of Health and Social Security. There are in England 97 centres of which about one-half are provided by health authorities (including general practitioners) and the remainder by large companies, travel firms etc. Enquiries made in recent years suggest that 70,000 civilians are vaccinated against yellow fever every year in England.

Smallpox vaccination

Since ratification by the World Health Assembly in 1980 of the declaration by the Global Commission that the world was free of smallpox, the only indications for smallpox vaccination have been:

- (a) Laboratory staff working with smallpox (not now applicable in the UK) or those working with vaccinia virus;
- (b) Those engaged in the manufacture of handling of smallpox vaccine;
- (c) Contacts, including health care staff, of any sick patient where there arises a suspicion of smallpox.

There is no indication for smallpox vaccination of international travellers although erroneous information is sometimes provided by Embassies. In these cases advice should be sought from this Department.³⁰

There is still evidence of inappropriate use of smallpox vaccine to treat conditions for

which there is no indication of any beneficial effect. The WHO has declared such action to constitute medical malpractice.

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(b) Environmental Health

(i) Environmental radiation: Report on 'The possible increased incidence of cancer in West Cumbria' — Inquiry led by Sir Douglas Black

Sir Douglas Black, a past President of the Royal College of Physicians, was asked to head an inquiry into '*The Possible Increased Incidence of Cancer in West Cumbria*' following allegations made in a Yorkshire Television programme in November 1983 that there could be a link between radioactive discharges from the British Nuclear Fuels plc (BNFL) Sellafield site and the incidence of leukaemia in the children in a nearby village called Seascale. Sir Douglas asked six experts in relevant fields to assist him with the inquiry, and the Department provided the Secretariat. The terms of reference for the inquiry were to:

- 1. Examine the evidence concerning the alleged cluster of cancer in the village of Seascale.
- 2. Consider the need for further research.
- 3. Make recommendations.

The Group first met on 22 November 1983. It visited Cumbria to talk to local medical staff and general practitioners and also to visit the BNFL site at Sellafield in January 1984. It asked the National Radiological Protection Board (NRPB) to prepare extensive reports assessing the doses received by members of the public in the area. The Group was also able to consider an impressive number of epidemiological studies on the incidence of cancer in Cumbria submitted to it by independent scientists.

The Group published its report on 23 July 1984.¹ It concluded that in the whole of West Cumbria, mortality from childhood cancer was near to the national average, particularly for cancers other than leukaemia, but that this did not exclude local pockets of high incidence. In a study of 675 electoral wards in the Northern Children's Cancer Registry¹ it was found that Seascale had the third highest ''lymphoid malignancy'' rate during 1968-82 in children under 15 years of age, the excess being entirely due to an increased incidence of leukaemia in the area. It also found that the former Millom Rural District (which includes Seascale) had the second highest rate among 152 comparable sized rural districts in England and Wales, ranked according to mortality from leukaemia among people under the age of 25 during 1968-78.^{1,2} However, it pointed out that the number of children who had developed leukaemia in the 30-year period under consideration in Seascale was less than 10, and that this relatively small number of cases were drawn meant that the true incidence of leukaemia in Seascale village could not be determined precisely.

With regard to the radiation exposure of the population, NRPB estimated for the Group the average radiation dose to the red bone marrow received by a model population of the young people in Seascale.³ These calculations were based upon the monitoring data, habit survey data and data on gut transfer factors for the various radionuclides that are available. They necessarily involved the use of models which made assumptions about the most significant exposure routes, and about the sites of the sensitive cell for leukaemia induction. In order to obtain a conservative risk estimate based on these dose estimates, the Group then made a "worst case" assumption that leukaemia in under-20 year olds in England and Wales is entirely due

to the dose of background radiation received by the red bone marrow. Using the upper limit risk factor for low dose rate radiation derived in this way the number of additional deaths were calculated that would be expected to occur from leukaemia in the under-20 year olds in Seascale attributable to the additional dose of radiation from discharges from the Sellafield site up to 1980, making the conservative assumption of a linear dose response curve. The maximum number of deaths from leukaemia expected to occur conseqent upon the Sellafield discharges was thus indirectly calculated to be 0.1 over the period up to 1980. In fact 4 deaths had occurred at Seascale during this period. Thus the additional radiation exposure of the young people living at Seascale could only be responsible for the observed numbers of cases of leukaemia, if all current assumptions about the hazards of radiation were very serious underestimates. There is no firm evidence to support this supposition.

The Group therefore found that these calculations of doses received by the young people in Seascale did not support the view that the radiation released from Sellafield was responsible for the observed incidence of leukaemia in Seascale and its neighbourhood. However, the report stressed the unavoidable uncertainties on dose estimation in this situation, and pointed out that it was impossible to establish for certain the environmental levels of radiation around Sellafield 20 or 30 years ago and that the existence of unplanned discharges, not detected by the monitoring programme but delivering a significant dose to humans via an unsuspected route could not be entirely excluded.

The Group concluded that they had found no evidence of any general risk to health for children or adults living near Sellafield when compared to the rest of Cumbria, and gave a qualified reassurance to the people who are concerned about a possible health hazard in the neighbourhood of Sellafield. In its general observations the Group pointed out uncertainties concerning the operation of the plant, the adequacy of the controls over present permitted levels for discharges, the quantitative assessment of apparent excesses of cancer, and possible genetic risks. It commented that there was some evidence of lack of co-ordination between the various agencies in considering the impact of the industry on the health of the community. It therefore made 10 recommendations covering epidemiological, radiation protection and organizational matters, in the interests of enhancing public safety.

The Government accepted all 10 recommendations made by the Black Advisory Group. In relation to the first four of these, further epidemiological studies of cancer in West Cumbria have already been commissioned by the Department's Office of the Chief Scientist. They include a case control study including all cases of lymphoma and leukaemia occurring in those up to 25 years of age since 1950 in West Cumbria, a study of cancer incidence and mortality in all children born since 1950 to mothers resident in Seascale and a study of cancer and mortality in children who attended schools in Seascale. These studies will enable the mortality and cancer incidence pattern of local residents who subsequently move out of the area also to be established. A more detailed and extensive analysis of the Northern Children's Cancer Registry data will also be undertaken. As well as reanalysing the data according to place of birth and using 1961, 1971, and 1981 census populations, the age range of this study will be extended form 0-14 years to 0-24 years to make it comparable with the other studies. In addition data will also be analysed from the North-West region.

Other recommendations dealt with improving the ways in which the doses received by members of the public are calculated. This involves a wide range of possible projects,

many of which the Government is still considering. However, work on direct measurement of levels of radionuclides (especially the alpha emitters) in post-mortem tissues is already being undertaken by NRPB in collaboration with physicians and pathologists in the Northern Region, and the Department of the Environment (DOE) is supporting studies using a mobile whole body monitor to provide further information on the levels of gamma emitters in members of the population.

Other recommendations dealt with the discharge authorizations, and from 1 January 1985 BNFL's authorization has been varied by the authorizing departments (DOE and MAFF) so as to prohibit as far as reasonably practicable the discharges of particulate matter and solvent and to impose short-term limits on the quantities discharged. More rigorous requirements are expected in a new authorization for Sellafield Liquid Discharges when new plant (SIXEP and the salt evaporator comes on line in 1985). The further investment by BNFL in a floc precipitation plant which was recently announced will also assist in the reduction of discharges to levels comparable to those from similar plants in other countries.

Finally the Government is at present actively considering the best way to implement the Black Group's recommendation for a designated body with significant health representation to consider the results of monitoring so that decisions on authorizations can take account of all relevant factors.

The setting up of the Advisory Group reflects the increasing public concern about the possible adverse health effects of low levels of environmental pollutants, whether radioactive or chemical in form. The fact that the Group was unable to reach definitive conclusions emphasizes the problems associated with the interpretation of epidemiological data which relate to relatively small numbers of people living near a point source of pollution. Distinguishing between a chance occurrence of a "cluster" of cases of a given disease and an excess due to an underlying cause is often not possible because the numbers of cases and the population at risk is too small. Yet if the study population is increased to give greater power to the study then the chance of observing any adverse effect may also be diminished because the study population is then diluted with those living further from the source and likely to be less exposed to any potential hazard. The Black Report highlighted this problem in its recommendation on small area statistics which dealt with hazards in general and did not confine itself to the effects of radioactivity.

The Department continues to give the work recommended in the Report priority, and regards the Report as a strategy for further work rather than as a final statement.

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(ii) Fluoride and fluoridation in water

The independent expert scientific advisers to the Department considered the evidence on the biological effects of fluoride in short-term tests, animal carcinogenicity tests, and in direct and extensive studies of human populations, in relation to the addition of fluoride to the drinking water of whole communities to achieve a concentration of one milligram per litre. The review of the mutagenicity data included a consideration of several papers published during 1984, as well as related work undertaken in the United Kingdom and commissioned in part by the Department. The Department's advisors concluded that there is no good evidence of any hazard to man in respect of cancer, birth defects, or Down's syndrome, and no evidence leading to an expectation of hazard through the induction of heritable abnormalities.

The examination of the epidemiological data on cancer rates was the task of the Working Party on Fluoridation of Water and Cancer, which completed its review under the chairmanship of Professor Knox. The Working Party had been constituted to investigate the assertion that fluoridation of drinking water had caused an increase in cancer rates. It considered some seventy studies of communities throughout the world, and commissioned additional analyses of cancer rates in fluoridated and high-fluoride areas in the United States and the United Kingdom. The Report of the Working Party was published in January 1985.¹ It concluded that we have found nothing in any of the major classes of epidemiological evidence which could lead us to conclude that either fluoride occurring naturally in water, or fluoride added to water supplies, is capable of inducing cancer, or of increasing the mortality from cancer.¹

The Water (Fluoridation) Bill received its First Reading in the House of Commons in December 1984 (see Chapter 4b). Topicality was thus added to the Department's routine monitoring of the suggestions that fluoridation of water could cause or aggravate any of a long list of other diseases. None of these additional claims has ever stood up to scrutiny, and no important new studies relating to them became available in the course of the year.

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(iii) Medical Research Council report on lead

Substantial reductions in the exposure of the population to lead are in hand in the UK, following a series of Government decisions last dealt with in the report for 1983. The Government's decisions in that year, notably to aim for the introduction of unleaded petrol by 1990, were a response to the recommendations of the Royal Commission on Environmental Pollution.¹ Those recommendations were based primarily on the view that the safety margin between the blood lead concentrations in the general population and those at which adverse effects have been proven is too small. At the time a number of research studies were in progress on the critical question of whether there are any neuropsychological effects in children from the concentrations of lead actually present in the environment. Despite the decisions taken by the Government the question continued to be important in relation to policy on the remaining uses of lead, a metal with unique and valuable properties, and to the details of the programme for the reduction of lead in the environment.

In 1983, therefore, the Department asked the Medical Research Council to advise on the validity and interpretation of the results of the current research on the neuropsyhological effects of lead in children. The task was undetaken by the Council's Lead Advisory Group and their advice was contained in a Report² published in 1984. The report dealt with all the studies of lead and neuropsychological deficits that had become available since the report Lead and Health³ was published, and it examined in depth the methodological issues which have led to difficulties in the interpretation of those, and earlier, studies.

The conclusion that was reached was that the evidence most appropriate for British children demonstrated no statistically significant association between body lead burden and intelligence after allowance for confounding factors. The report commented that, because of the nature of cross-sectional population studies, it is never possible to demonstrate conclusively that there is no effect, but that the available evidence suggested that a moderate elevation in the body lead burden, as found in some British children, has little or no effect on the intelligence quotient.

Although the conclusions of the report are generally reassuring, some uncertainty remains, underlining the case for prudence and for the steps to reduce exposure further which Government, in concert with many public agencies, is continuing to take.

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(i) Smoking

With smokers now being in a minority in the population as a whole, increasing support is being given by the public to the requirement that non-smoking should be the norm in public places. A notable example of this occurred in July, when smoking was banned on all London underground trains, initially for an experimental period of six months, and the ban was subsequently extended.

In the March budget the Chancellor announced an increase of 10p in the excise duty on a packet of cigarettes thus increasing their price substantially faster than the rate of inflation. The increase did not apply to pipe tobacco or cigars, which carry lower, though appreciable, risks of smoking-related diseases.

There were new commercial developments in the "smokeless tobacco" field during the year, particularly through promotion of a product comprising moist, fine-cut tobacco in a miniature "tea bag", intended to be held between the cheek and the gum. Advice provided through the Committee on Carcinogenicity indicated risks of oral cancer associated with analogous "snuff dipping" habits, and arrangements were put in hand to issue appropriate warnings to the public. These needed to make clear that while the use of such products as an alternative to cigarette smoking would lead to lower risks of cancer of the respiratory tract and of other conditions, the adoption of the snuff-dipping habit would undoubtedly increase the risk of cancer within the mouth. The use of this material is not recommended.

The product modification programme continued with the conclusion of a new voluntary agreement with the tobacco industry, aiming at a further reduction in salesweighted average tar yields, from 15 to 13 mg, by the end of 1987. It was further agreed that new tar groupings should be drawn up and published and that funding should continue to be provided by the industry for independent research work on the effects on health of modified products. Proposals for such research are considered by the Independent Scientific Committee on Smoking and Health (ISCSH), and during the year projects on the effect on respiratory symptoms of switching to lower tar cigarettes, on methods of determining nicotine uptake in individuals with a view to linking findings with subsequent morbidity or mortality, and on the role of smoking different types of cigarettes in cardiovascular disease aetiology were started. One underlying feature of all these studies is the question of "compensation", ie the extent to which smokers may vary their consumption or manner of smoking to compensate for reduced nicotine yields when switching to lower-tar cigarettes. Declining trends in lung cancer mortality support the view that the major reductions in tar yields over the past few decades have had a substantial beneficial effect.

The Laboratory of the Government Chemist, in addition to conducting the routine tar/ CO/nicotine testing of most of the brands of cigarettes on sale in the United Kingdom, has undertaken special studies at the request of ISCSH to examine the effects on yields of varying smoking patterns, and to extend some series of analyses to specific components such as nitric oxide, hydrogen cyanide, acrolein, formaldehyde and total aldehydes. Further extensions of this work are planned, to provide basic information for investigations into the constituents of smoke as well as its quantity from different cigarettes, and for consideration of the role of various components in the development of the whole range of smoking-related diseases. The ISCSH has also continued to control new additives to tobacco, under the terms of the Voluntary Agreement. Since the commercial failure of the tobacco-substitute programme, which had offered a possible route to reduce substantially the carcinogenic activity of the tars, most recent applications have been concerned with flavourings intended to be added in trace amounts to tobacco to improve the acceptability of lower-tar cigarettes.

(ii) Diet and cardiovascular disease

The Committee on Medical Aspects of Food Policy (COMA) first examined the relationship between diet and cardiovascular disease in the early 1970s and a report was published in 1974.¹ The main conclusions then were that obesity should be avoided in adults and children; the amount of fat in the diet, especially fat rich in saturated fatty acids, should be reduced; the consumption of sucrose should be reduced if only to reduce the risk of obesity; that proposals for softening the water supply should be considered in the light of evidence of a positive relationship between soft water and the risk of death from coronary heart disease; and that the increased consumption of polyunsaturated fatty acids as a means of prevention could not be recommended.

Since 1974 death rates from coronary heart disease in the United Kingdom have remained high, although in some countries, notably the United States and Australia, there have been appreciable declines. Because of the continuing high death rates in the UK and the importance of coronary heart disease as a cause of death in middle age it was decided that a further review by an expert Panel of the COMA was warranted. A new expert panel was convened and their Report² was published on 12 July 1984. The Report's recommendations are not substantially different from those of the earlier Report, but the recommendation on dietary fat is quantified and full consideration is given to the means of implementing the advice, which includes recommendations to medical practitioners, health educators, producers and manufacturers of food and caterers, and to Government. Guidance is also given on how the recommendations should be applied to special groups within the population at higher risk of coronary heart disease.

The Panel's advice on *fat* is that it should provide no more than 35% of dietary energy and that saturated fatty acids together with trans fatty acids should provide no more than 15%. These are reductions of one sixth and one quarter respectively from current levels of about 42% and 20% of dietary energy. The Panel considered the evidence was insufficient to advise an increased intake of polyunsaturated fatty acids as a means of prevention but agreed that use of some fat rich in these fatty acids would be an acceptable way to implement the recommendation. However, an upper limit on the ratio of polyunsaturated fatty acids to saturated fatty acids (P/S ratio) at approximately 0.45 restricts the use of such fat and implies that polyunsaturated fatty acids should not exceed about 7% of dietary energy. The reason for this constraint was that the safety of higher intakes had not been demonstrated. The Panel on Child Nutrition advised that the recommendation on fat is not appropriate for children below the age of five who normally obtain a substantial proportion of energy from cows' milk.

There are no specific recommendations about the dietary intake of *cholesterol*, but the average intake would tend to fall a little as a result of adopting the recommendations on dietary fat.

The Panel was in favour of a diet which contained relatively less simple carbohydrate and more *complex carbohydrate* and *fibre*, as the latter was likely to have a favourable effect on the risk of coronary heart disease. Complex carbohydrate would also make good the energy loss from such a reduction in fat. Such a change would require a moderate increase in consumption of cereal foods such as bread (some of which should be wholemeal or brown) and vegetables and fruit. About sucrose itself there was little evidence for an independent role in the causation of heart disease, but foods rich in added sugars tend to have a relatively low ratio of essential nutrients to energy, and their immoderate use might predispose to obesity. The Panel noted that reduction of intake of simple sugars had been recommended on other health grounds such as the prevention of dental caries.

On body weight, the Panel recognized that *obesity* was commonly associated with risk factors for coronary heart disease, and that there was good evidence that weight reduction in the overweight helped to lower elevated levels of blood cholesterol and blood pressure.

As part of its responsibility for monitoring the health and nutritional status of the population, the Department commissioned a survey which was undertaken in 1980 of height and weight of adults in Great Britain.

The full report of this survey was published in December 1984. It showed that a significant proportion of young men and women were overweight or obese. For example, among 20-24-year olds, 22% of men and 21% of women were overweight. Although the prevalence of overweight increases with age, it is overweight in younger people that seems to be the most important; in older age groups moderate overweight may not be a risk to health. A number of factors including a decline in physical activity and changes in diet appear to be important in determining this high prevalence of overweight. Diets rich in fat and simple sugars with little fibre are considered to be conducive to weight gain.

Many medical scientists consider that an excessive consumption of common salt is likely to be an important factor in the cause of raised blood pressure, which is a major risk factor for stroke and coronary heart disease. The COMA Panel recommended that the intake of common salt should not be increased further and that consideration should be given to ways and means of decreasing it. In Western countries the intake of salt is excessive in relation to estimates of physiological need. The Panel noted that although much of the evidence linking salt consumption and raised blood pressure was not strong, there was an important degree of consistency in the facts. This had led a number of authorities in several countries to advise the public to consume less salt and reductions of around 10-25% in salt intake have been recommended. In implementing the Panel's advice on salt the main emphasis will be on avoiding any rise in consumption as a consequence of adopting other recommendations such as increasing the consumption of cereal foods. To avoid a possible rise in the intake of salt from increased consumption of bread consideration is being given to reducing its salt content. In addition discussions are taking place with food manufacturers about giving information on the salt content of foods which can make a significant contribution to salt intake, and about the possibility of making available lower-salt alternatives. More public education will also need to be provided about the facts on salt and health.

The COMA Report's recommendations are directed to Government and to a number of other groups. The Government has embarked on implementing those recommendations directed to Government and is encouraging each of the other groups concerned to do likewise. Government's announcement in March 1985 of the intention to introduce legislation requiring fat content labelling of foods is part of the implementation programme.

Discussions are continuing between MAFF, DHSS and food industry representatives about the practicability of fat content labelling and other aspects of the Government's implementation programme. There are several practical difficulties to overcome, including matters concerning food analysis, product variability and consumer understanding of information provided on labels.

Educating the public about diet and cardiovascular disease and persuading individuals of the need to modify their diet when this is indicated are closely associated and equally complex parts of the implementation programme. The Secretary of State therefore invited the British Nutrition Foundation and the Health Education Council to ask their Joint Advisory Committee on Nutrition Education (JACNE) to turn the COMA recommendations to the public into practical advice for families about achieving a healthy diet. In addition the Report has been drawn to the attention of the Secondary Schools Examination Council so that school curricula reflect up-to-date advice on diet and health. The medical profession is also taking careful note of the Report, and is considering the implications for medical practice.

The COMA Panel's recommendations enjoy the support of the medical profession as being moderate and practicable. However, in the implementation of the Panel's advice, care must be taken to avoid overreaction and the advocacy of the need for extreme and needless changes in dietary habits. For example, excessive changes in the consumption of polyunsaturated fatty acids, fibre or salt should be avoided. The message is moderation, and variety, and providing consumers with a wide range of choice. The Report presents a challenge to the Government, the food industry, health educators and health professionals. The public health problem posed by cardiovascular disease is likely to be with us for many more years to come and a moderate, balanced approach is needed if all the complex issues are to be resolved effectively.

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(d) Mental health, mental handicap, forensic psychiatry, drug, solvent and alcohol misuse

Community mental health

As mental health services are increasingly being developed outside institutions the primary care services will be playing a greater part in them. It has been recognized for some time that much of the work of a family practitioner is concerned with psychological problems in patients and families and that much of this does not need to be referred to specialist mental health services. Thus it is important to look at the appropriateness and effectiveness of training and the links that are developing between specialist services and primary care services.

A two day conference *Mental Illness in Primary Care Settings* was held in July at the Institute of Psychiatry. This was organized by the General Practice Research Unit and the Department of Health and Social Security.¹ The conference considered, amongst a range of subjects, the classification of mental disorders, and recognized that a different classification or description of minor psychiatric disorders is required to represent the combination of symptoms of depression, anxiety and physical symptoms that present in general practice.

The value of screening and early case finding was debated. This was seen as uncertain without a more accurate knowledge of diagnostic criteria and the natural history of minor mental disorders in the population.

Professional team roles were discussed with descriptions of the use of social workers, community nurses, and psychologists and counsellors. The importance of links with non-medical agencies and self help groups was emphasized.

A research study ² on patterns of collaboration revealed that one in five consultant psychiatrists was working in general practice settings and that the number is increasing with varying patterns of work including consultation over individual cases and general problems, out-patient sessions in health centres and liaison attachments.

It was agreed that further research was needed to look at descriptive studies of mental health problems presenting to primary care services, the nature and effectiveness of treatment methods, the use of psychotropic drugs, possible alternative management of patients maintained on tranquillizers, and the training requirements for family practitioners and others in psychiatric skills.

National development team for mentally handicapped people

The National Development Team (NDT) for Mentally Handicapped People is an independent advisory body which advises health and social service authorities in England on the development and planning of their services for mentally handicapped people and their families, and Department of Health and Social Security about current health and social service provision.

In July 1984, after consultation, Ministers decided that reports of the NDT for Mentally Handicapped People should, in future, be published. There was almost unanimous support for this proposal provided views given in confidence were not published nor individuals named. It was felt that parents and relatives in particular, as well as the general public, should be able to see the advice which authorities had
received on their services. It is hoped that publication will help to promote better understanding of what is involved in the transfer from institutional care and will show what progress is being made on the development of locally based services.

The Teams's newly appointed Director, Dr. George Kerr wrote to interested authorities on 31 October 1984, announcing the arrangements for publication and the intention to make the reports shorter, focussing on the strengths and weaknesses of the service and limiting detail to that sufficient to substantiate the recommendations or necessary to help wider public understanding.

Mentally handicapped people with special needs

There has been reconsideration for many years now of the need for and nature of specialized hospital provision for mentally handicapped people. Currently about 40,000 places are still provided in mental handicap hospitals and units and recent surveys by the NDT suggest that around 50% of the residents could be discharged home or to a hostel immediately or after only a short period of training, if resources were available.

Our present policy maintains that some form of specialized health service provision will continue to be needed. However, whereas the White Paper *Better Services for the Mentally Handicapped*³ tentatively suggested norms for hospital provision the 1980 Review of mental handicap services *Mental Handicap: Progress, Problems and Priorities*⁴ concluded that it had over-estimated the number of hospital places which would eventually be required and that few Health Districts were likely to need more than 150 health care places for mentally handicapped people and that these need not all be on the same site. The Review did not give any precise guidance on optimum size for hospitals and units but advised authorities to think small.

The Jay Report ⁵ proposed a model of care based on small residential units sited in local communities run either by health or local authorities. The Government accepted this part of the Report in principle at the time, but recognized there was considerable controversy and uncertainty over the extent to which the relatively small numbers of the most severely multiply handicapped could be cared for in small homely non-health care settings as well as the potential problems arising from the creation of separate special health care units. The Government saw the need for further consideration of the best way of providing for the special needs of mentally handicapped people with sensory handicap, and physical disabilities, as well as profound intellectual retardation and disorders of behaviour.

A study team consisting of Departmental officials assisted by Professor Mittler of Manchester University was set up by the Secretary of State to look at the needs of mentally handicapped people with additional handicaps or problems and to consider different ways of providing, within available resources, an effective service for them and their families. Its report *Helping Mentally Handicapped People with Special Problems*⁶ was issued in January 1984. It provides an account of visits to a wide range of units and centres in different parts of the country for clients with special needs which are being provided by health and local authorities and voluntary bodies. A number of specialist schools were also visited. Very different approaches to similar problems were seen. Prescriptive advice on the development of a service for a particular group is not given since neither the methodology of the study nor its remit permitted this.

What the report does do is to present a description of different types of service, highlighting where possible elements in them that seem to lead to success and generally to provide a unique picture of many interesting developments up and down the country and the views of those engaged in working in these services. It is hoped that it will provide a valuable reference point and stimulus for those dealing with mentally handicapped people with very difficult problems to overcome.

A multi-disciplinary team of Departmental officers began looking at approaches to meeting the needs of mentally handicapped people who are also mentally ill or seriously behaviourally disturbed, and also at day services for mentally handicapped people.

Forensic psychiatry

Services continued to develop. Consultant forensic psychiatrists have increased from 43 in 1982 to 59 in 1984, and senior registrars from 7 in 1982 to 11 in 1984.

The NHS Regional Secure Unit programmes continued to expand. By the end of 1984, seven permanent regional secure units, in Northern, Yorkshire, Trent, East Anglia, North East Thames, South Western and Mersey, providing 264 beds, had admitted their first patients. Units in North Western RHA (an adolescent unit) and Wessex RHA were at the commissioning stage. These will provide 51 beds. A 90-place multi-site scheme in South East Thames was nearing completion and was expected to admit its first patients early in 1985. Two further permanent regional secure units — in North Western and North West Thames RHA — were under construction. These will provide a further 128 places. Four more units, giving a further 175 places, in South West Thames, Oxford, South Western and West Midlands RHA, are at planning and design stage. Building work is expected to start in West Midlands in 1985.

Mental Health Act, 1983

A Circular⁷ was sent out to authorities notifying them that Section 35, 36 and 38 of the Mental Health Act 1983 were to be brought into action in October 1984. These sections provide new powers for the Courts to remand accused persons to hospital for a report on their mental condition, or for treatment for up to three months or to make an interim hospital order for up to six months.

It will be up to hospitals to decide as cases arise whether they have the facilities for a particular patient. It is up to Regional Health Authorities to consider the whole spectrum of provision within their Region and see what can best be arranged to give the courts and patients as much help as possible. Section 39, which requires Regions to give evidence as to available places, applies to interim hospital orders but not to remands. It is likely that some hospitals or units will be particularly involved with these cases. For example, some Regional or Interim Secure Units may have the facilities to perform speedy assessments of patients who are potential candidates for hospital orders, perhaps including patients who would be transferred to another hospital for treatment. They will also be well placed to provide the degree of security that courts will probably look for in many cases, though varying levels of security are also available in many other mental illness and mental handicap hospitals.

The special hospitals will also have a role to play in respect of patients for whom their particular expertise and facilities are appropriate.

The intention of the Government in suggesting to Parliament that these Sections should be brought into force at a later date, was to avoid placing extra burdens on the NHS at the same time as they had to cope with the introduction of the rest of the Act. It has, however, been reported that staff in some hospitals and units were ready to implement the provisions. Those who were anxious to make an early start, emphasize that the objective of the new provisions is to help ensure that the right people are eventually made subject to hospital orders, so that people who should properly be in hospital do not remain in prison, and people who are not suitable for hospital treatment are not put on a hospital order.

Mental Health Act Commission

Under the leadership of its Chairman — Lord Colville — The Mental Health Act Commission, has made an impressive start in setting up a regional organization with a central policy committee, developing procedures for visits and recording and responding to issues arising during visits. They also began the detailed work necessary to prepare a Draft Code of Guidance.

Drug and solvent misuse

Response to the continuing problem of drug misuse remains a Ministerial priority. During 1984 there was a further 25% increase on 1983 in overall notifications of addicts. It is recognized however that these figures represent only the tip of the iceberg.

Illicit heroin, despite an increase in the volume of seizures of illicit supplies remains relatively easily available. There is some concern that attempts to establish an illicit cocaine market are being made, with growing signs of its misuse outside the more affluent groups in the population.

The United Kingdom is a party to the United Nations Single Convention on Narcotic Drugs 1961, which provides for international controls over the production and availability of opium and its derivatives, and other drugs including cocaine and cannabis. In late 1983 the Government announced that it would ratify the Convention on Psychotropic Substances 1971, which provides for international control over a wide range of synthetic drugs (hallucinogens stimulants, sedatives and tranquillizers). A general consultation on the changes in domestic legislation that will be necessary to enable the UK to comply with the requirements of the Convention was undertaken in October.

The Advisory Council on the Misuse of Drugs Report on Prevention was published in June (1984)⁸. The Report was primarily concerned with ways of preventing drug misuse and of reducing the harm associated with it, through the provision of education and information.

To emphasize this need the Department wrote to all the relevant training bodies seeking their view on action, in the light of the Council's training recommendations; and £2 million additional central monies were ear-marked for an education and information campaign addressed to parents, young people at risk, and professionals in 1985. Preliminary market research on the credibility and approach of such a campaign was conducted from September to December.

An Inter-Departmental Ministerial Group on the Misuse of Drugs was set up by the Home Secretary to co-ordinate policy on all aspects of drug misuse; with the first of regular monthly meetings in July.

In June a Circular ⁹ was issued to health authorities requesting information on district prevalence of drug misuse, and within the context of regional strategic plans, and on their short and long-term plans for tackling it. During the year further projects were funded under the Central Funding Initiative to a total of 95 projects costing ± 7.3 million. The fund was increased from ± 7 million to ± 10 million, and a second round of applications has been invited.

In response to the Council's earlier report on Treatment and Rehabilitation 1982, ¹⁰ an expert medical working group was invited to draw up Guidelines of Good Clinical Practice in the Treatment of Drug Misuse¹¹. The Guidelines were issued to all general practitioners, hospital based doctors and the Prison Medical Service in October.

Solvent misuse among young people remains a cause for concern, but the Government's low key approach and measures taken in 1983 to improve information to parents and training for professionals appear to have been effective in reducing anxiety, and improving responses to the problem. There are grounds for cautious optimism that the phenomenon may be levelling out. Nevertheless it is important to maintain continued awareness of the problem.

Alcohol misuse

Trends

The 1960s and 1970s saw a steady increase in the annual per caput consumption of alcohol in the UK from 5.2 litres in 1960 to a peak of 9.7 litres in 1979. Since then there has been some decline to 8.9 litres* in 1984. (see Table 2.10).

Thousand hectolitres of alcohol/litres per caput				United Ki	United Kingdom: 1973-1984	
			Type of dr	ink	NOCED REALING	An of the later
Year	Allalcohol	All alcohol per caput aged 15+ in litres	Beer ^{1,2}	Spirits	Wine ^{3,4}	Cider, perry ^{4,5,6}
1973	3476	8.2	2192	786	499	
1974	3660	8.6	2272	863	526	den he in firster
1975	3678	8.6	2363	823	490	and the second
1976	3848	8.9	2395	925	528	
1977	3758	8.7	2371	794	504	88
1978	4081	9.4	2441	958	593	89
1979	4238	9.7	2457	1055	634	93
1980	4070	9.2	2358	997	626	90
1981	3942	8.8	2243	945	657	96
1982	3868	8.6	2209	891	653	116
1983	3995	8.8	2240	916	708	130
1984	4038	8.9	2235	912	762	132

Source: Her Majesty's Customs and Excise.

Table 2.10: Alcoholic drink released for home consumption.

¹ These figures take account of brewing at high gravity with the addition of some brewing liquor after fermentation.

- ² Alcohol content assumed to be 3.5% in 1973; 3.55% in 1974; 3.6% from 1975 onwards.
- ³ Alcohol content assumed to be 12% for light wines; 17% for medium wines from 1976 onwards (the category did not exist until 1976); 18% for heavy wines from 1973 to 1975 and 20% for heavy wines from 1976 onwards; 15% for British/made wines from 1973 to March 1981 and 13.5% for British/made wines from April 1981 onwards.
- * Figures for British/made wines and cider, perry relate to the month in which duty was paid from 1972 to 1979 and to the month in which duty was charged from 1980 onwards.
- ⁵ No duty was payable on this category until 6.9.76 so no statistics were held prior to 1977.
- ⁶ Alcohol content assumed to be 4%.

It is not possible to put figures to the prevalence or incidence of drinking problems and the most helpful approach to gauging trends over time lies in monitoring certain indicators of social and physical harm such as admissions to mental illness hospitals with an alcohol-related diagnosis, deaths from alcohol-related mental illness, deaths from choronic liver disease and cirrhosis, findings of guilt for offences of drunkenness, and findings of guilt for driving after consuming alcohol or taking drugs (Tables 2.11 to 2.16). Factors other than increased misuse of alcohol could affect each of these, and taken on their own it would be difficult to assess the significance. However, throughout the 1960s and 1970s all of these indicators generally moved together to show a deteriorating situation. The movement of indicators since 1979 does however suggest some levelling out of these trends.

England	Numbers Igland per 1	
Year	Numbers (thousands)	Rates
1973	11.5	24.8
1974	12.4	26.7
1975	12.7	27.3
1976	13.7	29.6
1977	13.9	30.0
1978	14.8	32.0
1979	16.5	35.5
1980	17.8	38.4
1981	18.0	38.4
1982	16.7	35.7

Notes: (1) This table includes all admissions with any alcohol-related diagnosis ie a main, underlying or other diagnosis.

17.2

36.7

(2) For the period 1973-78, the Mental Health Enquiry used the Eighth Revision of the International Classification of Diseases (ICD8); in 1979 the Ninth Revision (ICD9) was adopted. For 1973-78, the table gives admissions for alcoholic psychoses and alcoholism (ICD8 291, 303). For 1979 onwards, it gives alcoholic psychoses, alcohol dependence syndrome and non-dependent abuse of alcohol (ICD9 291, 303, 305.0). Thus, the figures for 1979 and later years are not strictly comparable with figures for earlier years.

Source: Mental Health Enquiry, DHSS.

1983

England and Wales Numbers and r million home pop		
Year	Number	Rate
1973	152	3.1
1974	190	3.8
1975	199	4.0
1976	154	3.1
1977	183	3.7
978	176	3.6
979	208	4.2
980	214	4.3
981	201	4.0
982	211	4.3
983	205	4.1

Notes:

For the period 1973-78 the cause of death was classified using the Eighth Revision of the International Classification of Disease (ICD8). For 1979-83 the Ninth Revision (ICD9) was used. Under ICD8, the table includes deaths from alcoholic psychoses and alcoholism. Under ICD9 it includes deaths from alcoholic psychoses, alcohol dependence syndrome and non-dependent abuse of alcohol. Thus, the figures for 1979 and later years are not strictly comparable with those for earlier years.

Source: OPCS.

Table 2.13: Deaths from chronic liver disease and cirrhosis

England and Wales	n allen and a	2 I River States States	e gerstatter i s s de se se si	Numbers and rates per nillion home population
	Deaths from alcohol-related liver disease ¹		All deaths from chronic liver disease and cirrhosis ²	
Year	Numbers	Rates	Numbers	Rates
1973	298	6.0	1804	36.5
1974	330	6.7	1754	35.5
1975	393	7.9	1835	37.1
1976	424	8.6	1890	38.2
1977	428	8.7	1820	36.8
1978	513	10.4	1926	39.0
1979	621	12.5	2186	44.2
1980	745	15.0	2218	44.7
1981	791	15.9	2212	44.6
1982	807	16.3	2152	43.4
1983	887	17.9	2184	44.0

¹ For 1973-78, the table gives deaths from alcoholic cirrhosis of the liver (ICD8 571.0). For 1979-83 it gives deaths from alcoholic fatty liver, acute alcoholic hepatitis, alcoholic cirrhosis of liver and alcoholic liver damage unspecified (ICD9 571.0-571.3).

² For 1973-78, the table gives cirrhosis of the liver, alcoholic and other (ICD8 571). For 1979-83 the table gives chronic liver disease and cirrhosis (ICD9 571).

Thus, the figures for 1979 and later years are not strictly comparable with those for earlier years.

Source: OPCS.

England and Wales	ine, sito p hand down	Numbers (in thousands) and rates ¹ 100,000 population aged 14 and c	pe ove
Year	Number (thousands)	Rate	2
1973	99	259	
1974	103	268	
1975	104	270	
1976	109	280	
1977	109	279	
1978	107	272	
1979	118	298	
1980	122	307	
1981	109	271	
1982	107	265	
1983	108	264	

¹ Rates are based on the population aged 14 and over because the number of offences of those aged under 14 is so small.

Source: Home Office

Table 2.15: Findings of guilt at all courts for driving etc., after consuming alcohol or taking drugs

England and Wales Number	
Year	Number (thousands)
1973	and the state of the
1974	62
1975	65
1976	58
1977	53
1978	58
1979	67
1980	78 78 78
1981	71
1982	75
1983	08

Source: Home Office.

	. Drinking und u	ining, summary of ores	can asis		
England and Wales			Numbers (thousands) and percenta		
Year	Roadside screening breath tests				
	Number required (thousands)	Positive result (%)	Negative result (%)	Refused (%)	
1973	132	58	35	6	
1974	124	56	37	7	
1975	134	53	40	8	
1976	134	43	49	9	
1977	131	41	50	9	
1978	142	42	49	10	
1979	164	42	48	9	
1980	180	41	50	8	
1981	177	37	54	8	
1982	207	35	57	8	
1983	245	33	58	9	

¹ There was a change in the law and police practice during 1983. A much greater increase in the number of tests was recorded after the introduction of evidential breath testing on 6 May 1983.

Source: Home Office.

1984 Budget — Changes in Excise Duty

Between 1980 and 1983 Excise Duties on alcoholic beverages have been adjusted in line with the movement of prices, and during this period, there was a significant rise in the real price of alcoholic beverages overall. In the 1984 Budget the Chancellor of the Exchequer was obliged to take account of a European Court of Justice Judgement that the British Government was protecting beer by under-taxing it in relation to wines. The Chancellor decided to increase the duty on beer by the minimum amount needed to comply with the Judgement and maintain revenue. The result of this decision was a reduction in excise duties on most wines and an increase in duty on spirits that was considerably below the amount needed to keep pace with inflation.

Health Education Council

During 1984 the Council established an Alcohol Education Programme in South West England, with the appointment of a Co-ordinator and Deputy Co-ordinator. A Regional Advisory Committee was set up and an Action Plan and Information pack was produced. Training courses for "key tutors" were held, and a considerable amount of local interest is being stimulated and co-ordinated in preparation for increased public activities in 1985/86.

In the rest of the country dissemination of 'Drinking Choices' courses continues and a project officer has been appointed to encourage the further development and use of these courses. The Alcohol Education at the Workplace Project which aims to produce training materials and develop educational strategies for use in the workplace made good progress, and a National Survey of Knowledge and Attitudes to the Use of Alcohol was conducted. The findings of this Survey will be available in 1985.

Centrally funded research

Responsibility for the consideration of research on alcohol misuse in DHSS rests with the Homelessness and Addictions Research Liaison Group (H and ARLG). During the year the H and ARLG considered the Department's future research needs in this field and published them in their 'Strategy for Research on Alcohol Misuse¹² in May. The strategy document is intended to promote awareness of the Department's interests in this field of research and to stimulate research proposals.

Research supported by the H and ARLG in 1984 includes projects on the development of local prevention strategies, the costs of alcohol misuse, the influence of problemdrinking parents on the drinking habits of their adult children, the effects of cognitive impairment on responsiveness to treatment, the inter-relationship between genetic and socio-economic factors in alcoholic liver disease, and the current state of research on detoxification. The Small Grants Committee also supported projects in 1984 on alcohol misuse on female problem-drinking and on a comparison of day-centre and out-patient treatment.

Among the reports of work, previously supported, received in 1984 were a study of a day-centre in Norwich for problem-drinkers and of the Alcoholism Community Centres for Education, Prevention and Treatment (ACCEPT) day services in West London for problem-drinkers.

In addition to research funded from the Health and Personal Social Services budget the Department funded a number of evaluation studies of experimental projects supported through Section 64 of the Health Services and Public Health Act 1968. These include Community Alcohol Teams in Liverpool, Salford and Kent, a night shelter in Plymouth and a new diploma course in alcohol counselling in Kent. Plans for 1985 involve new research on detoxification and the dissemination of the output of the local preventive strategies project.

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DEVELOPMENTS IN MEDICAL SCIENCES AND SERVICES

3

(a) Acute services

(i) Supra-regional services

In the Report for 1982 the introduction of a means of designation and of funding supra-regional services was foreshadowed, and the background to these arrangements briefly mentioned. In 1983 a Health Notice (HN [83] 36) was issued giving guidance on the arrangements for selection and funding for such services.¹ In January 1984 the Secretary of State announced his decision that neonatal and infant cardiac surgery be added to the four existing supra-regional services. The designation in respect of neonatal and infant cardiac surgery took effect from 1 April 1984. Bone marrow transplantation had been considered by the Supra-Regional Services Advisory Group who had recommended to the Secretary of State that the best way forward for this service was for it to be developed on a Regional basis. During 1984 the Supra-Regional Services Advisory Group considered a number of applications for designation including liver transplantation and services for liver diseases.

(ii) Heart transplantation

The developments of heart transplantation in 1979-83 and the setting up in 1982 of a team to evaluate the programme was described in this Report for 1983 (p 144-146). The availability of donor hearts improved dramatically over the year so that 132 transplants were performed in 1984 at the two centres (Harefield and Papworth Hospitals) as compared with 54 in 1983.

As a result of the success both units had spent their allocation ($\pounds 218,000$ each for 1984-85) before the end of the year. To enable the programme to continue, to capitalize on the achievements so far and in view of the favourable comments in the final evaluation report (see below) Ministers announced in December an extra allocation of about £150,000 to each unit. At the same time, to ensure continuity and enable rational forward planning to take place they announced an allocation of £800,000 for each unit in 1985/86.

The draft final report of the Evaluation Team was received, on time, in mid-December.² The report shows that during the evaluation period the costs of heart transplantation have fallen and the benefits, measured in terms of increased life expectancy and improvements in the quality of life of the transplanted patients, have risen. The cost of an operation and six months follow-up is about £12,700 and thereafter the cost of maintaining a transplanted patient is about £5,000 a year at 1984 prices; these figures exclude medical salaries. About 69% of transplanted patients are likely to be alive one year after operation and 54% three years after operation. Calculations in the report showed that the eventual demand for the service might be as high as 700-900 cases a year, but the calculations are based on inadequate data and may have to be revised.

The draft report was considered by the Standing Medical Advisory Committee, the Transplant Advisory Panel and the British Cardiac Society. All three bodies

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commended highly the clinical and scientific work done by the two units and by the evaluation team. They advised that the report provided a sound basis for recommending a gradual expansion of the cardiac transplantation programme. They recommended that professional advice be made available to Ministers on the possible timing, location and resource implications of any new developments.

(iii) Organ donor campaign

On 22 February Secretary of State launched a campaign to increase the public awareness of the benefits of organ transplantation and to promote the donor card scheme. New posters were produced, television and press advertising commissioned and a major new distribution of organ donor cards initiated. In the nine months from 1 March to 30 November, 1129 kidney transplants were performed which was an increase of 35% over the same period in 1983 and 54% over the same period in 1982. The numbers of hearts and livers transplanted also more than doubled in 1984 as compared to 1983. Accurate figures for corneal grafts are not available but the impression is that these too have become easier to arrange. Over 12 million new donor cards have been distributed.

These figures are very encouraging and Ministers are considering what further steps might be taken in the Spring of 1985 to ensure that the momentum is not lost.

Regional targets for treatment of renal failure

Health Authorities were informed in Health Circular $(84) 2^3$ of the need for facilities for the treatment of end-stage renal failure to be developed as a priority within the acute sector, and of Ministers' intention to set targets to ensure that an expansion of renal service provision was achieved. On 20 December, Mr John Patten, Parliamentary Secretary for Health, announced that Regional Health Authorities had agreed a target of accepting at least 40 new kidney patients per million total population per year by 1987. Mr Patten went on to hope that in as many Regions as possible the targets would be exceeded significantly and stated that it was the Government's intention that the provision of renal services would continue to expand after 1987. Progress in achieving these targets will be monitored as part of the annual regional planning cycle.

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(b) Scientific services and biotechnology

(i) Improved diagnostic services

Exciting scientific and technical developments give promise, not as yet realized, of radical changes in the practice of cytology, cytogenetics, virology, haematology and clinical chemistry. Fast Interval Processing (FIP) developed by the MRC Cytogenetics and Population Genetics Unit in Edinburgh could lead to the production of computerized image processors which will identify abnormalities in the microscopic appearance of cells in cervical cytology smears, or of chromosomes in cells in metaphase, at 10-20 times the speed of human processors and without their liability to fatigue; the instruments are at an advance stage of development. The chemical or biological synthesis of DNA and RNA probes, which is now proceeding apace, may revolutionize diagnostic virology (as well as providing the basis for the development of safer vaccines) - quite apart from their uses in detecting genetic disorders (see next section). Successful synthesis of the gene for Factor VIII, announced during the year, is of course only the first, but essential, step in the development of a treatment for haemophilia not based on blood donations. The marketing of immensely sensitive assay kits for thyrotropin (TSH), which are under evaluation, now offers the possibility of a single first-line test for hyper- as well as hypothyroidism; and the development of a monoclonal antibody to acetylcholinesterase should place on a more secure basis the prenatal diagnosis of fetuses with neural-tube defect in cases where amniotic fluid AFP assays are ambiguous.

Evaluation of the clinical advantages of nuclear magnetic resonance (NMR) imaging at several NHS sites is nearing completion, and the use of NMR spectroscopy to analyse intracellular biochemical processes non-invasively *in vivo*, which is at an earlier, research, stage is being studied in several centres. Developments in digital radiology have brought the possibility of a "filmless hospital,, onto the horizon, and a large-scale evaluation of its feasibility, cost and benefits is under consideration at a London teaching hospital.

The demand for pathology services has risen at about 5% per annum for the past 10 years; laboratory costs and manpower have risen at only just over half that rate. Clearly, the pathology services have constantly increased their efficiency over these years, partly as a result of automation and partly through more streamlined management. Nevertheless, the rising expenditure on pathology is a cause of concern, and the Department has been co-operating with professional bodies in publishing careful reappraisals of the usefulness of tests which, it is suspected, are being inappropriately requested in some clinical situations. Methods of costing diagnostic procedures accurately are being developed and computerized both for pathology and radiology departments for use in the NHS (and internationally, in conjunction with WHO; see chapter 6). It is hoped that an awareness of the true total costs of diagnostic procedures will influence clinicians' requesting patterns.

(ii) Genetic laboratory services: gene probes and related techniques

The Department has kept a close watch on advances in molecular biology in the past 5 years. That DNA technology will have an important impact on medical practice is undoubted: apart from the contributions to diagnostic practice discussed above and later in this paragraph, it will provide new insight into risk factors for disease, new therapeutic agents and the possibility of new treatments of inherited disorders

involving the manipulation of an individual's cellular DNA.

Prevention of inherited metabolic disorder is a major health goal which two new techniques — chorion biopsy and the use of DNA probes — bring closer to realization. The genetic defects are usually not simple gene mutations identifiable by reaction with a single reagent but entail the matching of *restriction fragment length polymorphisms* (RFLPs) in a number of relatives before the defect can be identified with certainty. Prenatal diagnosis is now possible, in favourable cases, for sickle cell anaemia, some forms of thalassaemia, Huntington's chorea, Duchenne muscular dystrophy and classical phenylketonuria. The defective gene in cystic fibrosis still eludes research workers.

Because the scientific principles underlying the work are new to the health service, the introduction of the new tools must be carefully monitored. The Department has therefore launched an evaluation of this new kind of service in three clinical genetics centres which are well placed to exploit recent advances in DNA technology and obstetrics. The requirements and conditions for general introduction of a prenatal diagnostic service based on these techniques will be studied. The techniques will supplement those already available to the expanding cytogenetics service which is provided from some 25 centres in England and Wales.

(iii) Development of tumour markers

Part of the thrust of biotechnology has been towards the development of monoclonal antibodies not only to tumour markers circulating in plasma but to surface antigens on malignant cells so as to make the latter detectable *in situ*. Such cancer-specific antibodies can be labelled with enzymic, fluorescent or radioactive molecules and used in various ways, eg in immunoperoxidase histochemical staining or, more recently, in the rapid screening of cerebrospinal fluid for cancerous cells by fluorescence microscopy instead of by conventional cytology. Work is proceeding on the use of such antibodies not only as detectors of malignant cells and tumours but as prognostic indicators for some types of breast cancer. Injections of radiolabelled antibodies followed by X-ray imaging in the technique known as immunoscintigraphy pinpoints centres of neoplastic activity which are otherwise undetectable. These techniques are the forerunners of a therapeutic application: the immunotargeting of cytotoxic and other cancer-inhibiting drugs.

(c) Aspects of human reproduction

(i) Report of the Committee of Inquiry into Human Fertilization and Embryology

The birth of the first child resulting from *in vitro* fertilization in 1978 caused public excitement but also provoked anxieties that ways in which the process of human reproduction could be assisted were moving too fast for the implications to be assimilated. Therefore, in 1982, a Committee of Inquiry under the chairmanship of the then Mrs. (now Baroness) Mary Warnock was set up with the following terms of reference:- "to consider recent and potential developments in medicine and science related to human fertilization and embryology; to consider what policies and safeguards should be applied, including consideration of the social, ethical and legal implications of these developments; and to make recommendations."

The Committee's report 1 was published in July. As well as discussing the technique of *in vitro* fertilization as a means of circumventing some forms of infertility, the Committee examined the growing practice of artificial insemination and the rarer practice of surrogacy. However, in the vigorous public and parliamentary debate since publication it has been the recommendations on the use of human embryos for research which have produced the deepest controversy. A majority of the members of the Warnock Committee considered it ethically acceptable to conduct research on human embryos up to 14 days after fertilization providing that no embryo used for research be transferred to a woman. In reaching this view the Committee were concerned that without research on human embryos it was not likely that the success rate of in vitro fertilization could be raised above the current 10-15% level. It was likely that basic facts about the processes of fertilization and implantation which might lead to reducing the number of spontaneous miscarriages and to better contraception would be foregone, and that studies of some genetic diseases which might lead to their prevention would not be possible. On the other hand the Committee recognized that such experimentation posed a profound moral dilemma for many people. They therefore recommended that there should be statutory control of human embryo research and some infertility services, with a licensing system.

(ii) Handbook of contraceptive practice

In 1974 the Standing Medical Advisory Committee commissioned a Handbook of Contraceptive Practice which was prepared by representatives of the Royal College of Obstetricians and Gynaecologists and the Royal College of General Practitioners. The resulting booklet was warmly welcomed, particularly by general practitioners. Advances in this field stimulated a revision of the Handbook in 1979 and in 1984 it was revised once more. The latest revision² is almost three times the length of the first edition, this being indicative of the growth of knowledge relevant to family planning.

The handbook brings together the major principles of current practice in contraception in an easily accessible form. A much enlarged section has been included on the technicalities of postcoital contraception; while in the chapter on hormonal contraception mention of vaginal rings has been added. Chapters dealing with contraception for older and younger women, and attitudes to contraception and to the contraceptive interview, clearly indicate the great importance which is now placed on ensuring that contraceptive advice relates properly to the clinical and social circumstances of clients.

(iii) Late abortions in England and Wales

In 1980 the Royal College of Obstetricians and Gynaecologists acceded to a request by the then Minister of Health to undertake a review of late abortion practice. The study was carried out by questionnaire addressed to Fellows and Members of the College which sought to gather details of the reasons for abortion and the method used, and in particular to record the factors associated with abortion in the second half of pregnancy³.

The study reported delays in getting pregnancy terminated and identified the major factor as being the delay occasioned by women themselves in seeking an abortion. Therefore it recommended that young women should receive more education about the recognition of pregnancy and have better counselling facilities made available to them when they became pregnant. Rather more important than failure to recognize the pregnancy itself were such factors as prolonged indecision, apprehension and

changes in personal relationships.

It was found that inefficiencies in the abortion service also caused avoidable delays: this was shown by long intervals between referral for abortion and consultation. Hence it was recommended that steps should be taken to improve matters, for example by appointments being made by telephone without necessarily waiting for the results of a pregnancy test. This study has been most valuable and provides background information for health education in this field and pointers to ways in which services may be improved.

(iv) Contraception for the under 16s

In 1980 and 1981 the DHSS issued to health and local authorities revised advice ^{4,5} dealing with family planning services for young people. It stated that family planning clinic sessions should be available to people irrespective of their age. Although it emphasized that children under 16 who attended clinics should always be persuaded, where possible, to consult parents or guardians when they sought contraceptive advice or treatment, the notice allowed that in exceptional circumstances the young could be advised and treated without the knowledge and consent of their parents. In particular, the notice stated that "the decision whether or not to prescribe contraception must be for the clinical judgement of the doctor".

Mrs. Gillick, a mother with daughters under the age of 16, wrote to her local health authority seeking an assurance from them that no contraceptive advice or treatment would be given to any of her children while under 16 years of age without her knowledge and consent. The health authority refused to give her such an assurance, expressing their intention of abiding by the advice contained in the notice. In 1982 Mrs. Gillick issued proceedings against both the health authority and the DHSS and asked for declarations to the effect that the notice gave advice which was unlawful and wrong and which adversely affected parental rights and duties. Mr. Justice Woolf refused her application. Mrs. Gillick subsequently appealed. On 20 December 1984, the Court of Appeal declared that (a) the 1980 DHSS notice was contrary to law and (b) no doctor or other professional person employed by the health authority, either in the Family Planning Service or otherwise, might give any contraceptive and/or abortion advice and/or treatment to any child of the plaintiff below the age of 16 without the prior knowledge and/or consent of the child's parent or guardian save in cases of emergency or with the leave of the Court. The main basis of the decision rested on parental rights and the welfare of the child. The Court ruled that a girl under 16 years of age could not give a valid consent to contraception and/or abortion. The Court of Appeal made clear that it was only concerned with the legal position and not with the conflicting moral and social arguments.

The DHSS immediately suspended its guidance ⁶ relevant to matters covered by the judgement and indicated that leave had been granted to appeal to the House of Lords.

The Gillick case was specifically concerned with the provision of contraceptive services for children under the age of 16 years. The judgement in the Appeal Court, however, has wider implications.

These issues will be further considered during the Department's appeal to the House of Lords. Judgement in this appeal was given in favour of the Department before this Report went to press.

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(v) Social Services Committee report on perinatal mortality¹

The third report from the social services committee (session 1983-84) on perinatal and neonatal mortality (follow up to the 1979-80 report²) was published in July 1984. The Government reply was published in October 1984.³

It took evidence from four regional health authorities and relevant professional bodies.

The committee noted that the perinatal mortality rate had fallen quite markedly since their previous report. While welcoming this reduction the committee noted that the perinatal mortality rate for England and Wales still lags behind that for Scandinavia and there are still large inter and intra regional variations. Other points to which the Social Services Committee drew particular attention were the persisting worse mortality figures for children born to parents of ethnic minorities and social classes IV and V, the continuing lack of minimum standards in maternity and neonatal care produced by the government for staffing and equipment and the apparent shortfall in the provision of neonatal intensive care facilities.

Since publication of the Social Services Committee's report the Asian Mother and Child Initiative has been launched.' The recently published Maternity Services Advisory Committee's third report on postnatal and neonatal care⁴ has also highlighted some of the comments made in the Social Services Committee's report and their advice was commended to health authorities by ministers.

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(d) Toxicology

(i) Developments in toxicological testing

There is increasing public awareness of the large number of chemical compounds to which we are all exposed as a result of the technological changes which are an integral part of the workings of a modern industrial society. These chemicals include industrial chemicals which may be present in the wider environment as well as in the workplace, chemicals with specific biological functions such as drugs and pesticides, chemicals intentionally added to foods to achieve some beneficial effect, or chemicals present in consumer products and other household materials. The use of such chemicals has undoubtedly brought substantial benefits over the years, but there is a need to monitor and evaluate chemical compounds to be as sure as possible that their use does not cause any hazard to human health; in fact this process of safety evaluation of new and existing chemicals to which the population is unavoidably exposed can be regarded as a necessary and important part of preventive medicine. Due to ethical and other constraints on the use of human volunteers, most toxicological testing of chemicals is carried out in animals. The subsequent extrapolation of animal data to judge safety-in-use for humans can be done with reasonable confidence. To try and allow for any uncertainties, chemicals are tested in animals at relatively high doses and steps are taken to ensure that there is a sizeable safety margin between the lowest dose causing adverse effects in animals and potential human exposure.

However, toxicologists continue to search for better ways of testing for potential human toxicity by development of methods which will carry advantages, not only from the scientific point of view, but which also recognize current concerns about the humane use of animals in toxicity testing, and will be more economic of scarce resources in toxicology. Towards these ends, fundamental toxicology research efforts are focussing on four main areas and the Government is contributing to these efforts by funding work through the Home Office, the Health and Safety Executive, Ministry of Agriculture, Fisheries and Food, Department of Trade and Industry and the Department of Health and Social Security.

First, there is the refinement of existing methods so that results may be of more predictive value for man. This includes, for example, gaining knowledge of species differences in the way chemicals are absorbed, metabolized and excreted, so that testing may be carried out on the species closest to man, and the significance of experimental findings, for man, be more accurately judged. It also includes measures that may be taken to reduce the inherent variability of existing methods, which currently not only diminishes their predictive value for man, but also requires larger numbers of animals to be used to overcome this variability. Examples of this approach are the utilization of defined genetic stocks of animals and improved control of laboratory animal diets.

Secondly, there is the emphasis on replacement of existing whole animal tests with alternative methods, utilizing, for example, sub cellular organelles, whole cells, tissues, and organs in isolation. Recent advances now permit many non-mammalian and mammalian cells, tissues etc to be maintained and/or grown in culture so that chemicals under investigation may be added directly, *in vitro*. The applications of these methods are potentially numerous. They now range from general methods applicable to many classes of chemicals (such as use of lower organisms like bacteria or yeast for screening for mutagenic effects, and culture of rodent liver cells to detect chemicals toxic to the liver) through to special methods for the investigation of

particular classes of chemical (such as the use of cultured epidermal cells to detect severely irritant or corrosive industrial chemicals, or the use of cultured neuroblastoma cells to detect the toxic effects of organophosphorus compounds). The culture of human cells and tissues, obtained from blood, biopsy material, or cadavers, perhaps holds most potential in terms of predictive value for human safety assessment, but restricted availability may limit their use on a routine basis. The development of most of these methods is still in its infancy and much validation work needs to be done on sensitivity, reproducibility and predictive value for man before they can be widely accepted for regulatory purposes.

Thirdly, there is now greater acceptance that less precise estimates of certain end points in toxicity are adequate for safety assessment. This applies particularly to acute toxicity testing. There is now widespread agreement that such tests are generally only necessary for chemicals such as pesticides and industrial chemicals, to which there may be accidental exposure to very high concentrations; and that a precise LD50 value, in which large numbers of animals are used to measure the lethality of a compound, is not required. A number of acute testing methods are now being investigated as alternatives to the traditional acute toxicity test, which employ fewer animals, and reduce potential suffering of animals by not requiring death as the end point. Furthermore, the use of increasingly sophisticated techniques of measurement and monitoring during acute toxicity testing allows more useful information to be obtained from these tests, while at the same time allowing for a possible reduction in the use of animals.

Finally, there is increasing research to develop methods to detect and assess potential toxic effects hitherto not routinely investigated, such as effects on the immune system and on behaviour. This research includes human clinical studies to attempt to define the extent of allergic and behavioural reactions to chemicals and animal studies, using both whole animals and tissue culture techniques, to define the effect of chemicals on the immune system. Although present evidence does not suggest that allergic or behavioural reactions to chemicals is a widespread or serious problem in the general population, further research should lead to greater reassurance on this point.

However, advances in toxicological science leading to the possibility of better predictive testing with reduced use of animals can only bear fruit if accepted by regulatory bodies. This is only possible if a flexible approach is adopted to toxicological testing for regulatory purposes, in which the use of a rigidly defined set of tests is not required, but instead any relevant information about a particular compound can be considered on its merits, including information obtained using new techniques. The guidelines drawn up by DHSS Committees giving advice on the safety testing of various classes of chemical have stressed the importance of such a flexible approach, and this is the approach generally adopted by advisory and regulatory bodies in the United Kingdom. There is also increasing international recognition of the need to adapt regulatory requirements to take account of scientific advances, for example by the Organization for Economic Co-operation and Development (OECD) and the Joint Expert Committee on Food Additives (JECFA) of the World Health Organization and Food and Agriculture Organization.

International agreement on methods for toxicity testing will make it easier for toxicological data produced in one country to be used for safety evaluation in other countries. Such an approach will avoid the need for repeated toxicological testing of a chemical in country after country and so reduce the use both of experimental animals and of costly and limited scientific resources.

(ii) Validity of toxicological data and Good Laboratory Practice

Whatever advances occur in toxicological methodology and in the promotion of internationally-agreed test methods, safety assessment of chemicals can only be performed if the quality and integrity of the data is of a high standard. In the past there have been instances in laboratories overseas in which inadequate, incompetent or even fraudulent testing has been performed, and the data generated in these laboratories have, as a result, been unacceptable for regulatory safety assessment purposes. In order to deal with this problem a number of countries introduced regulations or guidelines for good laboratory practice (GLP), and the OECD has established GLP principles which have been accepted in many countries. These specify criteria for the proper conduct of toxicological testing by laboratories, and also require that a competent national authority should inspect laboratories to ensure that they are operating in compliance with GLP guidelines. In the United Kingdom monitoring for compliance with GLP was introduced in respect of toxicological data on a limited range of chemicals in 1982 and 1983. During this interim phase the task of inspecting laboratories involved in the pre-clinical testing of pharmaceutical products and cosmetics was performed by the DHSS while the Health and Safety Executive had responsibility for monitoring for GLP compliance in respect of data generated on certain new industrial chemicals.

In October 1984 the arrangements for a comprehensive and permanent scheme for GLP monitoring in the United Kingdom were announced. Under the new arrangements GLP monitoring is extended to be available to cover laboratories which are producing toxicological data for regulatory assessment purposes on any type of chemical. All GLP monitoring will be performed by the DHSS monitoring unit, and arrangements will be made for DHSS to take over those GLP monitoring activities which are the responsibility of the Health and Safety Executive.

While it is necessary for national authorities to be able to monitor compliance with GLP, it is the laboratories themselves which institute good laboratory practices, and ensure day-to-day compliance with the principles of GLP. Because of the export orientated nature of the UK pharmaceutical and chemical industry many toxicology laboratories in this country adopted the principles of GLP when they were first drawn up by the United States Food and Drug Administration in the late 1970s, and were subject to inspections by United States authorities on a voluntary basis. As a result, the major part of the UK toxicology industry is now operating according to accepted GLP standards, and the more recent inspections by UK GLP monitoring authorities have generally revealed a highly satisfactory situation, with data of excellent quality being produced.

There has been considerable international activity in this field, with the aim of ensuring that toxicology laboratories all over the world operate to internationallyagreed standards of GLP. The DHSS GLP monitoring unit has been closely involved in this work, and in 1984 carried out joint GLP monitoring activities with United States and Japanese authorities, and was active in other international bodies, particularly the OECD. In the majority of countries where there is a significant toxicological testing industry, laboratories have introduced GLP standard, and monitoring by competent national authorities has been or is about to be set up. This means that regulatory authorities world-wide can have increasing confidence as to the quality and integrity of toxicological data used for safety evaluation purposes, irrespective of where these data have been produced. The end result is that the safety evaluation of chemicals is more reliable and therefore the avoidance of potential harmful effects is more certain. At the same time the need for repeated testing is further reduced, leading to a reduction in the use of animals for toxicological purposes and avoidance of a wasteful reduplication of scientific resources.

(iii) DHSS Toxicology Department at St Bartholomew's Hospital Medical College

The development of the DHSS Toxicology Unit began in the late 1970s with the primary objectives of providing training in toxicology, carrying out toxicological research on issues of regulatory concern, and acting as a lead institute in the UK for the WHO/UNEP/ILO International Programme on Chemical Safety. It became clear that the functions of the Unit were more appropriate to, and could best be achieved within, a university department led by a Professor of Toxicology. Arrangements were made with St Bartholomew's Hospital Medical College to take over responsibility for the Unit as an academic Department of Toxicology of the University of London, with a professorial director. Professor Dayan took up this new post in March 1984. DHSS continues to provide support and there is close liaison between staff of the Department and members of the relevant Division in DHSS.

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DEVELOPMENTS IN THE NHS

(a) Primary health care

The first and most frequent contact people have with the health service is with the primary care services, which include the family practitioner services and the community health services provided by health authorities. 1984 was a year of steady progress, with a continuation of many trends which have been established over the years. Some of these are described in *The Health Service in England*,¹ the annual report of the DHSS. The number of doctors in general practice continues to increase and list sizes to fall. There is a steady increase both in the proportion of family doctors working in group practice (77% in 1984) and in the number of doctors working from new or substantially modified premises designed to assist team working. More general practitioners are supported by their own ancillary staff and there are steady increases in district nurse staffing. These and other developments are helping to improve the attraction and standing of general practice, to which more and better trained doctors are seeking entrance. Against this background of steady progress there are a number of initiatives worthy of note.

Inner city practice

This Report for 1983 (page 62) described a number of developments in inner city primary care. During 1984 funding was made available for a limited period, to establish four posts in academic general practice in London. These departments will relate to the medical schools and colleges of St Barholomew's, St Thomas', Guy's and St Mary's and will enable closer liaison with general practicioners in surrounding districts, and better dissemination of information and practical experience amongst them.

Ten regional health authorities received a total of $\pounds 1.2$ million, in proportion to the populations in inner city partnership areas, to continue developments in primary health care. These have incuded services for ethnic minorities, mobile clinics, improvement in transport and in clinic premises and equipment. One authority plans to appoint a general practitioner to develop collaboration between primary and the secondary care services, to assist in the development of shared care schemes. Others are improving primary care services for travelling families or the homeless.

A new scheme was introduced to encourage group practice in inner cities by making additional inducement payments available. Practices in several of the areas qualifying have taken advantage of the scheme.

Practice premises — minimum standards

The government has been concerned that practice premises sometimes fail to reach standards which might reasonably be expected of a doctor's surgery in the 1980s. Ministers looked to all family practitioner committees (FPCs) — not only those in inner cities — to adopt an active role with regard to their responsibilities for practice premises under the doctor's terms of service. Doctors are obliged to allow their premises to be visited at a reasonable time where this is authorized by the FPC to

enable an assessment of the premises to be made. The majority of FPCs now have developed systems of routine visiting of premises in consultation with the local medical committees.

To assist FPCs with their work consultation took place with the General Medical Services Committee of the BMA to set minimum standards of accommodation. In December 1984 a Health Notice HN (FP) (84) 42 was issued.² The new guidance covers provision of advice on improving premises, arrangements for visiting, the application of revised guidance on minimum standards and the withholding of abatement of rent and rates after due notice and consultation where premises do not reach an acceptable standard. FPCs have been asked to provide information which will enable the department to assess the progress made towards improving the standard of practice premises following the introduction of these arrangements.

Information technology

The general recognition of the importance of information in the development and management of health services has been reflected in the primary health care field. In 1983 management consultants (Arthur Andersen and Company) were commissioned to make recommendations on a strategy for family practitioner services (FPS) administration including computing for the next 10-15 years.³ Following publication Ministers welcomed the general thrust of the report and a start has been made on the implementation of the strategy. The main aims are the development of computer systems within the FPS including those computers used by family doctors, and their linkage and co-ordination with other health service computer systems. This infra structure provided by administrative and practitioners computers should be exploited in the interests of improved patient care.

The report stated that delays in harnessing practitioner computing could lead to divergent developments which were expensive and of limited benefit, from which it would be difficult to recover. It laid stress on the priority of design work for a family practitioner system network, and the definitions, standards and protocols it should use.

Reference was made in this Report for 1982 (page 68) to the scheme to encourage the introduction of microcomputers for general practitioners. By September 1984 enough information was available to publish an interim report on systems evaluation. On the experience of the first 6-12 months it was found that it took most practices four or five months to install a working system. Much of this time related to the pre-existing manual systems, for practice registration data needed checking, and many doctors who wished to use the computer for repeat prescribing did not have a completely satisfactory manual system which could be easily computerized. Similarly, clinical information had to be gathered before patient call or recall systems could be introduced. Some practices had problems with the hardware and software, and these were discussed with suppliers. It is anticipated that a final evaluation report may be published in 1985 and this will demonstrate some beneficial changes in practice management following the introduction of a microcomputer.

Deputizing services

Deputizing services have been a matter of interest to the profession and the department for many years. Over 10 years ago Sir George Godber, when Chief Medical Officer, chaired a joint Working Party on General Medical Services⁴ which

recognized that changes in the pattern of life made it essential for family doctors to have some form of deputizing arrangement, organized in the way least harmful to continuity of care. Doctors cannot work for 24 hours a day, seven days a week and it is now generally accepted that there is a need for good deputizing services. The department itself issued a code of practice within Circular HC (FP) (78) 1.⁵ Nevertheless, during the parliamentary debate in April 1983 on the Health and Social Services and Social Security Bill,⁶ there were adverse comments about deputizing services and similar statements appeared in the media. The principal allegations were of inefficient organization, inexperienced or inadequately qualified deputies, a poor service to patients and excessive use of deputizing services by individual doctors. Some believed that the existence of deputizing services in inner cities tended to impede changes in the structure of general practice.

Currently about 60 services operate in England, mostly in urban areas where arrangements are most viable commercially. About half of the country's general practitioners have consent to use deputizing services, although many of these are low users. Of the claims for night visit fees (visits requested and made between 11.00 pm and 7.00 am) a little over 40% are made by doctors from deputizing services.

This Report for 1983 (page 4) referred to a letter to chairmen of family practitioner committees from the then Minister for Health, Mr. Kenneth Clarke, and the issue in December 1983 of a draft circular on deputizing services issued for consultation.

Following the review it was seen that fresh guidance was needed to help FPCs discharge effectively their responsibilities in relation to the use by gps of deputizing services. Tighter proposals on their use were issued for consultation. There was widespread support for the majority of the proposals, the profession sharing the aim of improving the standard of deputizing services. However, basic objections were made to the proposals for limiting the use made of deputizing services and to a system of monitoring use. Extensive discussions followed and in May 1984 a definitive circular was issued, HC (FP) (84) 2,⁷ which contained a revised code of practice. A major change was the replacement of professional advisory committees by sub-committees of the FPCs, half of the membership of which were to be lay members. In relation to consent of use FPCs were advised to formulate and issue policies which took into account local conditions, and which might be modified for different parts of their areas. Consent should not be given to any standing arrangement under which a deputizing service would care for a doctor's patients every night and every weekend. Control on the use of deputizing services might include a limitation on the period during which deputizing services might be used, the setting of limits for different times of the day or week, or the establishment of a maximum number of visits per month which doctors could pass to deputizing services. FPCs should appoint liaison officers and monitor services, either seeking information with the doctor's agreement from the deputizing service, or relying on statements signed by the doctors. An annual review of consent to use would take place.

The objective is to ensure that deputizing services are of a satisfactory standard, that the extent of their use is reasonable and arrangements are regularly reviewed. The changes in the code were designed to ensure that staffing and operational policies are adequate and sound, and subject to satisfactory and continuing local control. Good quality well run services can provide general practitioners with necessary relief from duty. The aim must be to ensure that patients receive a satisfactory service at all times while enabling doctors to have reasonable time for leisure and study.

Prescribing

The profession and the department have long recognized the need for efficient and cost effective prescribing by general practitioners. A number of the initiatives in this field have been recorded in previous reports, and on 8 November 1984 the Secretary of State announced in parliament the government's intention to limit, from 1 April 1985 the range of drugs available for prescription on the NHS. The drugs affected would be those prescribed mainly for the relief of symptoms, and would include tonics, cough and cold remedies, antacids, laxatives, analgesics for the relief of mild to moderate pain and low dose vitamin preparations. It was also intended to limit the range of benzodiazepine tranquillizers and sedatives available under the NHS to a small number of generic drugs.

There were immediate protests both from the pharmaceutical industry and members of the public and from sections of the medical profession. Representatives of the medical profession were opposed to the scheme in principle and declined to take part in consultations on the consent of the list.

It was apparent that modifications would be needed to the initial consultative list, if all real clinical needs were to be met at the lowest possible cost to the NHS. As a result of discussions within an expert advisory group a modified and extended list was issued and became effective in the general medical services on 1 April 1985. A committee has been established to keep the selected list under review and to advise UK health ministers on its consent.

Family practitioner committees

During the year work was undertaken on the roles and responsibilities of the FPCs which were to be established as autonomous bodies on 1 April 1985. A joint working group on collaboration between family practitioner committees and district health authorities produced a report in April 1984⁸ which dealt with areas of collaboration, and the information requirements of the new autonomous authorities. Members and chairmen were selected and appointed by the Secretary of State, and plans were announced to extend the system of accountability reviews which has operated since 1982 between the department and regional health authorities, and since 1983 between regional and district authorities. The intention is to bring district health authorities and family practitioner committees into a closer working partnership to serve the interests of the community, especially in respect of primary health care, and to improve the efficiency and accountability of FPCs.

The Regional Medical Service

The traditional objectives of the regional medical service are to provide a medical reference service and to maintain liaison with general practice. The introduction of statutory sick pay on 6 April 1983 for the first eight weeks of incapacity resulted in an initial reduction in the number of references made, but the numbers rose once more in 1984. In fact only a small minority of references refer to short term incapacity so no great change in workload was to have been anticipated (see page 105).

To enable the Department of Health and Social Security to continue to monitor prescribing in general practice, the Prescription Pricing Authority identifies a number of high cost prescriptions, which are subject to enquiry. A selection is made by the regional medical service, and direct contact with the general practitioners who issue the prescriptions is made by a regional medical officer (RMO) (Table 4.1). Many prescriptions relate to expensive items and the average value of the items involved in each enquiry was £228. Reports from the RMOs indicate that in many instances doctors are unaware of the cost of the items prescribed, particularly in the case of stoma care products, and as these have a short life expectancy the risk of waste is inevitably present.

Many general practitioners are deeply interested in their prescribing costs, have appreciated the informative approach adopted by RMOs, and have asked for an ever increasing number of practice analyses for the purpose of self audit.

and diversity of the second second second	1984	(1983)
Routine	3327	2875
Prescribing	455	934
Misuse of Drugs Act	63	83
Practice premises & organization	985	910
Other	289	328
TOTAL	5119	5130

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(b) Dental health

General dental services

The number of estimates submitted by dentists and authorized for payment in 1984 was 30,971,427 an increase of nearly 2% and similar to the increase which occurred in 1983. The number of permanent teeth filled decreased by 2.3%, the number of permanent teeth extracted decreased by 4.6%; overall the number of permanent teeth filled or extracted decreased by 2.5% compared with the slight increase noted in 1983. The number of teeth root treated increased by 6.6%, a lower rate than that recorded last year which itself was a lower rate of increase than in 1982. Although courses of treatment including crowns increased by 5.9%, the level of provision of such estimates did not regain the figure recorded in 1982. However the number of teeth restored by crowning increased by 7% to a figure 4.5% higher than in 1982. The number of bridges provided increased by 18.8%, a lower rate of increase than in 1983. There was also a lower rate of increase in the number of courses of treatment including provision of a bridge or bridges compared with 1983. The number of treatments including general anaesthesia declined by 9.2%. Courses of treatment including treatment of chronic periodontal disease increased by 10.7%, a lower increase than last year and courses including scaling and polishing and simple periodontal treatment increased by just over 1%, a similar increase to that recorded in 1982. Courses of treatment including periodontal surgery and occlusal equilibration also showed a slight decrease of just over 1% compared with the 36% decrease registered in 1982. Amongst courses of treatment relating to the dental care of children, the number of deciduous teeth filled decreased by 3.7%, the number of deciduous teeth extracted decreased by 6.8%, in each case a larger decrease than in 1982. Also, the number of permanent teeth filled for children up to the age of 16 years decreased by 12.2%. These figures reflect the continuing improvement in children's dental health.

In 1984 dental officers in the reference service of the Department examined 22,569 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 slight modification, to 57.9% of the treatment plans. For patients whose treatment had been completed 56.0% were in the dental officers' opinion dentally fit but 37.3% were not completely satisfactory. In 5.7% of the patients seen the dental officers considered that they had not had the majority of their treatment completed satisfactorily. 2,211 patients were examined in connection with the provision of orthodontic treatment. This is an increase of 28% over the previous year's figure. The percentage of prior approval cases where the dental officer was unable to express an opinion as essential evidence was not available is now 9%, an improvement on figures for previous years. The rate for adult patients failing to complete treatment stays at around 40%.

Community dental services

At the beginning of 1983 the maintained school population in England was 7.75 million, a small decline in the previous year's numbers. Just over 5.3 million school children, 68% of the school population, were inspected, 82% of these at screening inspections which took place in schools. The proportion found to need treatment was 38.5%, and of these 87% were offered treatment. Approximately 1.1 million school children were treated in a total of 1.4 million courses of treatment, 1.2 million of

which were completed in the year. In the mother and child service the number of adults inspected and treated declined slightly while the number under 5 years of age inspected and treated increased by 15% and 12% respectively. These numbers, however, represent only a small proportion of the total number of patients inspected and treated (less than 6.5%) and indeed only a small proportion of the total numbers of these particular priority groups receiving dental treatment. The numbers of handicapped adults inspected increased by 22% to 29,000 and those treated increased by 25% to 18,000. A further 8% increase in the time devoted to Dental Health Education continued the trend of the last few years.

Hospital dental services

An increased demand for and use of the services offered by the various dental specialties is shown by a 2% rise in the numbers of new out-patients seen as well as a similar rise in the total patient attendances. However, in oral surgery, despite increased use of day care facilities and improved bed usage the in-patient waiting list increased by 4%.

Dental capitation study

Following the recommendations of the Dental Strategy Review Group that there should be a voluntary scheme for providing dental care to children up to the age of 16 years based on a capitation method of remunerating general dental practitioners, the Dental Health Service Research Unit of Manchester University was commissioned to carry out a study of the feasibility and effects of a capitation system of payment. The first stage began on 1 October 1984, and is a one year pilot study to test the administrative arrangements. The pilot includes 50 dentists in 21 dental practices in 5 areas in different parts of the country. Subject to the final outcome of the pilot study, consideration will be given to setting up a controlled experiment based on a much larger and more representative sample of dentists. The aim of the controlled trial will be to compare a capitation system of dental care with item of service arrangements and evaluate the comparative costs, the feasibility, the acceptability and effectiveness of the two systems.

Dental research

For some time, there has been concern within the dental profession both about the level of support for dental research a dabout the need for more training in research techniques for dentally qualified scientists. The Dental Strategy Review Group drew attention to the need for "a major expansion in dental research with recruitment of more dental graduates and non dental scientists" and noted that the multiplicity of sources of support for dental research called for some co-ordinating machinery to be established.

Following discussions between the MRC, the Science and Engineering Research Council (SERC), and the Health Departments a new Joint Committee was set up with a view to assisting the co-ordination of dental research in Britain. The Committee, under the Chairmanship of Professor Denis Noble FRS, met for the first time towards the end of 1984. Its terms of reference include maintaining an overview of the whole field of dental research and development (including the promotion of technology transfer) and to identify needs, together with advising the MRC, Health Departments and SERC, as requested, on the clinical and scientific merits of grant applications and other proposals for the funding of research in the field of dentistry.

Water (Fluoridation) Bill

The Government announced in December 1983 its intention to legislate on fluoridation following Lord Jauncey's judgement in the Strathclyde fluoridation court case. After lengthy consideration of detailed evidence, which included that of the leading anti-fluoridationists, Lord Jauncey concluded 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 Strathclyde and that there was no evidence that the addition of fluoride at such a concentration was harmful to health. Lord Jauncey did however find that Strathclyde Council had no legal power to add fluoride to the water supply and in consequence fluoridation was halted in Scotland. The Water (Fluoridation) Bill was introduced in the House of Commons on 20 December 1984 and at the same time of writing of this Report was progressing through its Parliamentary stages. The Bill seeks to give specific legal powers for the arrangements under which fluoridation has been considered and implemented for the last thirty years. Decisions on fluoridation will continue to be taken locally by health authorities and statutory water undertakers after consultation of public opinion. The Bill will restore the option of fluoridation in Scotland and will also apply to England and Wales where there has been doubt about the existing legal powers for fluoridation. Parallel legislation will be introduced for Northern Ireland.

(c) The Artificial Limb, Vehicle and Appliance Service

The Artificial Limb Service

The review of the Artificial Limb and Appliance Service under the Chairmanship of Professor Ian McColl, mentioned in this Report for 1983 (page 103), started taking evidence in May. Much evidence was given and the recommendations of the Working Party are expected to be presented to the Minister by the autumn of 1985.

During 1984 the Cunningham report on the Wheelchair Service and the Hammett report on the large wheelchair and vehicle store at Heywood, Lancashire were received by the Department. Both reports were passed to Professor McColl's Working Party for their consideration.

The findings of the survey of artificial limb users conducted by the Research Surveys of Great Britain (RSGB) Ltd were submitted to the Department and were, in general, quite reassuring. Most limb users expressed satisfaction with both the Service itself and the prostheses provided (88% said they were satisfied or fairly satisfied).

The provision of an appropriate and well-fitting artificial limb enabled most users to perceive their life-style as being "normal" when compared to their non-disabled peer group.

The least satisfied patients were in the age group 16-45 years who had lost a limb through war injury within the last five years. A possible explanation may be that their expectations of what the Artificial Limb Service could achieve were unrealistic. Those patients who complained most about the function of their prostheses were amputees of less than a year's standing.

For some time both the Department and the artificial limb contractors have felt that the training of prosthetists (limb fitters) should be improved. Accordingly, they agreed jointly to set up the London School of Prosthetics which will be situated in the Limb Fitting Centre building at Roehampton. The School is expected to open formally in October 1985.

Whilst the socket for a below-knee prosthesis has long been prepared by taking a plaster cast of the stump, this has not until recently been possible for above-knee amputees. Because of the large soft tissue in relation to the bone it has been traditional to prepare above-knee sockets by direct measurement from the stump. However, this proved rather inaccurate. Two of the major lower limb contractors have now developed promising methods of casting the above-knee stump. If fully successful these should ensure a better fit, greater comfort for the patient, and the need to replace sockets less frequently. A satisfactory above-knee stump casting technique is an essential prerequisite for the wider introduction of modern thermoplastic socket materials.

In 1978 the Department began an ambitious programme to supply myoelectric hands to children. As that need became satisfied, older age groups were accepted for treatment. Finally, in 1984, a programme for supplying powered hands to adult upper-limb amputees began.

The annual DHSS/RCS Symposium took place in Leeds on 26 October.

Statistics

In 1984 there were 5,370 new patients (236 fewer than 1983) — Table 4.2. The overall ratio of arm amputations to leg amputations was 1:29.4. There were 152 non-amputation cases, 115 having congenital deficienciés or malformations.

The overall ratio of male to female amputees was 2.02:1 (2.04: 1in 1983). There was no change in the male to female ratio for the 0-9 age group from last year. (1.2:1). In all other age groups, 10-59, 40-79, 60-79, and over 80, there were only very minor changes from last year — 3.35:1, 2.32:1, 2.13:1, and 0.9:1 (3.4:1, 2.3:1, 2.2:1, 1:1.2 in 1983).

The ratio of arm to leg amputations following trauma (Table 4.3) was 1:2.93 (1:3.18 in 1983). The corresponding ratio of arm to leg amputations due to disease was 1:71 (1.73 in 1983).

Prostheses for non-amputees

Table 4.4 lists the reasons for providing a prosthesis to non-amputees — as last year, three quarters were for congenital defects.

Reason for amputations

In 1984 3,332 (63.9%) of all leg amputations were performed for peripheral vascular disease (PVD) (Table 4.5). This compares with 3,380 (62.4%) in 1983. Of all amputations 21.4% were performed for diabetes, mainly because of vascular complications.

Peripheral vascular disease and diabetes now account for 85.3% of new amputees. Recent research from America suggests that the real percentage of diabetics in vascular amputees is nearer 65%. The limited trial at Roehampton mentioned in the 1983 report tended to support this. It is hoped to undertake a larger project to confirm this association in the future.

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 61.3%: 38.7%. For the first time in the last three years there has been an increase in the percentage of above-knee operations. Whilst prosthetically this is an undesirable trend — rehabilitation of the above-knee amputee is more difficult — it might be explained by the greater number of restorative procedures being undertaken by vascular surgeons in an ageing population. In these circumstances, above-knee amputations are often the only solution.

Road traffic accidents (RTAs) — pedestrians, riders or occupants of road vehicles — accounted for 219 attendances (i.e. amputations and non-amputations). This is a welcome reduction on last year's figures, 271, and is mainly accounted for by the drop in the number of 2-wheeler drivers and passengers (Table 4.6).

Table 4.2: First attendances at Artificial Limb Centres, England, 1984. (Total first attendances for 1983 in parentheses)

and the second se	Male	Female	Total	
Single arm amputations	103	52	155	(180)
Single arm non-amputations*	65	51	116	(152)
Single leg amputations	3,026	1,526	4,552	(4,771)
Single leg non-amputations*	17	8	25	(26)
Double arm amputations	2	1	3	(0)
Double arm non-amputations*	3	0	3	(1)
Double leg amputations	362	131	493	(456)
Double leg non-amputations*	3	2	5	(3)
Other multiple amputations	12 10	3 10	15	(12)
Other multiple non-amputations*	2 alter 2	na line n <mark>1</mark> eo	3	(5)
	3,595	1,775	5.370	(5,606)

(* eg congenital shortening, polio, etc).

Figures for 1983 in parentheses)		
	1984	
Traumatic injuries (total)	448	(506)
Arm trauma	132	(144)
Leg trauma	312	(362)

1970 En	Male	Female	Total	Per cent of total non-amputations*
Trauma	27	4	31	20.4
Congenital	60	55	115	75.7
Disease [†]	3	3	6	3.9

(*e.g. Patella tendon bearing (PTB) brace for non-union of fractured tibia and fibula or flail arm splint). († Causing shortening, instability or wasting).

non-	-amputees).			an shared a			
			distili.	Male	Female	Total	% of Tota
(i)	Age distribution						
	Age range 0- 9			72	60	132	2.5
	10-19			90	35	125	2.3
	20-39			228	59	287	5.3
	40-59			634	190	824	15.3
	60-79			2,224	1,044	3,268	60.9
12	Over 80	16	- 49, -	347	387	734	13.7
Tota	al	THE CON	1 - D.G.	3,595	1,775	5,370	100.0
(***							
(11)	Vaccular	ons		2 202	1.020	2 222	63 (
	Matabalia (i) diabat	11		660	1,029	1 119	21
	(ii) other	cs.		5	450	1,110	21.
	Traima			326	01	417	8.1
	Malianancy			109	76	185	nkaber 2
	Neurogenic deformit	1. 1.95°		105	70	105	
	(i) acquired	y		9	3	12	0.3
	(ii) congenital			28	20	48	0.0
	Infection (including s	gas gangrene)		63	32	95	1.8
Totals			- shite da	3,505	1,713	5.218	99.9×

Table 4.5: Patients seen for the first time at Artificial Limb Centres in England, 1984 (Amputees and non-amputees).

(* 0.1% being other congenital cases).

The Vehicle Service

An analysis of the motor vehicles and wheelchairs on issue is shown at Table 4.7. As in 1983, more disabled patients are opting for the Mobility Allowance benefit, the War Pensioner's Mobility Supplement with the result that the number of powered vehicles and private car allowances on issue has continued to decline. The Department no longer issues motor vehicles to any category of patient.

The total number of motor vehicles on issue at 31 December 1984 was 9,623.

The Appliance Service

Charged under Royal Warrant with the prescription and supply of orthoses to war pensioners, the Service is responsible for 13,804 pensioners, a decrease of 348 (2.46%) on the number for 1983.

97

					% of tota
		Male	Female	Total v	ascular case
(a)	Breakdown of vascular aetiology				
	(Total 3,332, diabetes not included)				
	Arteriosclerosis	2,069	876	2,945	88.
	Embolism	148	83	231	6.
	Thromboangiitis	21	12	33	1.0
	Varicose ulceration	25	27	52	1.0
	Other	40	31	71	2.
					100.0
(b)	Breakdown of trauma actiology				
	(Amputation and non-amputation*)				
	Total	326	91	417	
	Industrial	85	9	94	22.
	RTA	136	22	158	37.9
	Pedestrian	36	25	61	14.
	Home	15	20	35	8.
	Recreation	9		9	2.3
	Armed Forces	13	-1	14	3.4
	Rail	17	11	28	6.1
	Other	15	3	18	4.
					100.0
(0)	Breakdown of RTA and nedestrian			dia di Integ	
(0)	Cases				
	Total	172	47	210	
	Pedestrian	36	47	61	27 (
	2 wheeler driver	102	25	107	18 0
	2-wheeler passenger	102	5	107	40.
	Otherwebicles	a de la companya de l	10 🗳 19	10	
	Driver	17	2	10	e .
	Passanger	17	2	19	0. 7 /
		metralinear u	linher (dit)	10	1
-		a she ha she ka she			100.0
(* 5	See footnote to Table 4.4 for explanatory	example on non-ar	nputation follow	ing road acc	idents).
Tab	lad 7. Analysis of vahicles and chairs	on issue in Engelnd	at 21 December	1094 (figure	e for 1083 i
pare	entheses)		at 31 December	1984 (liguit	.5 101 1905 1
(a)	Powered vehicles and private allowance	es		224	(5 (0)
	Potrol propollod three wheelers		2	,894	(5,091
	Petrol propelled three wheelers		6	,606	(7,510
	Electrically propelled three wheelers			123	(149
	Private Car Allowances (PCAs)			357	(424
(b)	Non-powered wheelchairs (including sp	pinal carriages,			
	pedal and hand tricycles)		396	361	(364.96)

98

(c) Powered wheelchairs Indoor electric chairs

Total

Outdoor electric chairs

(9,658) (7,528)

(395,921)

10,380

7,890

424,611

Table 4.8. Patients using the Artificial Limb, Vehicle and Appliance service in England in 1984 (Figures for 1983 in parentheses).

Artificial Limb Service	66,230	(66,600)	
Vehicle Service*	376,093	(350,064)	
Appliance Service	13,804	(14,152)	6

*Figures in Table 4.8 refer to patients whereas figures in Table 4.7 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.

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(d) Organization and management

NHS Management Inquiry

Following the report of the NHS Management Inquiry Team in October 1983 the Department circulated health authorities with an amplification of the Government's response to the report and setting out action required of authorities.

The circular (HC [84] 13 — June 1984)¹ stressed the aim of ensuring that the management of the health service is geared primarily to the interests of patients. It also emphasized the Government's overriding concern to see the NHS providing the best possible service to patients within the available resources, and that the initiatives being taken were designed to promote the most efficient use of necessarily limited resources.

The circular accepted the view of the Management Inquiry Team that the general management function should be established in health authorities and be clearly vested in one person (at each level) who would take personal responsibility for securing action. It asked authorities to identify a general manager for each RHA, DHA, hospital SHA, and unit. The appointments at region and district level were to be made first, and by the end of the year twelve regional, and sixty district health authorities had made appointments.

The circular emphasized the need for improvements at the point where the patient receives a service — at unit level or below, and recognized that such improvements rested on the involvement of all professionals concerned, particularly doctors and nurses. It strongly endorsed the view that clinicians should be both encouraged and enabled to be more active in management and recommended further management training for them. To facilitate clinicians playing an enhanced role in management the need for access to relevant and timely information and adequate administrative support was recognized.

The Department accepted the view that details of districts' own arrangements, including the organization of units, could not be prescribed centrally, and that authorities needed scope to take account of local needs and potential.

Further guidance on implementing management arrangements has therefore been kept to the very minimum. However some functions of authorities are common to all, and in an annexe to the circular it was stated that professional chief officers appointed by their authorities would continue to be directly accountable and have a right of access, to the authority on the provision and quality of professional advice. The

Department subsequently confirmed that it expected authorities to maintain the appointment of a chief medical officer whose first or main responsibility is ensuring the provision and quality of such advice.

These initiatives are only a beginning in the process of establishing effective management in the NHS. The criteria of success will be improvements in services as perceived by patients and the community, and this will require the active commitment of all concerned with care.

NHS/DHSS Steering Group on Health Services Information

In April 1984 the DHSS issued Circular HC (84) 10² outlining the arrangements and timetable for the implementation of the six main reports of the Steering Group. Authorities were asked to draw up detailed implementation plans, to be reflected in their strategic plans and annual programmes, with an implementation date of April 1987 for most of the recommendations and April 1988 for the remainder, mainly those dealing with community based services.

During the year the remaining five of these six main reports were published.

---- second report on patient transport services³

- third report on hospital and community health services manpower⁴

- fourth report on activity in hospitals and in the community⁵

- fifth report on services for and in the community⁶

With the main task of drawing up these recommendations completed, the chairman, Mrs Körner retired from the Steering Group in July. Her lasting contribution to the service is the first major review of NHS information systems.

Confidentiality of personal health data

The Data Protection Act received Royal Assent in July 1984.

This Act aims to protect personal data by establishing and exposing standards for data processing. It enables the United Kingdom to ratify the Council of Europe Convention on Data Protection ensuring that data flow freely and safely between the United Kingdom and other countries.

A Data Protection Registrar has been appointed and users of computerized personal information will have to register before the end of 1985 when data protection principles will be enforceable.

In October 1984 the Department issued for consultation a draft code on the confidentiality of personal health information in the NHS. The code was drawn up in association with the Interprofessional Working Group on Access to Personal Health Information, chaired by Sir Douglas Black. It is intended that the code, which sets out the principles which govern the protection of the patient's right to confidentiality will receive statutory backing.

One of the principles of the Data Protection Act is that personal data should be made available to data subjects on request. Under section 29 of the Act the Secretary of State may by order exempt from the subject access provision or modify those provisions in relation to personal data consisting of information as to the physical or mental health of the data subject.

The Steering Group on Health Services Information chaired by Mrs. E. Körner issued a report, October 1984, on the Protection and Maintenance of Confidentiality of patient and employee data⁸.

Performance indicators

During the year the working groups set up by the Joint NHS/DHSS Group on Performance Indicators produced their reports. Work is continuing on assembling these into a single comprehensive report which will form the basis of the performance indicators to be distributed to the service in 1985.

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- ⁴ Steering Group on Health Services Information. A report on the collection and use of information about manpower in the National Health Service: third report to the Secretary of State. London: HMSO, 1984. Chairman: Mrs. E. Körner.
- Steering Group on Health Services Information. A further report on the collection and use of information about activity in hospitals and the community in the National Health Service: fourth report to the Secretary of State. London: HMSO, 1984. Chairman: Mrs. E. Körner.
- ⁶ Steering Group on Health Services Information. A report on the collection and use of information about services for and in the community in the National Health Service: fifth report to the Secretary of State. London: HMSO, 1984. Chairman: Mrs. E. Körner.
- Steering Group on Health Services Information. A report on the collection and use of financial information in the National Health Service: sixth report to the Secretary of State. London: HMSO, 1984. Chairman: Mrs. E. Körner.
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Joint NHS/DHSS Group on Performance Indicators. A report to the Secretary of State for Social Services. London: Department of Health and Social Security, 1985. Chairman: C. Graham.

SOCIAL SECURITY

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Severe disablement allowances

A new benefit, severe disablement allowance (SDA), was introduced on 29 November 1984, to replace non-contributory invalidity pension (NCIP) and housewives' non-contributory invalidity pension (HNCIP). Like these two benefits, SDA is a non-contributory and non-means-tested income replacement benefit. It is primarily for those of working age who are unable to work because of long-term sickness or disablement, but who have not paid sufficient contributions to qualify for contributory invalidity pension. The new benefit does away with the much disliked "household duties" test for married women claiming HNCIP and is available equally to men and women regardless of marital status.

All those people drawing NCIP or HNCIP on 28 November 1984 were automatically transferred to SDA, and will continue to receive the new benefit for as long as they remain incapable of work. New claimants can qualify for SDA simply on a test of incapacity for work, provided that their incapacity began on or before their 20th birthday. Those who first become incapable after this time can qualify if they are also at least 80% disabled.

SDA is normally payable only to eligible people between the age of 16 and pensionable age (65 for a man, 60 for a woman); however, where a person is entitled to SDA immediately prior to pensionable age, it can continue in payment indefinitely. Furthermore, to enable claims to be processed within existing Departmental staffing levels, the introduction of SDA is being phased in for new claimants. Those aged 16 to 35 years, and those aged 50 years and over became eligible from 29 November 1984 onwards. Those aged 35-49 years can qualify from 28 November 1985.

The claimant's level of disablement will be assessed in accordance with criteria similar to those already in use in the industrial injuries and war pensions schemes. However, in certain prescribed circumstances, for example where attendance allowance or mobility allowance is already in payment, a person will automatically be accepted as satisfying the 80 per cent disablement test without the need for further medical examination. In other cases the level of disablement will be assessed by an independent Adjudicating Medical Authority, usually consisting of either one adjudicating medical practitioner acting alone, or two acting as a medical board.

A decision of an Adjudicating Medical Authority can be varied by a Medical Appeal Tribunal if the claimant appeals or the Secretary of State directs a reference. There is a further right of appeal, on a point of law only, to the Social Security Commissioners and, with leave from the Commissioner, to the Court of Appeal. To assist the Adjudicating Medical Authorities, guidance will be published in the form of a handbook along the lines of the handbook which is already available for industrial injury cases. This has been widely circulated in draft form to interested organizations.

When fully implemented it is estimated that SDA will provide a regular weekly payment as of right to several thousand more disabled people than were able to qualify for the previous benefits.
Social Security Appeal Tribunals and Medical Appeal Tribunals Presidential system

Prior to April 1984, Supplemenatry Benefit Appeal Tribunals (SBATs), National Insurance Local Tribunals (NILTs) and Medical Appeal Tribunals (MATs) were administered by the Departments of Health and Social Security (DHSS) and of Employment (DE). The judicial independence and impartiality of these tribunals was never seriously questioned, but their administrative procedures were cumbersome and appeared to many to be mere adjuncts of Departmental structures.

Under the Health and Social Services and Social Security Adjudications Act 1983 (known colloquially as "HASSASSA") and consequent procedural regulations, SBATs and NILTs were, with effect from the 23 April 1984, merged to form Social Security Appeal Tribunals (SSATs), and both they and MATs were brought under the direct control of a President, appointed by the Lord Chancellor.

The HASSASSA Act prescribes the administrative duties of the President as to arrange such meetings of chairmen and members of SSATs and MATs, and such training for such chairmen and members, as he considers appropriate; and to secure that such works of reference relating to social security law as he considers appropriate are available for the use of chairmen and members. Beyond these statutory requirements, however, the President has very clear obligations to establish and maintain the complete judicial and administrative independence of the tribunal system; to improve its standards of adjudication; and, through greater administrative efficiency, to reduce delays in bringing cases to appeal.

The first President of SSATs and MATs is His Honour Judge John Byrt QC, whose office is in Almack House, London. He is assisted in his tasks by seven Regional Chairmen and a number (at the time of writing four, but eventually seven) full-time Chairmen, appointed by the Lord Chancellor from barristers, advocates or solicitors of several years' standing, and exercising judicial and administrative functions on the President's behalf in Regions which are geographically coterminous with those of the Social Security component of DHSS. At present housed in DHSS premises, these Chairmen will, during the course of 1985, move into their own accommodation in major cities throughout the country. Their offices, like that of the President, will be staffed by civil servants on secondment from DHSS. Once it is fully operational, the Presidential organization will assume responsibility for its own financial management and control.

The tribunals themselves, of which there are a total in excess of 300, draw upon approximately 7,000 part-time chairman and members. HASSASSA requires all newly-appointed part-time chairmen, who hold their appointments from the Lord Chancellor (or, in Scotland, from the Lord President of the Court of Session), to be legally qualified — that is, to be barristers, advocates or solicitors of not less than five years standing — but there is a five year transitional period during which existing lay chairmen may continue to serve. Members of SSATs require no formal qualifications: they are appointed by the President, to serve on panels in each Region, from persons appearing to him "to have knowledge or experience of conditions in the area and to be representative of persons living or working in the area". Members of MATs are qualified medical practitioners, typically of consultant status. To the extent that they are appointed by the Presidential system. SSATs and MATs are subject to the appellate jurisdiction of the Social Security Commissioners.

Statistics

The following figures show that Social Security medical work, to which more than 4,000 doctors contribute, continues to increase — except in the field of industrial injuries.

Industria	l injuries	1984	(1983)
18 g	Cases boarded	177,695	(184,848)
Attendan	ce allowance		
	Decisions made	325,529	(297,701)
	Examinations performed	311,170	(290,101)
	Reviews	33,314	(29,843)
	Allowances in payment at 31.3.84 (estima	ited)	
	Higher rate	192,000 (40.9%)	
	Lower rate	277,000 (59.1%)	
War pens	ions		
	Cases boarded		
	(including treatment examinations)	12,271	(11,797)
Mobility	allowance		
C 1	New claims received	152.687	(121,960)

Occupational respiratory disease

137 cases of occupational asthma were diagnosed during the year, attributed to:

Isocyanates	51
Platinum salts	4
Hardening agents	14
Soldering flux	27
Proteolytic enzymes	5450 King 1
Animals/insects (mainly in laboratories)	8
Dusts arising from flour & grain	32
TOTAL:	137

Figures for pneumoconiosis and allied diseases are not available, due to industrial action.

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The Regional Medical Service

Tables 5.1 and 5.2 summarize work undertaken by the Regional Medical Service (RMS) in relation to patients referred for examination.

Table 5.1: References received, England, 1984.

Source	Type of reference	Number	(1983) figure in parentheses
DHSS	Sickness and invalidity benefit	484554	(468744)
	*Injury benefit	1983	(9347)
	Maternity benefit	48	(74)
	Supplementary benefit	550	(655)
	Repeated short period claims	412	(1818)
	Selfcertification	240	(1850)
	Statutory sick pay	26	(_)
	Statutory sick pay (self certification)	152	()
Doctors	Form RM7 (request for 2nd opinion)	4278	(4150)
Dept. of	Form Med 6 (vague diagnosis)	3296	(3447)
Employment	NUMBER OF STREET, MARKING AND AND AND	12265	(16026)
EC		46	(58)

*Includes Section 50A cases (Sickness benefit when incapacity results from industrial accident or prescribed industrial disease).

	A CONTRACTOR OF	Contract of the second
TOTAL:	507850	(506169)
	CONTRACTOR OF STREET	1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1

Table 5.2:	Sickness and invalidit	v benefits. Outcon	ne of RMS examination.	. England, 1984.
The second se	Divitire of and in the	1 0011011101 001001		and a second sec

Opinion	Oftotal	references	Of those	examined
	1984	(1983)	1984	(1983)
Not incapable of work	6.19%	(5.92%)	14.91%	(14.82%)
Incapable of work	29.48%	(29.55%)	71.03%	(70.98%)
Incapable of work at present	5.83%	(5.99%)	14.06%	(14.21%)
occupation but capable of suitable				
alternative work				

Reference

Health and Social Services and Social Security Adjudications Act 1983. London: HMSO, 1983.

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INTERNATIONAL HEALTH

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World Health Assembly

The thirty-seventh World Health Assembly was held in Geneva in May. The United Kingdom delegation was led by the then Mr. Kenneth Clarke, Minister for Health who, in addressing the Assembly, reiterated the UK Government's commitment to the Health for All strategies and to the Organization's Action Programme on Essential Drugs.

The major item on the agenda was a report from the Executive Board to the Assembly on the progress achieved so far by member states in the drive to achieve Health for All by the Year 2000. The report was based on answers to questionnaires sent to all the Member States in the first of a cyclical reporting system extending to the end of the century. The report showed up a number of weaknesses prominent among which were the lack of adequate information systems in many countries, insufficient management capacity, lack of trained manpower, and difficulties in changing the distribution of health budgets. Notwithstanding these shortcomings there were encouraging signs of a growing political commitment to the philosophy behind the Health for All strategies and a discernible effort in many countries towards building up health systems based on primary health care.

The Assembly also devoted considerable attention to the WHO Action Programme on Essential Drugs and Vaccines. The successful outcome of the programme, which is to provide developing countries with a regular supply of safe and effective drugs of acceptable quality at lowest possible cost, depends ultimately on a collaborative effort among governments, national and multinational drug companies, the medical and other health professions and the consumers. There is still some way to go before this can be realized. At the request of the Assembly the Director General is to invite experts of the concerned parties to a meeting in 1985 to discuss the promotion of rational drug use and the role of marketing practices.

In an interesting two days' technical discussion on the role of universities in the strategies for Health for All at which over 80 academics took part there were calls for greater co-operation between universities and Ministries of Health and for the forging of links between the universities and the communities. A resolution was passed urging Member States to encourage universities and other institutions of higher education to include the social and technical concepts of Health for All in their educational curricula. The resolution also invites universities to disseminate the concept of Health for All through integrated teaching, collaboration with governments, and education of the general public.

WHO Regional Committee for Europe

The thirty-fourth session of the Regional Committee was held in Copenhagen in September. The United Kingdom delegation was led by Dr. E. D. Acheson, Chief Medical Officer.

Her Majesty Queen Margrethe II of Denmark, who attended the opening ceremony of the session, inaugurated a new building put at the disposal of the Regional Office by the Danish Government.

This was Dr. Leo Kaprio's last Committee as Regional Director and many warm tributes were paid to him and to the outstanding service he has rendered the Organization over almost two decades. The Committee nominated Dr. Jo Erik Asvall as the next Regional Director subject to confirmation by the WHO Executive Board.

During the session the Committee adopted a number of Regional targets for better health in Europe together with a preliminary list of indicators to monitor progress and evaluate implementation of the strategy for Health for All, and a plan of action. Specific European targets include the reduction of infant mortality to below 20 per 1000 live births, of maternal mortality to less than 15 per 100,000, of mortality from accidents by at least 25%, and from diseases of the circulatory system and from cancer by not less than 15%. Action is proposed in the fields of diet, smoking, dangerous driving, violent social behaviour, the over-consumption of alcohol, and the use of illicit drugs and dangerous chemical substances. Regular evaluation reports will be submitted by Member States on the progress achieved.

The Committee also endorsed the programme budget for activities in the European Region for the 1986-87 biennium.

The Programme for WHO and Council of Europe Medical Fellowships in the United Kingdom

During 1984 the Department was involved with 551 programmes for WHO fellows visiting the United Kingdom; 337 programmes commenced with an average duration of 5 months. Before the beginning of studies 75 programmes were initiated but cancelled by either the WHO or the Department. On 1 January 1984, 139 programmes were in progress. Thirty-six fellows sponsored by the Council of Europe came to the United Kingdom for periods of about four weeks. Details of both programmes are shown in Table 6.1.

Eight United Kingdom candidates were awarded fellowships by the WHO and five by the Council of Europe for study overseas during 1985.

WHO Collaborating Centres

The use of national health institutions for international health work goes back to the days of the League of Nations when national laboratories were first designated as reference centres for the standardization of biological products. Since the establishment of the WHO more reference centres have been established, the first in 1947 being the World Influenza Centre in London for world-wide epidemiological surveillance. With the expansion of the WHO's programme of medical research the number of centres in reased rapidly from 1958 onwards and by the end of 1984 there were 777 centres in 75 countries. Two of the WHO regions, Europe and the Americas, accounted for 588 centres, with the United States, the UK and the USSR having nearly one-third of the global total (243 out of 777).

The functions of the collaborating centres include the following:

The collection, collation and dissemination of scientific information; the standardization of terminology and nomenclature of diagnostic, therapeutic and prophylactic substances, and of methods and procedures; the provision of reference substances to laboratories; assistance in the development of national

		WHO fel	lowship	s comm	enced ir	ı UK dui	ring 198	34	Council of - Europe	Total fellowships
ultan int si Marina kata di	Europe	Eastern Mediter- ranean	Africa	South East Asia	West Pacific	Ameri- cas	Total	Average duration in months	fellowships begun in 1984	begun in 1984
Public health		ing sings No mas l	reisol."	nighta Na sent		oja ti Telfoni		ା ଏହି । ଏହି ମାସନ୍ତୁ । ସି ଶ		ante e 1 de se
and administration	9	16	10	11	8	5	59	41/2	3	62
Environmental health	41	9	3	1	6	2	62	11⁄2	l-naik pil 1 dai 101	63
Nursing	2	3		4	а. <u>—</u> л	1	10	3	4	14
Maternal and child health	1	5	3	2	4	1	16	8		16
Communi- cable				1	16a	(4) (4)			1444 - 148 1444 - 148	
diseases	6	6	1	6	2	<u></u> 195	21	5	1	22
Clinical medicine	16	16	3	16	8	7	66	5	15	81
Basic sciences	7	6	12	19	5	4	53	9	6	57
Other health services	8	15	3	15	4	5	50	7	6	56
Total	90	76	35	74	37	25	337	Sing of t	36	373
Average duration in months	1	7	15	5	3	31/2		5		
WHO fellowshi but cancelled	ip progra	ammes req	uested d	uring l	984	ardas Autoria	75		en de lini 1811 yapar 1911 en ba	a (<u>1977)</u> a (1977)
WHO fellowshi	ip progra	ammes alre	eady in p	rogress	at 1.1.8	34	139			
Other programm	nes arrai	nged durin	g 1984		1.1	12	33			
			a a							

Table 6.1: WHO and Council of Europe medical fellowships administered in the United Kingdom during 1984.

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scientific institutions; the participation in collaborative research with the WHO; the provision of facilities for training, including research training; and the development and application of appropriate technology.

High among the criteria for the selection of institutions as collaborating centres are the scientific and technical standing of the institutions concerned at the national and international levels with particular reference to their record of achievement and ongoing activities. The normal practice is for centres to belong to established academic institutions. The procedure for selection and designation of a WHO collaborating centre is usually initiated by the Organization with the Institution concerned. At a later stage when agreement has been reached in principle on the nature and extent of the collaboration, comments are invited from the National Health Administration concerned. The ultimate responsibility for designating WHO collaborating centres rests with the Director General. The Centres are designated for periods of four years renewable by mutual consent for further periods of four years or less.

There are currently 74 designated collaborating centres in the UK (66 in England, 7 in Scotland and 1 in Wales). The fields covered include immunology, cancer, cardiovascular diseases, virology, biological standardization, nursing, communicable diseases, tropical diseases, zoonoses and disease vector control.

WHO Health Laboratory Technology

The Department collaborated closely with the WHO in developing a protocol for the costing of clinical laboratory tests, a vital tool in an international programme for assessing both the costs and benefits of laboratory test procedures.¹

The Special Programme for Research and Training in Tropical Diseases

The Special Programme for Research and Training in Tropical Diseases was established in late 1975 as an international effort to tackle the major tropical diseases in the developing countries. It was initiated and planned by the WHO with the assistance and co-sponsorship of the United Nations Development Programme and the World Bank. Governments and national research institutions participate at all levels of its management, operations and evaluation.

The programme's two main objectives are the promotion of research and development of new methods to control six tropical diseases, and to provide support to national institutions in the tropical countries to develop and increase their research potential. The six target diseases are: malaria, schistosomiasis, filariasis, trypanosomiasis (both African sleeping sickness and Chagas' disease) leishmaniasis and leprosy.

The management of the programme, which depends for its existence almost entirely on voluntary contributions from Governments and from other institutions, is entrusted to a Joint Co-ordinating Board (JCB) consisting of members drawn from Member States contributing to the programme, the three co-sponsoring organizations and members selected by the Board. The Board reviews and decides on the planning and execution of the programme. The technical bodies include the Scientific and Technical Advisory Committee, a multi-disciplinary group of scientists serving in their personal capacities which advises the JCB on the scientific and technical aspects of the programme, and Scientific Working Groups made up of concerned scientists who make the principal scientific judgements concerning clearly defined research goals. The WHO provides the Programme Director and services the programme.

One of the characteristic features of the programme has been its endeavours to promote research and development activities through a network of institutions in both the developed and developing countries. This approach has provided a viable means for bringing together researchers from both sides to pool resources towards the development of new methods for controlling the target diseases.

Although the target diseases still pose major challenges to health authorities in the endemic countries, the programme has already made valuable contributions towards their control. Among these are the development of simple and accurate diagnostic field-test kits for malaria, leprosy, and African trypanosomiasis; advances on the development of a leprosy and antimalarial vaccine; development and testing of new antimalarial drugs; a screening mechanism for filaricidal drugs; and the development of biological agents for the control of vectors. Above all the programme has had a positive influence on the strength and quality of the scientific world-wide effort devoted to the target diseases.

The United Kingdom has been closely involved with the programme since its inception. It has provided financial support and has also played an active part in its management through its membership of the JCB. Over the past decade British Institutions and scientists have carried out over 200 research and development projects commissioned under the aegis of the programme, and they continue to play an important part in its work including its scientific management.

The Council of Europe

European Pharmacopoeia Commission

The 60th Session of the European Pharmacopoeia Commission in November 1984 marked the completion of 20 years of international co-operation, and United Kingdom participation, in the compilation of common European standards for medicinal substances and articles. During this period the original eight states, including the United Kingdom, party to the European Pharmacopoeia Convention have increased in number to seventeen. In addition, Spain and Portugal attend regularly as observers with the affirmed intention of acceding to the convention at an early date. The EC is also represented at Commission meetings on a regular basis by an observer.

The accomplishments of the European Pharmacopoeia Commission are substantial. Work on the first edition of the European Pharmacopoeia was terminated in 1977 in favour of the preparation of a second edition. This is being published serially and is now well advanced. It contains many new monographs and revised monographs from the first edition. Legally binding common standards are now in force (or agreed) in the States party to the convention for a wide range of materials for use in both human and veterinary medicine and automatically constitute or supersede the standards adopted by national pharmacopoeias, such as the British Pharmacopoeia. These include hormones, antibiotics, synthetic medicinal agents for the treatment of a wide range of conditions, radiopharmaceuticals, vaccines, sera, blood products, dressings and sutures, in substantial and steadily growing number. Standards for only a very small number of specific formulated medicinal preparations (dosage forms) have so far been issued. During the past twenty years the European Pharmacopoeia has provided acceptable and enforceable standards of quality and related safety for many medicinal substances most widely used throughout Europe. The licensing arrangements for medicine in the European Communities, as set out in the relevant Directives, require compliance with its requirements as essential controls of human and veterinary medicines and is proof of the effectiveness of European co-operation in this important field.

European Communities

Extensive discussions took place with the European Commission, other Government departments and the Research Councils regarding the proposed European Community (EC) developments in biotechnology. These culminated in the acceptance by the Council of the EC in December 1984 of a 5-year programme (from January 1985) of collaborative (transnational) research and training in biotechnology. The programme is directed towards the application of fundamental research to precompetitive areas of work underpinning various industries. Of particular interest to this Department are the programmes to develop methods of *in vitro* testing of substances for their toxicological or pharmacological effects and to improve techniques for cell culture and the cryopreservation of cell lines and microorganisms. The EC programme also aims to provide a research infrastructure which favours the mobility of scientists in Community-wide biotechnology developments.

Health co-operation agreements²

A Memorandum of Understanding of Health Co-operation to cover the next two years was agreed with the People's Republic of China in October 1984. Co-operation will take place mainly in the following fields: cancer epidemiology; cardiovascular diseases; hospital management; nursing; hepatitis; medical bio-engineering; reproductive biology and neurology. Co-operation will take the following forms: exchange of specialists up to a total of 40 man-weeks from each side over the next two-year period; exchange of information; co-operation in matters relating to equipment, the safety, quality and efficacy of medical products, and technological developments; and the encouragement of direct links between appropriate institutions in each country.

The Health Co-operation Agreements with the German Democratic Republic, Hungary and Czechoslovakia were renewed for a further two years.

International mortality rates

At the WHO Regional Committee in September, the Member States of the European Region agreed a set of 38 targets intended to support the implementation of the European regional strategy for attaining Health for All by the Year 2000.

The targets cover a number of areas of concern including equity in health between and within countries, the promotion of healthy lifestyles and the reduction of specific behaviours harmful to health, the elimination or reduction of certain communicable and non-communicable diseases as well as environmental health risks, and the improvement of both the structure of, and accessibility to, the health services.³

Seven of the outcome targets relate to reduction in mortality. These are expressed in terms of either increased life expectancy or decreased overall mortality (infant and maternal mortaliy) or mortality from specific causes (diseases of the circulatory

	Discond								
Series neta Alle 2 Double and a Alle Antoi Sal Antoi Sal Antoi Sal Antoi Sal Antoi Sal Antoi Sal Antoi Sal	circulatory system	Ischaemic heart disease	Cerebro- vascular diseases	mangnant neoplasms all causes	Lung cancer	Cancer of the cervix	RTAs all ages	Suicides all ages	
England & Wales (1983)	114.20	80.00	17.50	00'66	25.70	5.09	9.46	8.42	
France (1981)	56.93	21.70	14.47	98.50	16.90	2.25	19.69	19.17	1
Federal Republic of Germany (1982)	87.48	44.25	14.90	88.40	16.40	3.43	16.21	19.93	1.5
Netherlands (1983)	76.40	49.40	10.50	89.40	22.70	2.60	11.17	12.21	12
Denmark (1983)	87.70	60.10	13.60	107.30	, 25.50	7.13	11.72	27.96	
Greece (1981)	67.91	30.80	18.54	75.80	17.10	1.32	14.99	3.27	*
Luxembourg (1982)	103.80	60.60	13.46	115.80	29.30	2.00	19.75	20.50	
Norway (1982)	84.69	61.20	11.07	78.30	13.70	5.73	9.69	14.48	
Sweden (1982)	79.40	55.00	12.00	72.70	10.80	3.29	8.82	18.70	
Finland (1981)	133.60	92.50	35.00	78.40	20.90	1.55	11.29	22.36	*
Italy (1979)	85.47	39.00	21.26	98.10	21.70	1.72	18.42	6.94	*
Ireland (1981)	128.85	88.86	20.59	93.67	22.03	4,44	18.06	77.T	
Belgium (1983)	**93.13	45.30	16.31	105.86	*28.32	3.75	22.41	22.45	
Regional average around 1981 for 28 member states	99.58	47.10	20.53	93.69	19.96	4.22	16.41(25)	15.28(25	6
* 1978 † 1983 ** 1981 ‡ 1984 *** 1982				aliy 1. Nortaji Tathagi Setti ing	8 I 	Ded	ta subplied by	the WHO F1	rone

system, malignant neoplasms, accidents and suicide).4

The Regional Office has been collecting data from Member States on mortality in selected areas covered by the targets, intended to assist Member States to measure their own progress over the next fifteen years in achieving the agreed targets.

An analysis of the mortality rates for six of the outcome targets (and their related subtargets) for the EC and Scandinavian countries is shown in Table 6.2. The figures have been provided by the WHO Regional Office for Europe and while they do not relate to the same year, they are the latest available, and provide rough baseline information around the year 1981. The data are expressed as age standardized rates per 100,000 population for the age group 0-64 years, except for suicides and road traffic accidents which cover all ages and infant and maternal mortality which are expressed in terms of crude death rates per 1,000 live births.

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CORRECTION

Page 3 (line 8): Delete (see Figure 1.6, page 29). See new figure below

Figure A:

Food poisoning notifications (formally notified) showing the highest and the lowest during years 1974 - 83 compared with 1984 (including Port Health Authorities) – England and Wales



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