DEPARTMENT OF HEALTH AND SOCIAL SECURITY

On the State of THE PUBLIC HEALTH for the year 1985

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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 1985

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 pleasure in submitting my report on the State of the Public Health in England during 1985.

The Report, shorter than recent predecessors, reflects a desire to present the most pertinent information clearly and succinctly while still achieving the main aims of the volume:

(i) to provide an historical record of the state of the Nation's health;

(ii) to act as a source of reference for statistical information;

(iii) to focus on the principal issues dealt with by the medical staff of the Department, including those relating to the NHS and its management.

I am grateful to the many colleagues who have contributed to the preparation of the Report. And my special thanks are expressed to members of the Office of Population Censuses and Surveys (OPCS) for the essential data presented in the section *'Vital Statistics'*.

Prevention

A considerable amount of disease and premature death in Britain is preventable, including not only much coronary heart disease, peripheral vascular disease, stroke and illness associated with obesity but also *many* cases of cancer, much infectious disease in childhood and accidents in all age groups. Further reductions in smoking, a reduction in the abuse of alcohol, changes in the diet in line with the recommendations of the Committee on the Medical Aspects of Food Policy and increased exercise would offer major benefits to the health of the nation.

The World Health Organization's (WHO's) strategy for 'Health for All' urges that priority should be given to health promotion and disease prevention and that stress should be placed on the role that individuals, families and communities can play in influencing their own health.

In Britain traffic accidents are a major cause of death especially in young males. The use of seat belts reduced the severity of injuries and the mortality from road traffic accidents in the year immediately after legislation was introduced. Fewer casualties needed hospital treatment, outpatient visits were reduced by 10% for drivers and 22% for the front seat passengers, admissions decreased by 23% for drivers and 43% for front seat passengers and the number of days in hospital fell by 27% for drivers and 35% for front seat passengers (see page 26).

This improvement demonstrates that preventive action of the right kind which carries conviction with the public is effective. It estimated that up to 450 lives have been saved and about 7,600 serious injuries avoided by the seat belt legislation.

Road accidents are the main cause of death in both males and females between the ages of 15 and 34 years and in 1985 were responsible for 28% of all deaths in young men in that age group. The aim should be to look at ways in which it might be possible to reduce further the number of deaths in road vehicle accidents. Accidents which involve alcohol are by far the most easily preventable. Measures to reduce the prevalence of driving under the influence of alcohol should be considered first of all.

Tobacco

OPCS data show a continuing reduction in the overall number of adult smokers. However more girls in the 14–15 age group seem to be taking up the habit, and the decline in smoking in women in general is slower than in men. These trends cause particular concern because of the known relationship between the increased risk of myocardial infarction, stroke and other cardiovascular disease in women who smoke and take the contraceptive pill. The adverse effects of smoking during pregnancy on the birthweight and perinatal mortality, and the increased incidence of respiratory disorders in infants under 3 years of age whose parents smoke ('passive smoking' effects) are additional significant reasons for seeking to decrease the prevalence of smoking in these groups. Studies are under way to find out the exact nature and reasons for this upswing in the 14–15 age group and to determine why they, and their mothers, seem more resistant to anti-smoking propaganda.

Since a plant to manufacture oral snuff tobacco was opened in Scotland in November 1984 medical opinion relating to the harm associated with the use of smokeless tobacco products has hardened. In addition to the fact that the use of oral snuff tobacco products leads to an increased incidence of cancers of the mouth there is the worry that 'snuff dipping' as it has been called may produce addiction to and dependence upon nicotine. In the United States of America the prevalence of this habit has increased rapidly among teenagers in recent years.

Alcohol misuse

Major difficulties exist in obtaining reliable estimates of the number of people with serious drinking problems and the costs of alcohol misuse in England and Wales. Rebecca McDonnell and Alan Maynard found significant gaps in the epidemiological data needed to compile relevant information, but their conservative estimate of the annual social costs of alcohol abuse, at 1983 prices, was in excess of £1500 million (see page 28).

Since 1965 the relative price of beer (the most popular alcoholic drink) in real terms has increased by about 20%. Those of wine and spirits have fallen by up to 50%. This is reflected in changes in per capita consumption which for beer has increased by 10% while for spirits it has doubled and for wine more than trebled over the same period.

Per capita consumption of alcohol per annum rose steadily from 5.2 litres in 1960 to 9.7 litres in 1979. It then declined slightly, but since 1982, the upward trend has been resumed and in 1984 stood at 9.2 litres.

Drug abuse

An increase in the reported availability and abuse of heroin focused attention on illicit drugs during 1985. Education programmes using television, pamphlets and audio-visual aids in schools were used to inform children, and their parents,

about the chemical properties of individual drugs, the symptoms and signs of abuse, and how to avoid involvement.

Two million pounds were allocated to education authorities to help them tackle the problems at local level. The importance of parental involvement in the fight against abuse is recognized and organizations such as Teachers Advisory Council, Alcohol and Drug Education (TACADE) are providing inservice training for teachers and life-coping skills programmes for pupils which help them make the right decisions when offered drugs — including tobacco and alcohol.

The worldwide nature of the drug problem was highlighted at the WHO/DHSS conference on drug abuse held in London in March 1986. Ministers of Health from 30 countries put aside political and cultural differences to discuss ways to establish an international network which would effectively restrict drug production (so lucrative for many poorer countries), trafficking and abuse. The emergence of home made ('designer') drugs is seen as a matter requiring urgent attention. Detection and control of these products, made popular as more efficient custom controls limit the movement of natural substances, will be extremely difficult. The Ministers' meeting was a precursor for further discussions to be held by the United Nations and the WHO.

Environmental health

Radiation in the environment

In 1985 a Committee on Medical Aspects of Radiation in the Environment (COMARE) was established to advise Government on the health effects of natural and man-made radiation in the environment and to assess the adequacy of the available data and the need for further research. This Committee has met four times and its first report has now been published.

On 26 April 1986 there was a serious accident at one of the nuclear reactors at Chernobyl in the USSR which caused the release of a cloud of radioactivity. Part of the cloud reached the UK on 2 May, and resulted in variable ground deposition of radiocative material. This was greater where rainfall occurred while the cloud was present. Intensive monitoring of external radiation, air concentration, ground deposits and certain foodstuffs, (eg milk, meat, fresh vegetables) was undertaken by the Ministry of Agriculture, Fisheries and Food (MAFF) and the National Radiological Protection Board (NRPB).

As an emergency measure DHSS instructed port health authorities to hold and test imports of certain fresh food from Russia and Poland. This instruction was later modified to take account of a European Community Regulation on food imports.

Members of the public returning from Russia and Poland were reassured by being monitored for radioactivity by NRPB or National Health Service Medical Physics Departments. Levels of exposure revealed were generally low, even for those who had been within a few hundred miles of Chernobyl.

Initial results of monitoring the UK food supply did not indicate any need for action. However, in June, the levels of radiocaesium in young lambs not yet ready for market in some areas of Cumbria, North Wales and Scotland were sufficiently high for the Government to decide to use powers in the Food and

Environment Protection Act 1985 to prohibit the movement and slaughter of sheep in the affected areas while further monitoring was undertaken.

Levels of radioactivity on the ground and in food generally are now declining; the situation continues to be monitored carefully. The results of monitoring are being made available to the public. A becquerel (Bq) measures the amount of radioactivity present in an item, while a sievert (Sv) measures the actual dose a person receives from radiation. To interpret the significance of the data more readily it may be helpful to realize that a chest X-ray gives a dose to the lungs of about 0.1 mSv (mSv = one thousandth of a sievert) while the average annual dose of radiation received from the background radiation to which everyone is exposed is 2 mSv. The average British person who eats lamb would receive a dose of less than 0.15 mSv if all the lamb he or she ate in the next year were to be contaminated at MAFF's action level for radiocaesium in lambs for slaughter (1000 Bq/kg). NRPB calculated that following the Chernobyl accident the dose of radiation that the average adult living in a high rainfall area is likely to receive over the next year is 0.3 mSv.

In the context of the average of 2 mSv we receive from background radiation in a year it can be appreciated that these doses should not give rise to concern. Nevertheless the public *were* very concerned when and after the radioactive cloud from Chernobyl reached the UK. Many people took actions which they hoped would reduce their exposure, although these actions were not always appropriate.

Fluoridation

In December 1983 the government announced its intention to legislate on fluoride following Lord Jauncey's judgement in the Strathclyde fluoridation court case. The Water (Fluoridation) Act, which followed, received the Royal Assent in October 1985. This Act clarified the powers of water undertakings and health authorities in the implementation of water fluoridation schemes.

Interim guidelines explaining the effect of the Act were sent to health authorities and at the time of writing plans to introduce fluoridation to the water supply of up to 1.25 million people in the West Midlands are well advanced.

Communicable diseases

AIDS

The spread of HTLV III/LAV within the population of the UK, and indeed throughout the world, provides one of the greatest challenges in communicable disease control in this century. The key feature which makes control of spread difficult is that infection is usually transmitted by sexual intercourse with persons who are often unaware that they are carrying the virus. A latent period of up to 5 years may exist between the date of infection and the development of the illness but not all carriers of HTLV III antibodies develop the syndrome. Studies of infected blood donors and seropositive homosexual men have shown that the virus can persist in the blood for more than 5 years. By far the most important non-sexual means of transmission is among drug abusers sharing needles, syringes and other equipment.

In the absence of any antiviral drug or an effective vaccine we have limited means at our disposal to control the virus. The three most important are informing the public how the infection is and is not spread, providing a safe supply of blood and

blood products and advising infected persons how they might avoid infecting others.

Public education is essential. Programmes should be aimed at the general public as well as at persons actually or possibly at risk. It is essential that everyone receives accurate information and myths are exposed.

Tests for specific antibodies to HTLV III infection were introduced by the National Blood Transfusion Service (NBTS) and made generally available in October 1985. The principal aim was to make blood transfusion as safe as possible. Provision has also been made for individuals who believe they might be at risk to be tested at centres such as clinics of genitourinary medicine.

Guidelines produced by the DHSS and listed later in this Report are revised and added to as new information becomes available. A direct information phoneline for professional enquiries is now linked to the special AIDS unit at headquarters and valuable information and support are being provided by community based organizations whose clients come mainly from high-risk groups and their families.

Food poisoning

Laboratory reports of Salmonella infections rose steadily from the mid 1960s until there was a small decrease in 1984 which continued into 1985. This may have been due to two cold summers. Education of the public as well as of caterers in food hygiene is not the only effective weapon available for protecting us from salmonellosis. All the stages in the chain that bring salmonella to man — farming methods, animal husbandry and transport, slaughter, food processing, retail and consumer practices — require attention in order to decrease or eliminate the salmonella load to which we are exposed.

The outbreak of salmonella food poisoning at Stanley Royd Hospital, Wakefield in August 1984 was the worst ever recorded in a hospital in the United Kingdom. Of the 788 patients resident in this psychogeriatric hospital at the time 355 were ill with suspected salmonellosis and 218 had positive stool cultures. An additional 81 asymptomatic patients were found to have positive stool cultures. Of the 980 staff, 106 were symptomatic, 51 having positive stool cultures. A further 29 members of staff had positive stools but were asymptomatic.

The causative organism was *Salmonella typhimurium* phage Type 49. This is found primarily in cattle and to a lesser extent in poultry, pigs and sheep. The strain which was epidemic in Stanley Royd Hospital conformed to that seen in poultry and not to that found in bovine animals in England and Wales. It is therefore presumed that it was brought into the hospital kitchens with raw poultry, which contaminated cooked beef later served to patients and staff.

The Report of the public enquiry into the outbreak at Stanley Royd Hospital made recommendations about the control of infection in hospital and about how to handle episodes of food poisoning. These have been referred to the Hospital Infection Working Group (Chairman — Professor Mary Cooke). Legislation to apply the Food Act and the Food Hygiene Regulations to health authority premises has also been brought forward and relevant Departmental guidance is to be revised.

Legionnaires disease

In April 1985, the newly built Stafford District General Hospital was the setting for the worst outbreak of Legionnaires Disease yet recorded in the United Kingdom. The Secretary of State appointed a Committee of Enquiry on 7 June 1985 (Chairman — Sir John Badenoch) with the following terms of reference:

- to enquire into the cause of the recent outbreak of Legionnaires disease in Staffordshire.
- to consider the adequacy of measures taken to investigate and to deal with the outbreak; and
- to report to the Secretary of State for Social Services and make recommendations on any action necessary to reduce the danger of future outbreaks originating in hospitals, other buildings and elsewhere.

The first part of the Committee's Report was published in June 1986 and dealt with the events at Stafford. Patients, visitors and staff at the hospital were exposed to a pathogenic strain of *Legionella pneumophila* (serogroup Pontiac 1A) from 9 to 19 April. The organism was disseminated via an aerosol from contaminated water in a cooling tower which fed the hospital air conditioning system.

Details of 68 confirmed cases and of 19 presumptive cases of Legionella pneumonia admitted to hospital and 14 cases treated by their general practitioners were given. All the patients had attended clinics or visited the Stafford District General Hospital during the two weeks before the onset of their illness. Twenty-eight of the 101 cases died. This mortality was second only to the episode in Pennsylvania from which the disease was first recognized in 1976.

The Report concluded that the outbreak could not be attributed to any single factor nor were any individual or groups responsible. Circumstances which might have had an effect were the design, installation and maintenance of the engineering services and the weather conditions during the month in which the infections occurred.

The Committee of Enquiry recommended a review of the Stafford microbiological services and a national investigation to determine the risk of Legionella contamination of air conditioning systems with water spray cooling devices. Following revised guidelines issued to Health Authorities in January 1986 and after consultation with Sir John Badenoch further guidance was issued to Health Authorities asking them to inspect sites and to take necessary remedial action.

Water spray cooling towers at present in use will be considered for replacement. Those towers near the end of their useful life or those which present particular maintenance problems will receive priority. Hospital building policy currently recommends smaller hospitals and this reduces the need to rely on air conditioning. Air-cooled systems are to be preferred.

The Committee of Enquiry will publish the second part of the Report which will cover the cause of Legionnaires disease and how to reduce its incidence later in 1986.

Primary health care

Primary health care is the fundamental basis of the Health for All strategy of the WHO. In 1984 member states in Europe developed a set of targets many of which needed the existence of comprehensive accessible services based on primary health care if a successful outcome was to be achieved.

This Report for 1984 identified a growing interest in this country in the future of primary health care, where first contact with the patient usually takes place and where much of the most effective work on health promotion and on the prevention of illness is done.

During 1985 the Royal College of General Practitioners published a policy statement concerned with the quality of care in general practice and the Government completed its review of primary care. *'Primary Health Care – an agenda for discussion* (see page 66) was published as a result of the review in April 1986. The latter document sets out a number of proposals many of which are concerned with ways of improving the effectiveness and efficiency of the four contractor professions — doctors, dentists, pharmacists and opticians — while making them more responsive to the needs of the patient.

An independent report on the future of the community nursing services in England appeared at the same time.

The discussions which are taking place following the publication of these documents are an opportunity for the health professions and bodies representing the interests of patients and the general public to help shape a future system of care which offers all patients high quality, efficient and cost effective services.

Clinical services

The Secretary of State publishes an annual report on the Health Service in England. This includes statistical information about hospital and personal social services and reviews current performance relating to management, manpower, funding and expenditure.

Some of these topics are also considered from a more clinical point of view in Chapter 6 of this Report eg heart transplantation, breast and cervical screening for cancer.

The Supra Regional Advisory Group considered future arrangements for funding heart transplantations and evaluated the costs and benefits of the heart transplant programmes at Harefield and Papworth Hospitals. A total funding of £2.6m was allotted for 1986/87.

Screening arouses much public interest and concern was expressed in the media during 1985 that not all cervical smears were being followed up properly. Ministers asked health authorities to give priority to improving cervical cancer screening programmes. This included making sure that laboratories could meet demands and avoid backlogs of more than one month's work. Computerized call and recall systems are to be implemented no later than 1987–88. Such systems will achieve a much higher screening rate for women over 35 years of age. This group of women are most at risk and least likely to have been screened.

Breast cancer screening by mammography has still to be fully evaluated. During the year a Working Party was set up to look at policy options and to assess

associated costs and benefits. An interim report concluded that mammographic screening could lead to the prolongation of life in women over 50 years of age with breast cancer. However, the Working Party recommended that screening should not begin until facilities had been provided to assess the abnormalities that would be detected. A final report is expected later in 1986.

The confidential enquiry into maternal deaths first presented in the triennium 1951–53 is one of the earliest examples of clinical audit. The latest report covering 1979–81 shows a maternal mortality rate of 8.9 per cent per 100,000 total births, a reduction of 90% since 1951.

Committee of Inquiry into the public health function

In January 1986 I was asked by the Secretary of State to chair a Committee of Inquiry with the following terms of reference:

> "To consider the future development of the public health function, including the control of communicable diseases and the specialty of community medicine, following the introduction of general management into the hospital and commmunity health services, and recognizing a continued need for improvements in effectiveness and efficiency".

Although the Inquiry was established following publication of the report of the Committee of Inquiry into the food poisoning outbreak at Stanley Royd Hospital, Wakefield in 1984 its work is not limited to the control of communicable disease. For example it has also been asked to look into the concern which has been expressed by a number of medical bodies about the specialty of community medicine and the impact recent changes in the management of the NHS might be having on its continuing ability to fulfil its functions and to examine certain wider aspects of public health.

By mid-1986 the Committee had begun taking evidence. It had already become clear that in view of the breadth and complexity of the public health function in today's society the remit of the Inquiry would need to be circumscribed to some degree. It will certainly need to examine the role of the Department of Health and Social Security in relation to public health together with those of the Public Health Laboratory Service, the Communicable Disease Surveillance Centre and the Health Education Council; also the roles of the Health and Local Authorities and the primary care sector including the Family Practitioner Committees. The Inquiry will consider those factors deriving from personal behaviour and lifestyle which play a part in determining health and will therefore be concerned with health promotion and health education. However, it will not be expected to cover those aspects of public health which are shared with the Department of Environment or the Ministry of Agriculture, Fisheries and Food or are discharged by specialized technical agencies such as the Health and Safety Executive or the National Radiological Protection Board. Nor will it be expected to deal in any depth with the complex social factors underlying health eg housing, employment, poverty, important though these are recognized to be.

I am, Sir
Your obedient servant

E D Acheson
July, 1986.

1. VITAL STATISTICS

a Population size

The estimated resident population of England on 30 June 1985 was 47,112,000 persons, an increase of 0.3% over 1984. There was a 4% increase in live births and a net gain in population due to migration of about 76,000. This was due to a rise of over 20% in the estimated number of immigrants from outside the British Isles while the number of emigrants leaving England for destinations beyond the UK increased by 8%.

b Age and sex structure of the resident population

Table 1.1 shows how the size of the population in various age/sex groups has changed since 1981. The number of children of school age (5–15 years) has fallen by over 10% since 1981 but the decrease of just under 2% between mid 1984 and mid 1985 was half that for 1981–82. On the other hand the number of adults of working age (16–64 years for men and 16–59 years for women) continued to increase in the year ending mid 1985. The number of people of pensionable age also continued to rise; in particular those aged 60–74 years (females) or 65–70 years (males) increased for the first time since 1980–81. The percentage increase for men in these age groups was higher than for women because a relatively large cohort of men were born in the year mid 1919 to mid 1920. The most dramatic change in the year ending mid 1985 was the increase of over 4% in those aged 85 years and over. In 1985 this group numbered 581,000. Men account for only one third of all people over the age of retirement and less than a quarter of people aged 85 years and over. These proportions have changed very little since 1981.

Table 1.1: Population age and sex structure 1985, and changes by age 1981-85: England

Age	Resident population 1985 (thousands)			Percentage change (persons)			
	Persons	Males	Females	1981-82	1982-83	1983-84	1984-85
Under 1	613	314	299	-2.2	0.4	0.0	4.2
1-4	2,361	1,210	1,151	3.1	2.2	0.5	-0.3
5-15	6,694	3,439	3,255	-3.5	-3.2	-2.2	-1.7
16-29	10,376	5,273	5,103	1.2	1.4	1.3	1.4
30-44	9,507	4,781	4,726	0.6	0.8	1.1	1.0
45-64/59*	8,999	5,112	3,888	-0.5	0.1	0.1	-0.8
65/60-74**	5,510	1,820	3,690	-0.4	-1.2	-1.1	0.4
75-84	2,471	882	1,588	2.4	2.7	2.5	1.8
85 & over	581	135	446	3.2	2.5	3.3	4.1
All ages	47,112	22,966	24,145	-0.1	0.1	0.2	0.3

* 45-64 for males, 45-59 for females
** 65-74 for males, 60-74 for females
Figures may not add due to rounding.

c Fertility statistics — aspects of relevance for health care

Teenage conceptions

New statistics covering all conceptions in residents of England and Wales which lead to a maternity or to a legal termination under the 1967 Abortion Act were

published during 1984 and subsequently updated (OPCS Monitor FMI 85/8). The figures do not include conceptions leading to spontaneous abortions. In Table 1.2 the numbers and rates of girls becoming pregnant at ages under 16 years and under 20 years are compared for the years 1973 and 1983 — the overall conception rate per 1,000 female population aged 13–15 years fell by 10% and the proportion of conceptions terminated by abortion increased (from 45% to 57%). The conception rate per 1,000 female population aged 15–19 years fell by a quarter between 1973 and 1983 but the proportion terminated by abortion increased from 23% to 33%. There were sharp falls between 1973 and 1983 in the proportion of teenage conceptions accounted for by births to married women.

First legitimate births to women aged 30 years and over

First births to women aged 30 years and over are of medical interest in view of the greater likelihood of obstetric problems with a first pregnancy at these older ages. Table 1.3 shows that during 1985 there were more first births within marriage to women in this age group than in 1965, when total numbers of births were close to a post-war peak. Increases have mainly occurred for women aged 30–34 years and in 1985 they accounted for an estimated 14% of all legitimate first births.

Average age of mother at first legitimate birth

The average age at which women marry and the longer interval between marriage and first birth increase the average age at which women have children. Table 1.4 shows that the average age at first legitimate birth has increased between 1975 and 1985 from 24.7 years to 26.0 years and that the differences between the social classes has widened.

Sex ratio of births

Table 1.5 shows that although the numbers of male live births were still about 5% greater there were relatively fewer live male births per 1,000 live female births in 1985 than there were in 1975 and 1965. The proportion of male and female births varied little for mothers of different ages.

d Mortality and morbidity statistics

The level of mortality was higher in 1985 than in the previous year — with a total of 553,150 deaths (531,314 in 1984) and a crude mortality rate of 11.7 per thousand population (11.3 in 1984). The analyses of sex, cause, and age are set out in Table 1.6. This presents the five commonest causes of death in each of five age sub-groups of the population for males and females, together with data by sex for all ages. Infant deaths are dealt with separately in the following sub-section.

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 (MN) of the digestive organs and peritoneum; if a finer split of the cause of death had been used, such as 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.

Table 1.2: Teenage conceptions: Numbers and rates, 1973 and 1983, England and Wales

Age at conception/ Year of conception	All Conceptions	Conceptions outside marriage					Conceptions inside marriage		
		Total	*Illegitimate maternities** Sole registrations	Joint maternities	Legitimate† maternities	Abortions under the 1967 Act	Total	Maternities	Abortions under the 1967 Act
(a) *Numbers (thousands)*									
Under 16									
1973	9.8	9.7	2.8	1.1	1.4	4.4	0.1	0.1	0.0
1983	9.4	9.3	2.3	1.5	0.3	5.3	0.0	0.0	0.0
Under 20									
1973	125.7	84.3	16.5	8.2	31.7	27.9	41.3	40.3	1.0
1983	112.4	91.0	17.7	22.1	14.6	36.6	21.3	20.6	0.7
(b) *Rates per 1000 girls*									
Under 16									
1973	9.2	9.1	2.7	1.0	1.4	4.1	0.1	0.0	0.0
1983	8.3	8.3	2.0	1.3	0.3	4.7	0.0	0.0	0.0
Under 20									
1973	75.3	50.5	9.9	4.9	19.0	16.7	24.8	24.2	0.6
1983	56.0	45.3	8.8	11.0	7.3	18.3	10.6	10.3	0.4

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 both mother and father (Joint).

Table 1.3: First legitimate births to women aged 30 years and over, 1965, 1975, 1985, England and Wales

Age of mother	Number of births (000s)		
	1965	1975	1985
All ages 30 and over	31.4	23.6	37.3
30-34	22.0	18.6	29.5
35-39	7.6	4.2	7.0
40-44	1.7	0.8	0.8
45 and over	0.1	0.0	0.0

Table 1.4: Mean age of women at first legitimate live birth according to social class* of husband: 1975, 1985.

Social class of husband	Mean age of woman at first legitimate birth	
	1975	1985
All Social Classes (including 'other')	24.7	26.0
I and II	26.7	28.0
III Non-manual	25.6	26.5
III Manual	24.0	25.2
IV and V	23.0	24.0

* Definition of Registrar General's Social Classes

Non-manual:	I	Professional occupations
	II	Intermediate occupations (including most managerial and senior administrative occupations)
	IIIN	Skilled occupations (non-manual)
Manual:	IIIM	Skilled occupations (manual)
	IV	Partly skilled occupations
	V	Unskilled occupations
Other:		Residual groups including for example, Armed Forces, students and those whose occupations were inadequately described

Table 1.5: Sex ratio of live births: 1965, 1975, 1985, England and Wales

Age of mother	Male live births per 1,000 female live births		
	1965	1975	1985
All ages	1,056	1,062	1,054
Under 20	1,066	1,063	1,050
20-24	1,057	1,057	1,063
25-29	1,056	1,065	1,048
30-34	1,056	1,067	1,053
35 and over	1,047	1,047	1,056

Table 1.6: Five main causes of death at different ages (and percentages of all causes of deaths) England, 1985

RANK	All ages		1-14		15-34		35-54		55-74		75 and over	
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
1	Ischaemic heart disease 31%	Ischaemic heart disease 24%	Road vehicle accidents 20%	Congenital anomalies 18%	Road vehicle accidents 28%	Road vehicle accidents 15%	Ischaemic heart disease 35%	MN* of bone, connective tissue, skin and breast 20%	Ischaemic heart disease 36%	Ischaemic heart disease 26%	Ischaemic heart disease 28%	Ischaemic heart disease 25%
2	Cerebro-vascular disease 9%	Cerebro-vascular disease 15%	Other causes of injury and poisoning 20%	Road vehicle accidents 13%	Other causes of injury and poisoning 17%	Other causes of injury and poisoning 12%	MN* of digestive organs and peritoneum 8%	MN* of genito-urinary organs 10%	MN* of respiratory and intrathoracic organs 13%	Cerebro-vascular disease 11%	Cerebro-vascular disease 13%	Cerebro-vascular disease 18%
3	MN* of respiratory and intrathoracic organs 9%	Other diseases of the circulatory system 10%	Congenital anomalies 12%	Other causes of injury and poisoning 13%	Suicide and self-inflicted injury 15%	Suicide and self-inflicted injury 9%	MN* of respiratory and intrathoracic organs 8%	Ischaemic heart disease 10%	MN* of digestive organs and peritoneum 9%	MN* of digestive organs and peritoneum 9%	Other diseases of the circulatory system 9%	Other diseases of the circulatory system 12%
4	MN* of digestive organs and peritoneum 7%	MN* of digestive organs and peritoneum 7%	Diseases of the nervous system and sense organs 9%	Diseases of the nervous system and sense organs 11%	Diseases of the nervous system and sense organs 6%	MN* of bone, connective tissue, skin and breast 8%	Other causes of injury and poisoning 5%	MN* of digestive organs and peritoneum 9%	Cerebro-vascular disease 8%	MN* of bone connective tissue, skin and breast 8%	Chronic obstructive pulmonary disease and allied conditions 9%	Pneumonia 8%
5	Chronic obstructive pulmonary disease and allied conditions 7%	Pneumonia 6%	MN* of lymphatic and haema-topoietic tissue 6%	MN* of lymphatic and haema-topoietic tissue 5%	MN* of lymphatic and haema-topoietic tissue 5%	MN* of genito-urniary organs 6%	Suicide and self-inflicted injury 5%	Cerebro-vascular disease 7%	Chronic obstructive pulmonary disease and allied conditions 7%	MN* of respiratory and intra-thoracic organs 7%	MN* of respiratory and intra-thoracic organs 7%	MN* of digestive organs and peritoneum 5%
Remainder	35%	38%	34%	39%	30%	51%	38%	44%	27%	40%	35%	31%
All causes of death	273,399 100%	279,751 100%	1,346 100%	947 100%	5,611 100%	2,534 100%	19,058 100%	12,031 100%	122,599 100%	81,092 100%	121,531 100%	180,685 100%

*MN = malignant neoplasms

In children aged 1–14 years road accidents are the first ranked cause of death in males and the second in females; other types of injury and poisoning also figure high in the lists. Congenital malformation is ranked third in males but first in females. In this age-group the high fatality from neoplasms of the lymphatic and haematopoietic system (predominantly Hodgkin's disease, non-Hodgkin's lymphoma, and leukaemia) is reflected by its appearance in fifth place for both males and females.

Accidents and other causes of injury and poisoning are also common causes of death in both males and females aged 15–34 years. Suicide and self-inflicted injury is in the third place for both sexes.

By the age of 34–54 years ischaemic heart disease has risen to the first in males, whilst breast cancer is responsible for a broader group of neoplasms being the commonest cause of death for females. Ischaemic heart disease is the commonest cause of death in both sexes at the two older age-groups.

The final row in Table 1.6 shows the number of deaths from all causes. Only about 0.5% of all deaths occur between one and 14 years of age with the main contribution occurring in the age-group 55–74 years for males, and 75+ years for females. Nearly two-thirds of all deaths (66.1%) in females occur after the age of 75 years.

Infant and perinatal mortality

The proportion of illegitimate live births has been increasing in England and Wales since 1955 and reached 17.3% in 1984. In that year 63% of illegitimate live births were registered jointly by both parents, and about three-quarters of these parents gave the same usual address. This suggests that these children were born into stable unions. A much lower proportion of illegitimate stillbirths were jointly registered.

The rates for perinatal and infant mortality continue to improve. Combined 1982–1984 data for England and Wales for these rates by birthweight, cause, age of mother and legitimacy are presented in Table 1.7.

Perinatal mortality rates are broadly considered to reflect the medical care of the mother and child, whereas infant mortality rates are generally taken to reflect the social conditions into which the baby is born.

From Table 1.7 it can be seen that the percentage of births under 2,500g was about 50% higher for illegitimate births, with little difference between those registered by one parent alone or by both. Although birthweight is one of the principal predictors of perinatal mortality, the perinatal mortality rate was appreciably higher for solely registered than for jointly registered illegitimate births. This apparent discrepancy is associated with a high proportion of solely registered illegitimate stillbirths. Couples may be less motivated to register illegitimate stillbirths jointly.

Decennial supplement on area mortality

Using mortality around each decennial census, OPCS prepares analyses of area mortality. On this occasion the geographical distribution of deaths from stomach cancer which has been a topic of interest for more than 50 years, has been selected

Table 1.7: Perinatal and infant mortality rates by birthweight, cause, age of mother and legitimacy, 1982-1984, England and Wales.

*Perinatal mortality**

	Legitimacy			
	All births	legitimate births	Jointly registered illegitimate births	Solely registered illegitimate births
Birthweight				
Total stated	10.0	9.5	9.5	16.8
under 2,500g	94.1	94.9	74.3	115.3
2,500g and over	3.6	3.5	3.0	5.4
Cause				
All causes	10.6	10.1	10.0	17.8
Congenital malformations	2.1	2.1	1.6	2.6
Other causes	8.5	8.0	8.3	15.3
Age of mother				
All ages	10.6	10.1	10.0	17.8
under 20	13.7	12.3	11.6	18.2
20-29	9.9	9.6	9.3	16.3
30 and over	11.1	10.8	9.8	23.8
Percentage low birthweight†	7.0%	6.5%	9.1%	10.4%

* rates per 1,000 live and still births
† under 2,500g as a percentage of total births with a stated birthweight

*Infant mortality**

	Legitimacy			
	All births	legitimate births	Jointly registered illegitimate births	Solely registered illegitimate births
Birthweight				
Total stated	9.5	8.8	11.7	14.9
under 2,500g	67.8	66.5	68.4	78.5
2,500g and over	5.3	5.0	6.3	8.0
Cause				
All causes	10.0	9.3	12.2	15.7
Congenital malformations	2.7	2.7	2.5	2.9
Other causes	7.3	6.6	9.7	12.7
Age of mother				
All ages	10.0	9.3	12.2	15.7
under 20	15.2	14.6	14.8	16.5
20-29	9.8	9.2	11.8	15.3
30 and over	8.9	8.7	9.3	14.4
Percentage low birthweight†	6.7%	6.2%	8.9%	9.8%

* rates per 1,000 live births
† under 2,500g as a percentage of live births with a stated birthweight

for consideration here. Figure 1.1 shows the results of the analysis for stomach cancer deaths in males in 1979–83.

Maps of the distribution of stomach cancer in 1921–30 showed an excess mortality in the north west of Wales with zones of high mortality also in the north east and north west of England. The pattern remained similar for 1951, with a further increase in the mortality in the north east. By 1981 there was an extension of high mortality to include Staffordshire. In all three time periods the south and east of England had low rates and mortality throughout Wales was high.

There is a genetic component affecting the risk of developing cancer of the stomach. Stocks[2] found an association with atmospheric pollution, whilst the Registrar General's decennial supplement on occupational mortality for England and Wales in 1970–72[3] revealed an increased mortality in dusty jobs such as coal mining. Alderson[4] in a review of the aetiology indicated that deficiency of fresh food, vegetables and salads was associated with increased risk. Andogenous or exogenous nitrosamines had been proposed as relevant but this was on somewhat tenuous evidence. Coggan and Acheson[5] concluded that though the causes are largely unknown, differences in diet probably provided an explanation for the geographical differences.

Decennial supplement on occupational mortality

Decennial supplements on occupational mortality were first published for 1851. The latest in the series covers Great Britain for the first time. Previous studies dealt with England and Wales and Scotland separately. The new edition[6] analyses deaths in 1979–80 and 1982–83 in relation to the 1981 Census population. The emphasis is on making the maximum amount of data available and on avoiding or overcoming any bias inherent in the study design. The commentary identifies several possible associations between specific occupations and causes of death. Even relatively small numbers of deaths can be profitably studied. For example, the suggestion of an excess of motor neurone disease in leather workers is based on only nine deaths, but the report notes this finding is consistent with findings in the previous two Decennial supplements and in another analysis.

Discharges from hospital

OPCS process a 10% sample of discharges from non-psychiatric hospitals in England; before 1982 the data included discharges in Wales. Figure 1.2 shows trends in discharge rates from 1958 onwards for males and females aged 65–74 years and 75 years and over following perforated duodenal ulcer. In males aged 65–74 years the rates have dropped but for those of 75 years and over they have increased slightly. In females aged 65–74 years the rates show a slight increase but for those aged 75 years or more the rise is more marked. The reasons for these findings are not clear[7] but it has been postulated that increased use of non-steroidal anti-inflammatory drugs may account for part of it[8].

The different patterns of disease reflected in statistics of cause of death, hospital discharges, and contact with general practitioners

Preliminary results from the Third National Study of Morbidity Statistics from General Practice which recorded face-to-face consultations with doctors in 48 practices in England and Wales between July 1981 and July 1982 were recently published[9].

Figure 1.1:
Deaths in males from stomach cancer, England and Wales, 1979–83. (1981 Standardised Mortality Ratios England and Wales, 1981 = 100).

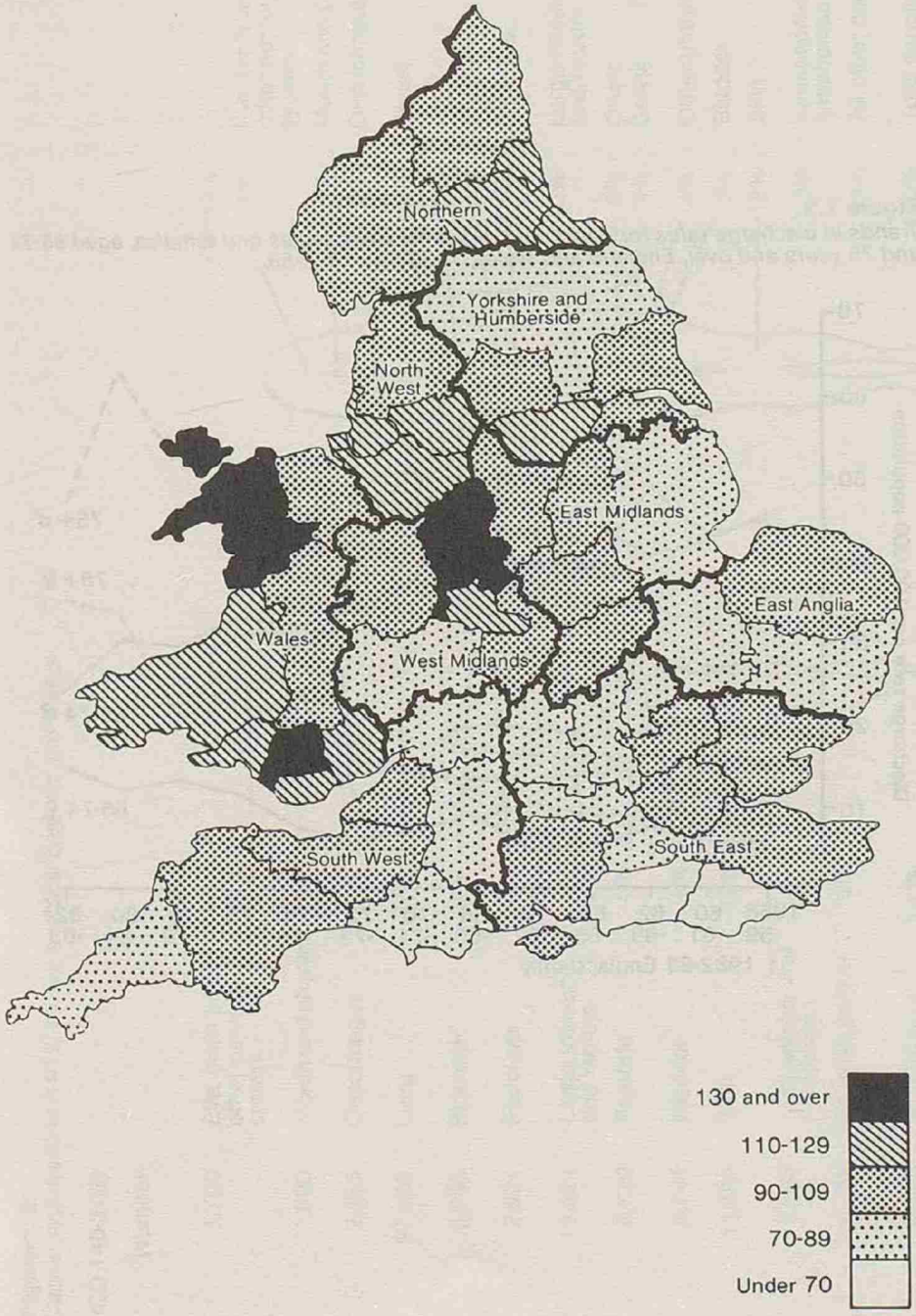


Figure 1.2:
Trends in discharge rates for perforated duodenal ulcer, males and females, aged 65-74 and 75 years and over, England and Wales, 1958-59 - 1982-83.

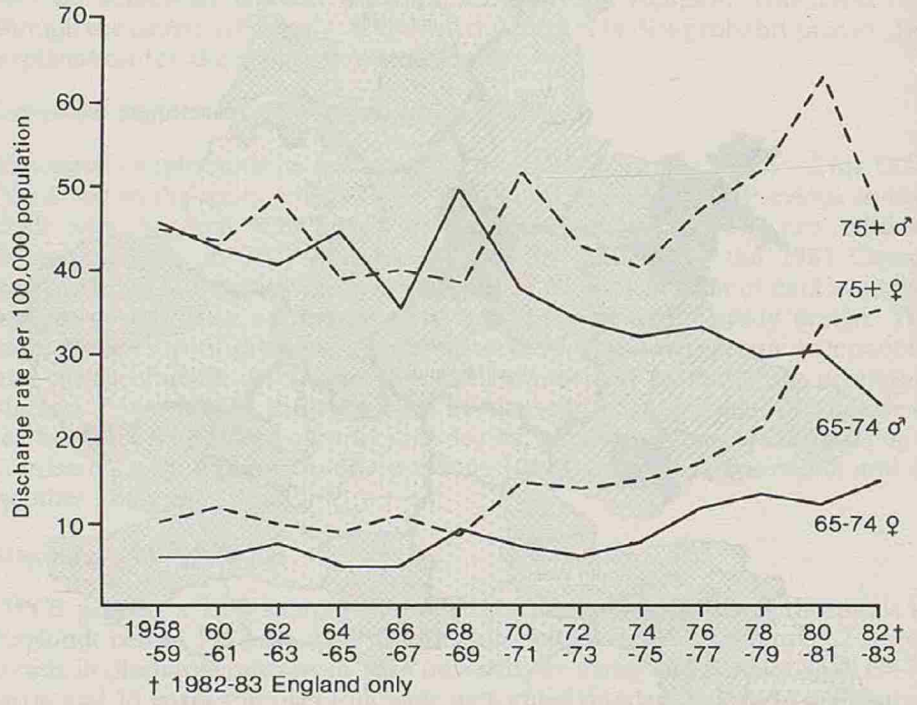
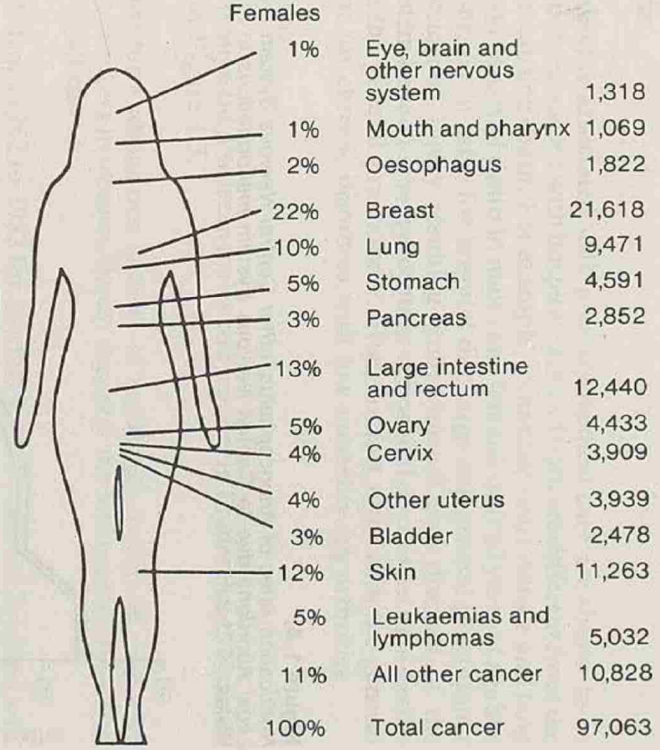


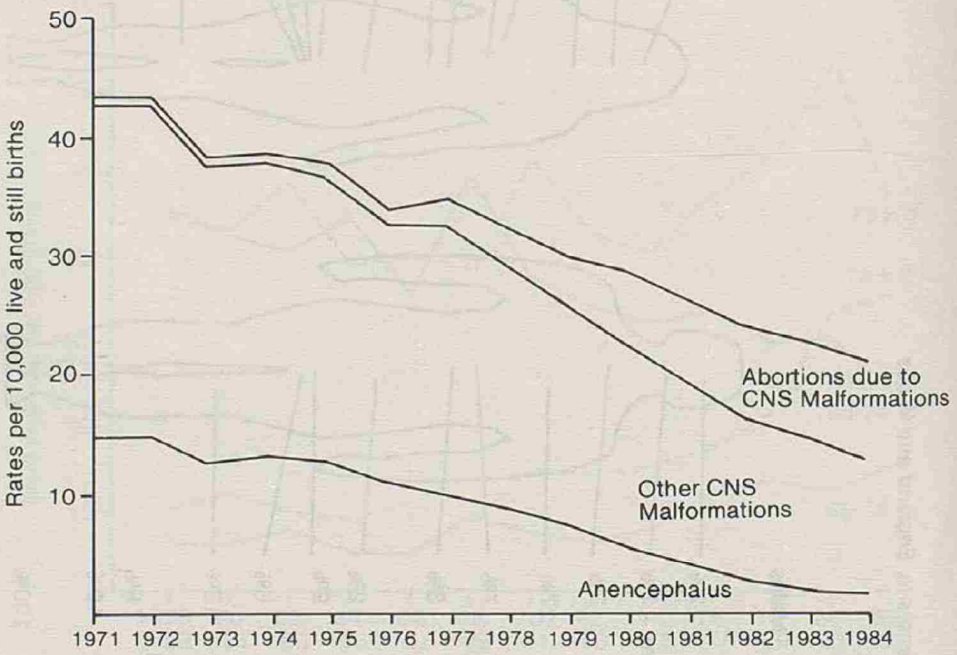
Figure 1.3:
Cancer registrations (1982) by sex and site, England and Wales

(ICD 140-208)



Number	Males		Females	Number
1,700	Eye, brain and other nervous system	2%	1%	Eye, brain and other nervous system 1,318
1,890	Mouth and pharynx	2%	1%	Mouth and pharynx 1,069
2,365	Oesophagus	2%	2%	Oesophagus 1,822
27,453	Lung	27%	22%	Breast 21,618
6,946	Stomach	7%	10%	Lung 9,471
2,901	Pancreas	3%	5%	Stomach 4,591
11,521	Large intestine and rectum	12%	3%	Pancreas 2,852
8,879	Prostate	9%	13%	Large intestine and rectum 12,440
6,741	Bladder	6%	5%	Ovary 4,433
11,693	Skin	12%	4%	Cervix 3,909
5,785	Leukaemias and lymphomas	6%	4%	Other uterus 3,939
12,458	All other cancer	12%	3%	Bladder 2,478
			12%	Skin 11,263
			5%	Leukaemias and lymphomas 5,032
			11%	All other cancer 10,828
100,062	Total cancer	100%	100%	Total cancer 97,063

Figure 1.4:
Notification rates of Anencephalus, other Central Nervous System malformations, and Legal Abortions due to Central Nervous System malformations in fetus, England and Wales, 1971-84.



If data obtained from this Study are compared with statistics on mortality and with returns relating to hospital discharge a more balanced picture of the burden of disease emerges.

The patterns of disease associated with primary medical care are shown to be different from those associated with hospital care and both are different from the pattern of disease causing death. For example, ischaemic heart disease and lung cancer are common causes of death in males and females over 65 years of age but figure less prominently in rates for hospital discharge and general practitioner consultation. Accidents, injury resulting from violence and diseases of the genitourinary system have a higher percentage of hospital discharges than deaths or contacts with the general practitioner. High contact rates with the general practitioner occur for chronic disorders with low mortality (eg arthritis).

Cancer registrations

The main sites of malignant disease in males and females in England and Wales in 1982 are shown in Figure 1.3.

Lung cancer constitutes about one quarter of registered cancers in men and about one tenth of cancers in women. Breast cancer is the most common cancer in women (22% of all cases).

Data are available from 1962 to 1982 for mortality from cancer in England and Wales. At four sites there has been an indication in the recent past of increases in incidence or mortality.

(1) *Cervical cancer:* Concern has been expressed that the incidence and mortality from cancer of the cervix has increased in younger women. [10,11] The statistics show that mortality decreased from 1962 to 1972 but that since that year there has been a rise from about 15 to 21 deaths per 100,000 population in women aged 35–44 years. Although the numbers involved are very small a rise in mortality has also taken place in younger women during that period.

(2) *Testicular cancer:* Several studies have drawn attention to an increase in testicular cancer[12,13]. In England and Wales the incidence has increased from 4 to 7 per 100,000 males aged 35–44 years between 1962 and 1982.

(3). *Cancer of the pancreas:* A marked rise in pancreatic cancer at older age groups has been noted[14]. Part of this rise is probably due to improved diagnosis. The malignancy appears to be associated with smoking.

(4). *Multiple myeloma:* Increased mortality from multiple myeloma has been reported in the UK and USA [15,16,17]. Part of this increase results from improved diagnosis but a genuine increase is thought to have occurred. The number of registrations in England and Wales, particularly in the elderly has increased in recent years.

Congenital malformations

The major source of information on congenital malformations in England and Wales is the national monitoring scheme which provides an early warning of any sudden increase in the prevalence of congenital defects. The voluntary nature of this scheme and the fact that it records only those cases diagnosed in the first

week of life does not affect its ability to monitor changes in prevalence of malformation but may affect its usefulness in the investigation of alleged environmental hazards to health in a specific area. The Welsh Office recently attempted to overcome this problem when investigating an environmental hazard in Gwent by performing separate analyses on specially collected local data as well as information obtained from the national notification scheme[18].

Figure 1.4 shows the steady decline in notification of central nervous system (CNS) malformations, particularly anencephalus between 1971 and 1984 in England and Wales. Mortality from CNS defects has also been decreased. The increment in abortions where CNS defects in the fetus were cited as the cause is also shown in Figure 1.4. It can be seen that screening and subsequent elective abortion has not been the major cause of the decline in congenital nervous system defects.

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2. PREVENTION AND ENVIRONMENTAL HEALTH

Prevention

(i) Smoking and health

Promoting non-smoking in the NHS

Health authorities make an important contribution to the Government's efforts to discourage smoking by persuasion and example. The NHS has an important exemplar role and patients in hospital and their visitors are likely to be particularly responsive to the attitudes to smoking they find there. In addition, as good employers, health authorities will wish to provide smoke-free canteen and rest room facilities for the two-thirds of their staff who do not smoke.

In March 1985 in conjunction with No-Smoking Day, the DHSS sponsored a one-day conference entitled *'The NHS and Action Against Smoking'*. The conference, which was opened by Mr John Patten, the then Parliamentary Secretary for Health, was attended by over 200 senior health service staff and included contributions on how the NHS could help people to give up smoking and the problems and opportunities presented to NHS management by promoting non-smoking on health services premises.

A revised circular *'Promoting Non-smoking on NHS Premises'* (HC(85)22), was issued in May 1985[1]. The new circular drew attention to the shift in public attitudes which was taking place, illustrated by the steady expansion of non-smoking facilities in public places, and gave guidance as to the desirable practice to be aimed at in hospitals and other NHS premises. In particular, where they had not already done so health authorities were asked to draw up written statements of their policy. The circular was accompanied by material produced by the Health Education Council (HEC), including model leaflets for patients, visitors and staff.

Smoking among young people

The level of cigarette smoking among young people continues to give cause for concern. The first national survey of smoking habits among secondary school children carried out by OPCS in 1982 was repeated two years later and the results were published in December 1985[2].

Overall, the findings of the survey were that despite the continued fall in adult smoking there had been no reduction in smoking among young people between 1982 and 1984. Among certain age-groups, for example 14–15-year-old girls, smoking appeared to be on the increase.

Most pupils accepted that smoking is associated with health risks. However, about a third of all pupils thought smoking was only harmful to those who smoked a lot.

The decline in smoking prevalence among women has been less rapid than among men. However, in the last 10 years the proportion of women who smoke has fallen by about one fifth, from 41% in 1972 to 32% in 1984.

During the year the Government in collaboration with the HEC initiated an advertising campaign specifically aimed at young people. This was a pilot project involving specially produced advertisements to be shown on television and in

cinemas in two television areas: Tyne Tees and TV South. The reaction to the campaign is to be carefully evaluated. The campaign was piloted on an advertising spend equivalent to a £6m national campaign. This represented a much heavier weight of advertising than had been tried hitherto in health campaigns.

In addition, an extra grant of £½m was made to the HEC specifically for a campaign aimed at women. It was to include television advertisements, supported by others in leading women's magazines.

British Medical Association (BMA) attack on cigarette advertising
Following the publication by the Royal College of Physicians of their fourth report[3] on the health hazards of smoking and as the Government prepared to re-negotiate its voluntary agreements with the tobacco companies on advertising and sports sponsorship, the BMA began to lay increasing emphasis on the need for a greater degree of control to be exercised over the advertising of cigarettes along the lines of the measures introduced in some Scandinavian countries.

In May Lord Pitt, a medically qualified peer and President-Elect of the BMA, introduced into the House of Lords a Bill to ban all advertising of tobacco products. The Bill attracted some attention but fell at second reading.

The campaign reached a climax towards the end of the year with the launch of a joint BMA/HEC publication entitled *'The big kill'*[4]. This consisted of a 15-volume report analysing the number of premature deaths, hospital admissions, and cost to the NHS of smoking-related diseases in England and Wales, by regional and district health authority, and Parliamentary and European constituency. The publication was distributed on a very large scale and received much media coverage.

Low-tar cigarettes
The fundamental objective of health in this field must continue to be to discourage people from starting to smoke and to help existing smokers to give up. But without in any way compromising these goals it must be recognized that not all smokers can be persuaded to stop. For people who cannot or do not wish to give up the habit, encouragement to adopt lower tar brands may be the most effective means of reducing the health hazard a little. The downward trend in lung cancer rates in men and the levelling off of rates in young women can be related at least in part to the major reductions in tar yields which have flowed from the Government's agreements with the tobacco industry on product modification. Whether there are corresponding benefits in terms of other smoking-related diseases such as bronchitis or heart disease is less clear, since there are other important factors that have affected trends. A research programme to look more closely at the effects on health of reduced-tar cigarettes is being developed through the Independent Scientific Committee on Smoking and Health (ISCSH).

Publication of the DHSS-sponsored tar/CO/nicotine tables were suspended during 1985, because of the transition to a new banding structure. Tables in the new format were prepared at the end of the year, and results from intermediate surveys carried out by the Laboratory of the Government Chemist (LGC) remain available to research workers. Because of variations in the way different products are smoked, LGC investigated effects of changing the smoking parameters (such as puff volume) used in their machine smoking work. While

such changes affect the absolute yields of tar, CO and nicotine, the rank order of brands has been shown to be largely maintained, supporting the value of the tables for comparative purposes.

Smokeless tobacco

A plant to manufacture oral snuff tobacco was opened in Scotland in November 1984. Since then there has been a hardening of medical opinion about the use of smokeless tobacco products.

There is an accepted international scientific consensus, enhanced by evidence from the IARC group and the US Surgeon General's Advisory Committee on the health consequences of using smokeless tobacco, that the use of oral snuff tobacco products leads to an increased incidence of cancers of the mouth and pharynx, and of cancers situated in those areas of the gum and cheek in immediate apposition to the placing of the snuff within the mouth. Cancers of the oral epithelium affecting the gum and buccal mucosa have a high morbidity and mortality, and treatment often involves mutilating surgery.

There is a strong evidence that the primary carcinogens in snuff tobacco are tobacco-specific-N nitrosamine compounds. The levels of nitrosamines in snuff tobacco are exceptionally high and substances have been shown to be mutagenic in *in vivo* tests.

The opening up of a new market for oral snuff tobacco products in the UK, the consequent introduction of a new additive tobacco habit and in particular the evidence that the products are being promoted in such a way as to attract young people, are matters for regret. This is particularly true in respect of the sweetened and flavoured products supplied in small sachets.

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(ii) The medical effects of seat belt legislation in the United Kingdom

The regulations under the Traffic Act 1981[1] were laid before Parliament in 1982. The law requiring drivers and front seat passengers of cars and light vans to wear belts was not implemented until 31 January 1983. The intervening period enabled a national prospective study on the medical effects of seat belt legislation in the United Kingdom to be undertaken. The aim was to compare the fatality, severity and multiplicity of injuries to occupants of front seats in the year immediately before the legislation with the year after.

The Casualty Surgeons Association supported the study and 15 Accident and Emergency (A & E) Departments took part. These departments were not representative of all A & E Departments in the normal statistical sense but their catchment areas contained typical rural, urban and mixed road patterns. The United Kingdom Health Departments funded the study which was published in August 1985[2].

The number of casualties and the severity and multiplicity of injuries sustained by accident victims was reduced in the second year of the study. The main findings were that fewer casualties needed treatment in the second year (6213 compared with 7273), out-patient visits were reduced by 10% for drivers and 22% for front seat passengers, admissions decreased by 23% for drivers and 43% for front seat passengers and the number of days in hospitals fell by 27% for drivers and 35% for front seat passengers.

Before the legislation was implemented the percentage of persons wearing seat belts rose from between 20% and 40% to 95%. Afterwards the higher figure was maintained but there was a rise in the number of victims with neck sprains and fracture of the sternum. Sprained neck increased by 22% for drivers, 8% for front seat passengers and 26% for rear seat passengers. In the second year of the study 48 drivers and 23 front seat passengers fractured their sternum compared with 24 and 9 in the first year. Myocardial contusion and other cardiac complications have been reported as a complication of fractures of the sternum[3].

The report concluded that the wearing of seat belts had saved lives and had reduced the severity and multiplicity of injuries. Some injuries would have been fatal had seat belts not been worn.

In another study[4] the Department of Transport reached similar conclusions. Independent assessors were invited to report on the statistical evidence relating to the effects of seat belt legislation[5]. The investigation suggested that 207 to 459 lives had been saved and serious injuries avoided in 7,600 persons. Among the recommendations put forward were

(i) that further research should be carried out on spinal injuries resulting from car crashes; (ii) that seat belt design should be improved to prevent drivers from hitting the steering wheel; and (iii) that the wearing of rear seat belts should be compulsory.

These recommendations are under consideration.

As part of the debate which followed the implementation of the law the *Lancet* published an editorial supporting the need for the public to be convinced of the value of wearing seat belts[6].

Parliament reviewed the legislation on 13 January 1986 and decided to make the legislation permanent. At the tenth time of asking it is now reassuring that the requirement for occupants of the front seats in cars and light vans to wear seat belts has reached the Statute books.

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(iii) Drug and solvent misuse

The response to the problem of drug misuse remains a Ministerial priority. During 1985 barbiturates and benzodiazepines were placed within the controls of the Misuse of Drugs Act 1971 and legislation to control the sale of solvents to young people under 18 years, where they were likely to be used for the purpose of intoxication, was implemented.

The misuse of illegal drugs, particularly heroin, received attention. A mass media campaign using television and the press began in March 1985, after intensive market research assessed the feasibility and credibility of a campaign addressed to parents, professionals, and young people.

Leaflets presenting facts about drugs and their effects were widely circulated. A training video package for professional workers was issued in December 1985 and one for schools in early 1986. The media campaign, directed primarily at young people, drew their and their parents' attention to the availability of the drug information leaflets.

Evaluation of the campaign is built in at every stage. The report covering the first six months showed improvements in young people's knowledge and awareness of drug effects, particularly heroin.

The Central Initiative has approved £17 million for projects designed to improve services for drug misusers and study methods of prevention.

(iv) Alcohol misuse

Alcohol misuse is an increasingly serious problem.

Annual per capita consumption of alcohol rose steadily from 5.2 litres in 1960 to 9.7 litres in 1979. It then declined slightly, but since 1982, the upward trend has been resumed and in 1984 consumption stood at 9.2 litres. Conventional indicators of trends in alcohol-related harm have closely mirrored the trends in consumption. It must therefore be a matter of concern that several such indices of alcohol-related harm are now at their highest levels for three decades. It is impossible to put precise figures on the prevalence or incidence of problem drinking and only the crudest estimate can be made of the true cost of alcohol-related problems. However, some idea of the magnitude of the problem may be obtained from recent research which calculates that the total financial cost to the nation of alcohol misuse was in excess of £1,500 million every year.

The nature of the relationship between the amount of alcohol consumed and its real price is a complex one. In recent years, the overall price of alcohol has held almost steady but consumption has increased against a background of rising disposable income. The balance of economic evidence is that changes in personal disposable income have a greater impact on consumption than changes in price.

This emphasises the importance of measures, directed towards the prevention of alcohol-related problems by providing the public with accurate information on the effects of alcohol in such a way as to encourage an informed choice on the extent and pattern of alcohol use. Bodies such as the Health Education Council and Alcohol Concern are currently directing their efforts towards this.

Changes in indicators of alcohol-related harm such as the number of admissions to mental illness hospitals and units with a main diagnosis of alcohol misuse (15,000 in 1984), and the number of deaths from chronic liver disease (approximately 45/million population) over the years 1979 to 1984 show a pattern of decline followed by a rise to new peaks.

Although convictions for drunkenness and for drink driving offences have declined during this period these have been affected by changes in police procedures and practice and give a less reliable guide to trends in alcohol misuse.

Surveys on drinking habits

During the year two surveys undertaken for DHSS by the OPCS were published.[1,2]

The Surveys of Regional Drinking Habits examined the drinking habits of men and women in four health regions: Mersey and Northern, which have a high incidence of alcohol-related problems, and East Anglia and Trent which have comparatively few. The findings were not surprising for men — those in high risk areas drank more, as did unmarried men and men of low social status, especially in high risk areas. There were no significant differences in women's drinking habits between the regions.

The Women and Drinking Survey which examined the drinking habits of 2,000 women aged 18 to 54 years in England and Wales, found that most women drank very little. Just over one third of the women surveyed had drunk no alcohol in the week immediately before the interview, and a similar proportion reported drinking five units of alcohol or less. Less than one per cent drank more than 35* units of alcohol per week and they tended to be unmarried women under 25 years, or married without young children at home. Six percent of women did not exceed 35 units per week but admitted to being drunk at least three times in three months, or experiencing problems suggestive of dependence. These were described as pre-problem drinkers and 30% of them were aged 18 to 20 years.

Both surveys provide information of use to workers developing preventive strategies and identifying target groups and areas for health education. They showed for example that people have inadequate knowledge of the relative strengths of different alcoholic beverages.

Centrally funded research

Responsibility for the consideration of research on alcohol misuse in DHSS rests with the Department's Homeless and Addictions Research Liaison Group (H and A RLG). Priorities for research on alcohol misuse presented in their *Strategy for Research on Alcohol Misuse*[3] are intended to promote awareness of the Department's interest in this field and stimulate research proposals.

Research supported by the H and A RLG in 1985 included projects on the development of local prevention strategies, the costs of alcohol misuse, the effects of cognitive impairment on responsiveness to treatment, the practicality of home detoxification and a review of research on alcohol detoxification centres. Results of two DHSS-supported research projects were reported in 1985. One reported on five examples of detoxification services.[4] The second estimated

*1 unit of alcohol = ½ pint of beer, a single measure of spirits, a glass of wine or a small glass of fortified wine.

total social costs of alcohol misuse as amounting to over £1,500 million every year at 1983 prices[5].

In addition to work funded from the Health and Personal Social Services research budget the DHSS supported evaluations of experimental projects. These included Community Alcohol Teams in Liverpool, Salford and Kent, a night shelter in Plymouth and a new diploma course in Alcohol Counselling in Kent. A report on the Plymouth night shelter was received in 1985.

Plans for 1986 include dissemination of DHSS research on alcohol detoxification and local prevention, and further work on community alcohol teams.

Alcohol forum

The Government discussion document *Drinking Sensibly*[5] published in 1981, proposed that a common alcohol forum should be established, quite independent of Government, in which all interests — industry, voluntary bodies and professions — could be voluntarily represented and encouraged to find common ground for action. During 1985 the Department was invited to chair informal meetings between groups who wished to establish such a forum. Representatives of the Health Education Council, Alcohol Concern, the Wine and Spirit Association, the Brewers' Society and the Scotch Whisky Association held preliminary discussions on the remit and constitution of such a body and initiated soundings of a wider range of potential participants.

Local councils on alcoholism

Local councils on alcoholism provide an important centre for stimulating interest in and knowledge about alcohol misuse. They create a focus for preventive activity and service provision.

In September 1985 an increase of £50,000, 70% of the previous year's provision, was made in the funds which the Department provides annually for the establishment and support of new local councils on alcoholism. The funds are administered together with Alcohol Concern, the National Voluntary Agency on Alcohol Misuse, with whom the Department liaises closely.

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(v) Child abuse

In recent years, Government Departments have issued a wide range of advice about the handling of cases of child abuse, but this guidance has been mainly confined to procedural aspects of case management. Two years ago, members of the Department's multidiscliplinary Child Abuse Group began a comprehensive review of existing guidelines.

They first produced a consultative paper[1] which gave essential, new guidance to statutory services and other agencies on the conduct of enquiries into serious cases. A wide consultation process was completed in 1985 and the final document will appear in 1986.

A second Consultative paper to be entitled '*Child Abuse – Working together*' will supersede earlier guidance on the management of cases of child abuse. Experienced practitioners from a wide range of professions have discussed the effectiveness of existing arrangements for inter-agency co-operation with those involved in formulating this guidance. The recommendations of the Beckford Report[2], the findings of other inquiries, and relevant work such as the Review of Child Care Law[3], could also be taken into account.

The Consultative paper will, for the first time, address the handling of cases of sexual abuse; with the recommendation that these should be included within the general system for the management of child abuse. The Department is currently exploring ways of increasing training in this field.

The Social Work Inspectorate is carrying out concurrent work, looking at supervision of social workers in the assessment and monitoring of cases of child abuse when children subject to a court order have been returned home. This will be published when completed.

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[3] Department of Health and Social Security. *Review of child care law: report to ministers of an interdepartmental working party.* London: HMSO, 1985.

(b) Environmental Health

(i) Possible health effects of environmental radiation: The Committee on the Medical Aspects of Radiation in the Environment (COMARE)

The Recommendations made by the Independent Advisory Group chaired by Sir Douglas Black, in their Report on '*The Possible increased Incidence of Cancer in West Cumbria*[1], were discussed in this Report for 1984 (p 57).

Good progress has been made in implementing most of these Recommendations. In particular, on 25 July 1985[2] the Government announced that it was setting up a Committee on the Medical Aspects of Radiation in the Environment to provide the 'designated body' with significant health representation recommended by the Group.

This Committee is an expert Advisory Committee with 17 members[3] chosen for their medical and scientific expertise. Its Chairman is Professor Martin Bobrow of Guy's Hospital Medical and Dental School, who was also a member of the Black Advisory Group. It will offer Government independent medical and scientific advice on the health effects of ionizing and non-ionizing radiation in the environment, whether from natural or man-made sources. Government departments are represented by Assessors and the Secretariat is provided jointly by the DHSS and the National Radiological Protection Board.

The terms of reference of this Committee are to 'assess and advise Government on the health effects of natural and man-made radiation in the environment and to assess the adequacy of the available data and the need for further research'.

In reaching decisions about discharges of radioactivity from nuclear sites and related activities on environmental monitoring the authorizing departments will give full weight to medical advice from this Committee and so will ensure, as recommended by the Black Advisory Group, that the control of permitted discharges takes account of all relevant factors.

The Committee held its first meeting in November 1985 and is expected to publish its first report in 1986 on the additional information provided to Government since the Black Group reported about discharges from Sellafield. It will then consider the allegations of a possible increased incidence of cancer in children living near the Ministry of Defence sites at Burghfield and Aldermaston.

References

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2 House of Commons. Parliamentary Debate. Nuclear radiation: Department of Health and Social Security Advisory Committee. Hansard 25 July 1985; 83:Col 771. (PQ 6081/1985).

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(ii) Environmental hazards and the study of health statistics for small areas

Several times in the past few years, public alarm has been created by reports of an unexpectedly high incidence of a disease in the neighbourhood of a nuclear or chemical plant or a waste disposal facility. These reports have characteristically appeared in newspapers or on television, following informal investigation in small areas close to the installations.

When people who live in the shadow of a major plant are told that the incidence of some disease in their neighbourhood is several times greater than average, the conclusion that the effect is real and the industry responsible may seem to them obvious. Those in the industry are likely to take a different view. After all, major industrial processes are chosen and emissions controlled under official arrangements meant to ensure that any exposures are far below those that might affect the health of the local population. Furthermore, strikingly high rates of disease can arise by chance. In other words the incidence of many diseases varies markedly from place to place, without a relationship with any environmental cause in a way which has the hallmarks of a random statistical phenomenon; the variation is particularly great in the case of small areas and of relatively rare conditions. If in any given area the statistics for many diseases are scrutinized some high rates are virtually certain to be found by chance alone. Apparently high rates can also be due to errors in statistical technique, such as when boundaries for a non-standard area are drawn close around the place where cases of disease are known to have occurred, or the period of time chosen is selected in a similar way.

Although measurable ill effects amongst the public from industrial discharges ought not to occur, it must not be forgotten that there are limits to current knowledge in any field of science and that there is always the possibility of human error in any type of work. Therefore, the most striking instances of high disease rates near industrial plants need to be investigated.

There is, however, much difficulty in the study of these questions. Statistics have not been routinely available for the very small areas concerned. The information that can be gained from routinely collected health statistics alone, for a single area, is extremely limited. To make progress it is usually necessary to identify specific agents discharged from the plant and the routes by which they reach the population. Only if several populations exposed in a similar way can be identified will the study of the health statistics themselves be a powerful weapon in testing the significance of the discharges.

There has been some controversy about the way in which clusters of disease near industrial plants should be investigated and the precise details of the statistical techniques which should be used; yet rapid investigation and firm conclusions are called for. Not only is it important to detect and deal with any hazards that may have survived the existing controls but it is important also that misleading claims should be identified as such before public alarm develops and unjustified economic damage is done.

There is authoritative backing for the view that work on the analysis of small area health statistics may prove useful in the identification of environmental hazards. In 1984 the Independent Advisory Group chaired by Sir Douglas Black, which reported on the incidence of cancer in West Cumbria[1] recommended that 'monitoring of small area statistics around major installations producing

discharges that might present a carcinogenic or mutagenic hazard to the public' should be undertaken. More recently a very similar suggestion was included in the 11th Report of the Royal Commission on Environmental Pollution on managing waste.[2] It says, in part, that

> 'there is a need for the systematic investigation of cases where unusual illness appears to occur in a cluster in the neighbourhood of ..... installations handling substances about which there is scientific uncertainty as to their toxic effects at very low levels in the environment...'

In response to these recommendations and so as to make the fullest use of the available statistics in the study of potential environmental hazards, this Department, in collaboration with the Health and Safety Executive and the other Health and Environment Departments of the United Kingdom, intend to establish a unit in an academic institution with a remit to:

(a) examine quickly any unusual incidence of disease in areas near to installations which might emit radiation or chemicals;

(b) study the patterns of clustering of the most relevant diseases in order to detect and investigate any striking associations between high rates of disease and particular forms of industry;

(c) develop the methodology for analysing and interpreting statistics relating to small areas.

It is envisaged that the greater part of the work of the unit will be in the analysis of already available data. Investigations in the field, whether to obtain information on emissions and population exposure, or as full scale epidemiological studies, would, however, be undertaken if necessary.

It is hoped that the scientific groups in the UK which are already active in the epidemiological study of certain of the diseases most likely to be relevant to environmental hazards, will collaborate with the new unit, sometimes taking on detailed studies identified as necessary in the unit's initial rapid analyses.

The OPCS has been developing the means of providing health data for small areas rapidly and will collaborate closely with the unit as well as with existing research groups with specific interests in this field.

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[2] Royal Commission on Environmental Pollution. *Managing Waste: the duty of care: eleventh report.* London: HMSO, 1985. Chairman: Sir R Southwood. (Cmnd 9675).

(iii) Fluoridation of drinking-water

The Water (Fluoridation) Act, which clarifies the powers of water undertakings and health authorities in the implementation of water fluoridation schemes, received Royal Assent in October 1985. During its consideration by Parliament, the safety of fluoridation and its consequences for human health were examined closely. In this Report for 1984 (page 60) it was noted that the Department's Working Party on Fluoridation of Water and Cancer[1] concluded in January 1985 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'. An analysis by Wynne Griffith[2] of cancer mortality in Anglesey, which has been fluoridated for thirty years, was published later in the year; it concluded similarly that 'no evidence has been found to support the hypothesis that water fluoridation affects cancer mortality'.

No basis was found for the many other suggestions, voiced by those opposed to water fluoridation, that it could be harmful to human health. On the contrary, a recent study from Finland[3] added some weight to the hypothesis that there may be an incidental beneficial effect in reducing the prevalence and complications of osteoporosis. This is not as clearly established as the role of fluoridation in helping to prevent dental caries, an effect again apparent in recent data from Anglesey[4] and Newcastle[5].

The Department has issued preliminary guidance[6] to health authorities on the effect of the Water (Fluoridation) Act, and arrangements by the West Midlands Regional Health Authority which would result in the introduction of fluoridation to the water supply of up to 1.25 million more people are well advanced.

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(iv) Irradiated food

In 1985 the Advisory Committee on Irradiated and Novel Foods (ACINF) completed its report to Ministers on the Safety and Wholesomeness of Irradiated Foods, and this was published in April 1986 with an invitation for public comment[1]. The general conclusion of the report was that irradiation of food up to an overall average dose of 10 kilograys, correctly applied, provides an effective food preservation treatment which can reduce the number of pathogenic bacteria in food, but will not have adverse effects on the safety and wholesomeness of the food. Further details of the report, the nature of comments received from the public, and the possibility of changes in the regulations on food irradiation will be discussed in this report for 1986.

Reference

[1] Advisory Committee on Irradiated and Novel Foods. *Report on the safety and wholesomeness of irradiated foods.* London: HMSO, 1986.

(v) Nitrate in water and food

The European Community Directive on the Quality of Water intended for Human Consumption[1] was notified to Member Governments in July 1980. They were required to comply with it within five years. The Directive was therefore implemented in the United Kingdom from July 1985.

The Directive lays down standards for the chemical, physical and microbiological quality of drinking-water. It allows Member States, in defined circumstances, to authorize departures from some of the standards, provided that these do not constitute a public health hazard. It also provided for Member States to obtain the agreement of the Commission to an extended period within which to achieve the Directive's standards by means of a timetable of action.

In considering applications by water undertakings for authorization of departures from some of the standards in particular water supply zones, the Department of the Environment sought advice from this Department on the medical aspects. The advice in respect of chemical and physical quality was formulated with the assistance of the Committee on the Medical Aspects of the Contamination of Air, Soil and Water (CASW). Most of the applications concerned chemical components, such as manganese and iron, which adversely affect the aesthetic quality of water at concentrations below those likely to have any consequences for health. For some other chemical components, it was necessary to consider the possible implications for health. The most notable was nitrate, the concentrations of which in water supplies in parts of Lincolnshire, Norfolk, Cambridgeshire and Staffordshire exceed the 'maximum acceptable concentration', as defined in the Directive, of 50 mg nitrate ion/1.

An excessively high concentrations of nitrate in water used for reconstituting infant feeds is known to be a cause of infantile methaemoglobinaemia, a rare condition in the UK. In 1976, the then Chief Medical Officer circulated advice[2] on this matter to those officers with responsibility locally for environmental health. In essence, water with concentrations of nitrate ion greater than 100mg/1 were to be regarded as unsuitable for use in reconstituting infant feeds; concentrations betwen 50 and 100 mg/1 in the public water supply were acceptable, provided that health professionals in the affected area were alerted. This policy has been successful in that there have been no reported cases of infantile methaemoglobinaemia associated with the use of water in the "acceptable" range over the last decade. The 1976 advice was reiterated in 1984 by the Joint Committee on Medical Aspects of Water Quality[3] (MAWQ), and was endorsed in 1985 by its successor committee, CASW.

A greater source of public concern about nitrate in water was the suggestion that it may cause stomach cancer, by the conversion which occurs to nitrate and then to N-nitroso compounds. Many N-nitroso compounds are powerful carcinogens in laboratory animals. The hypothesis has given rise to a large and expanding body of epidemiological investigations, which were reviewed initially by MAWQ[3], and subsequently by CASW. The conclusions were summarized as follows in a circular[4] to officers with responsibility for local environmental health:

> '.... the epidemiological evidence, looked at as a whole, gives no support to the suggestion that nitrate is a cause of cancer of the stomach, or of any other organ, in the United Kingdom ...'.

The epidemiological data relate predominantly to nitrate ion concentrations under 100 mg/1; less is known regarding higher concentrations. there is no benefit to health from nitrate in water, and it is reasonable to exercise caution when considering the exposure of the general population. For this reason, the maximum concentration of 100 mg/1, which was set originally in the context of infant feeding, has been adopted as a maximum for the public water supply for infants, children and adults alike.

For most of the population of the UK, food rather than water is likely to be the major source of nitrate intake. The Ministry of Agriculture, Fisheries and Food (MAFF) set up a working party at the end of 1983 to draw together surveillance data for nitrate, nitrate and volatile N-nitrosamine levels in food on retail sale, and to identify priorities for further analytical work. Information assembled by the working party, including estimates of exposure to these compounds in the diet, has been submitted for consideration by the Department's independent expert advisory committees who will report in 1986.

References

1 Council of the European Communities. Council Directive of 15 July 1980 relating to the quality of water intended for human consumption (80/778/EEC). *Off J. Eur Com* 1980;23;L229:11–29.

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(vi) Food contact materials

Consumption of pre-packed foods and beverages has greatly increased in the last few years, posing new problems for the control of substances which may migrate out of packaging materials into food. Chemical analyses by MAFF, as part of a continuous surveillance programme of food contaminants, and analyses by regulatory authorities in other countries have shown that chemicals can migrate out of many types of packaging materials, occasionally reaching quite high concentrations in the food. Factors which can influence the rate of migration of chemicals include storage temperature, fat content of the food, nature of the surface in contact with the packaging material, and cooking times and temperatures of foods cooked without removing them from the packaging. However, this information is insufficiently reliable to predict the likely levels of migration of individual packaging constituents into the many different types of food wrapped in one type of material. Specific analytical surveys have been done in the United Kingdom on the levels of vinyl chloride, vinylidene chloride, styrene and acrylonitrile in food contact materials and in foods [1-4]. These are monomers, used as building blocks for polymers in plastic films. Recently, extensive work has been undertaken by MAFF to investigate the migration of softeners from regenerated cellulose film (widely known as 'Cellophane') and currently a programme is under way to ascertain the levels of plasticizers, such as the phthalate and adipate esters, in food and beverages in contact with plastic tubing, storage vessels and film. Plasticizers and softeners are essential in some food packaging materials to give them flexibility.

Specific regulations control the amounts of vinyl chloride that may be present in food[5]. Other regulations provide general control of food contact materials[6], whereby materials and articles in contact with food shall be manufactured so that they do not transfer their constituents to foods in quantities which could endanger health. Ministers are advised about the safety-in-use of food packaging materials by the Committee on Toxicity of Chemicals in Food, Consumer Products and the Environment.

Mono - and di-ethylene glycols in food

One particular problem involving the migration of substances from packaging materials into food arose in 1985. This concerned the chemicals monoethylene glycol (MEG) and diethylene glycol (DEG) which are used as softeners in regenerated cellulose film (RCF). RCF has particular physical properties which make it useful for a number of food items. It can be twisted to form an effective seal and subsequently untwisted by hand to allow the consumer to remove the food from its wrapping. It is used particularly for wrapping chocolate and sugar confectionery, cakes and biscuits, and savoury items such as pies, pasties and sausages. MEG and DEG have been the main softeners used in RCF for over 20 years, and they may constitute up to 20% of the total weight of the packaging film.

Following the discovery of significant amounts of DEG in sweets in the Federal Republic of Germany, extensive testing of retail food items wrapped in RCF was performed by MAFF in the autumn of 1985. These tests showed a very wide variation in the levels of MEG and DEG migrating into food, but for some foods, especially those with high fat and/or moisture content such as chocolate, fudge and pasties, relatively large amounts of these glycols could be detected, typically several hundred milligrams per kilogram of food. These findings were in marked contrast to a previous assessment performed on a more limited range of food

which showed much lower levels. This was considered by the European Community in 1976 and formed the basis for the approval of regenerated cellulose film as a wrapping material for food under EC Directive 83/229.

The Department and the Committee on Toxicity considered the implications for human health of those findings. We concluded that there was no acute health risk, and that it was unlikely that any adverse effects on human health had occurred as a result of this exposure to MEG and DEG over the past 20–30 years. However the possibility that untoward effects (for example, effects on the kidney) might have occurred in some individuals over the years could not be ruled out. We did not consider that there was any immediate risk to the public in consuming these items, and there was therefore no need to remove them from retail sale. Nevertheless, the levels of MEG and DEG found in foods implied a significant erosion of the large safety margins which are desirable for the intake of these two compounds. We advised that steps should be taken to secure an early and substantial reduction in the levels of MEG and DEG migrating into food.

Manufacturers of RCF in the UK then stopped using MEG and DEG as softeners, switching to more expensive compounds whose permissible intakes are higher than those of MEG and DEG and which would therefore be acceptable even if they migrated into food to the same extent as MEG and DEG. Meanwhile discussions have started on modifying the EC Directive on RCF to stipulate a maximum amount of MEG and DEG which is permitted in food as a result of migration from the packaging material. Early in 1986 it was agreed that the level should be set at 50 mg per kg of food for combined levels of MEG and DEG, a level which will not lead to undesirable intakes of these compounds even for people who have unusually high intakes of foods wrapped in RCF.

The emergence and resolution of this problem indicates the variability and complexity of the patterns of migration of chemicals from food packaging material into food. It also indicates the desirability of having reliable information on the levels of certain food packaging chemicals in food, and the need to consider the possibility of adverse health effects. The rational application of analytical and toxological science in these areas can rectify a situation where an existing use of a packaging material has led to an undesirably high level of a chemical in food, and can help to ensure that new developments in food packaging offering practical benefits to the consumer are not associated with possible risks to health.

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3. COMMUNICABLE DISEASES

(a) Acquired immune deficiency syndrome (AIDS) and Human T-Lymphotrophic Retrovirus III/Lymphotropic Associated Virus (HTLV III/LAV)

The spread of HTLV III/LAV within the population of the UK, and indeed throughout the world, provides one of the greatest challenges in communicable disease control in this century. The number of new cases of clinical AIDS reported in the United Kingdom (UK) between 1 January and 31 December 1985 was 167 (77 cases in 1984). By 31 December 1985 the number of clinical AIDS cases reported to the Communicable Disease Surveillance Centre (CDSC) since the national reporting system was established in 1982 was 275, and 140 of these patients had died (Tables 3.1, 3.2 and 3.3).

Table 3.1: Clinical AIDS in the UK up to 31 December 1985

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1982										—	—	3
1983	—	1	1	1	2	2	4	2	8	—	3	4
1984	5	2	2	2	5	4	3	15	12	7	14	6
1985	10	14	8	19	10	7	20	10	19	16	16	18

Table 3.2: Characteristics of AIDS patients, sex and number of deaths, 1982—85, UK.

Patient characteristics	Male	Female	Deaths
Homosexual/bisexual men	245	—	119
Haemophilia	9	—	8
Recipient of blood	4	1	4
Intravenous drug abuser	2	—	1
Heterosexual contact	—	2	1
Visited USA/Caribbean and at possible risk	3	—	1
Directly associated with sub-Saharan Africa	1	5	6
Indirectly associated with sub-Saharan Africa	—	2	—
Other	1	—	—
Total	265	10	140

Table 3.3: Cause of death in AIDS patients, 1982–*85, UK*

Disease	Cases	Deaths
Kaposi's sarcoma	67	30
Pneumocystis carinii pneumonia	121	58
Kaposi's sarcoma + *pneumocystis carinii* pneumonia	19	11
Other opportunist infections	64	38
Cerebral lymphoma	2	2
Non-Hodgkin's lymphoma	2	1
Total	275	140

Epidemiological features of the outbreak

The principal epidemiological features of the outbreak of HTLV III infection are wellknown. From the point of view of control, the key facts are that the infection is blood-borne and sexually transmissible and that there is a very long period of infectivity in persons who are usually unaware that they are carrying the virus. The virus may be transmitted from infected mother to fetus in utero or during delivery.

Of the 275 cases of clinical AIDS reported up to the end of 1985, 216 were reported from London and most of the others were reported from large urban centres in England. Six cases were reported in Scotland, five in Wales and two in Northern Ireland. Whatever success public education may have in changing sexual behaviour in the immediate future, the long incubation period indicates that the number of cases of AIDS will increase for several years.

Predictions using two different approaches suggest that in the UK in 1988 there may be about 2,000 cases[123]. Provided efforts to reduce the rate of spread of infection begin to take effect immediately, it is possible that some favourable change in the gradient of the epidemic will be seen thereafter.

More important than the number of cases of AIDS, from the epidemiological point of view, is the number of persons who have been infected with the virus. It is estimated that from 25 to 100 persons are likely to have been infected for every case of AIDS reported. In other words, by the end of 1985 between 5,000 and 27,500 people, mostly men, had probably been infected in the United Kingdom.

Prevention of AIDS and HTLV III infection in the UK

Control of HTLV III infection

Surveillance

Epidemiological surveillance of AIDS in the UK was begun in 1982 at the CDSC with the collaboration of the Communicable Disease (Scotland) Unit (CD(S)U).

Following receipt of increasing numbers of reports of the syndrome from the USA, data were examined retrospectively in order to detect the appearance or absence of cases in the UK. Death entries mentioning Kaposi's sarcoma and laboratory reports of opportunist infection in young patients who were previously well were studied. No significant increase in these conditions could be detected in the previous five years, but it was concluded that insufficient information was available. A surveillance scheme specifically designed to detect AIDS, to monitor trends and to describe the epidemiology was organized. The case definition compiled by the Center for Disease Control (CDC) in Atlanta, USA was adopted. Sources of reporting were: copies of death entries received on a weekly basis from OPCS; laboratory reports of opportunist infections in previously well patients and voluntary clinical reports received by the responsible medical epidemiologist in strict confidence from physicians. Monthly and yearly analyses of these data were made. Whenever a report of a patient, who did not belong to a recognized risk group was received an epidemiological interview was undertaken with the permission of the physician in charge of the patient.

The scheme has continued to operate. From October 1985 the amended case definition compiled by the CDC was adopted by the CDSC. This was agreed by

the Conference of State and Territorial Epidemiologists (CSTE) at its annual meeting in Madison, Winsconsin USA in June 1985. The case definition now includes *HTLV III antibody positive cases* of disseminated histoplasmosis, isosporiasis, candidiasis, non-Hodgkin's lymphoma and Kaposi's sarcoma in patients over 60 years but excludes *HTLV III antibody negative cases* without a low T helper: T suppressor ratio.

Sero-surveillance
Sero-surveillance of the HTLV III infection has been in progress since March 1985 at CDSC. The purpose is to monitor trends in the prevalence of this infection. Reports of positive antibody tests are received through the voluntary reporting scheme and analysed on a weekly basis. During the first nine months of surveillance more than 1,765 reports were received of which 98% were male subjects. The geographical distribution of reports may at present be a reflection of the availability of testing (many more are occurring in urban areas). A more accurate indication of sero-prevalence may be expected during 1986 after initial fluctuations following the introduction of widespread sero-testing on 14 October 1985.

Surveillance of health care staff
A prospective evaluation of the health of health-care personnel with exposures to blood or body fluids of patients infected with HTLV III has been in progress at the CDSC since January 1985. Exposures are reported by the local microbiologist with the permission of the exposed person and are treated in strict medical confidence.

Blood transfusion and blood products — The Advisory Committee on Dangerous Pathogens (ACDP) Guidelines

The ACDP Interim Guidelines on AIDS for the Safety of Health Care Staff were published at the end of 1984 with the proviso that they would need to be revised as more information about the behaviour of the AIDS virus and its effect, became known. Revised guidelines were published in June 1986.

Much further epidemiological and scientific knowledge has become available as a result of research and monitoring of the disease in the USA and elsewhere. In particular, it has become increasingly apparent that the virus is not transmitted by the airborne route. Furthermore, although several hundred health care staff have suffered needle stick injuries or mucosal contamination with material from infected patients there had been up to December 1985 only one fully documented case of seroconversion.

With this information in mind the ACDP set up a Working Group to consider the evidence and revise the guidelines appropriately. It is expected that these will be published in 1986.

HTLV antibody test

In March and April 1985 three commercial anti-HTLV III kits produced by manufacturers in the USA were licensed by the Food and Drug Administration thus enabling them to be marketed also in the United Kingdom. DHSS commissioned the Public Health Laboratory Service (PHLS) Virus Reference Laboratory to undertake an evaluation of all commercial diagnostic kits available

prior to their introduction nationwide for screening all blood collected by the National Blood Transfusion Service (NBTS).

Five commercial kits were available for evaluation, all using an enzyme-linked immunosorbent assay method, although one made by Wellcome Diagnostics and based on the British isolate uses a competitive assay as opposed to the others which use the familiar sandwich or indirect method. The evaluation revealed an acceptable performance by all the test kits. Two which seemed to be particularly suitable for use by the NBTS were then used in a field trial by two Regional Transfusion Centres to assess the organizational requirements raised by the introduction of the test as a routine.

Introduction by the NBTS of Anti-HTLV III screening tests

A leaflet requesting blood donors who believed that they might be at risk for AIDS not to volunteer to give blood had first been issued by the Department and NBTS in August 1983. The leaflet was revised and distributed individually to all donors at the beginning of 1985.

The PHLS was funded by the Department to provide any diagnostic tests requested on this basis. A network of PHLS laboratories was organized to undertake the test and eight laboratories were designed as Reference Laboratories in order to provide a confirmatory service.

Prior to the introduction by the NBTS of the test to screen blood donations a leaflet was made available to donors informing them that their blood would be tested. All donors are asked to sign a form confirming their good health and consent to their blood being tested.

The testing of all blood donations commenced in the NBTS on the 14 October 1985. In the event of any donations giving a positive result when tested at the Transfusion Centre the donation is retested. If the donation is repeatedly positive then a sample is sent to a PHLS Reference Laboratory for confirmation. If the sample is confirmed as positive the Regional Transfusion Director contacts the donor to arrange an interview when a further sample is obtained for confirmation and the donor counselled. RTDs and doctors in the NBTS have attended training courses in counselling on these sensitive issues.

Heat treatment of clotting factor concentrates

The inactivation of HTLV III by heat suggested that heat-treating clotting factor concentrates would render them safe and prevent transmission of the virus through their use. A number of heat-treated commercial Factor VIII concentrates were licensed for prescription in the UK in early 1985. The Blood Products Laboratory has issued heat-treated Factor VIII concentrate since April 1985 and has developed a new concentrate Factor VIII Y which is able to withstand prolonged heat treatment (72 hours at 80° centigrade). This new product is proving highly acceptable to haemophiliac patients and the early results of clinical trials suggest that it is an extremely safe product. Factor IX produced at the BPL which provides sufficient for the needs of patients with Christmas Disease in England and Wales is also heat-treated.

Heat treatment of these concentrates is expected to prevent transmission of the AIDS virus through their use.However a survey carried out by the Haemophilia

Centre Directors has revealed that, of those haemophiliac patients tested, 35% have been infected with HTLV III. This adds a considerable burden to the patients, their relatives and those responsible for their care and counselling.

Provision of testing facilities

While most individuals infected with the AIDS virus will be antibody positive it is believed that there will be a few who have not developed antibodies but who are infectious. It is for this reason that it is so important that any individuals who are members of any of the high risk groups for AIDS do not donate blood. Because of concern that the introduction of screening tests for all blood donations might tempt members of high risk groups to attend donor sessions to find out if they have positive tests, Health Authorities have been asked to make provision for testing the serum of individuals who believe themselves to be at risk at clinics outside the NBTS. In many cases facilities are already available at Genito-Urinary Medicine clinics (GUM clinics). There will also be a need to provide some facilities to enable people who fear they may have been at risk of infection with the AIDS virus but who do not wish to attend GUM clinics. The PHLS has arranged for a number of its laboratories to undertake testing of blood specimens which are collected by GUM clinics, by general practitioners or through hospital clinics and other sources.

Counselling

As a positive HTLV III antibody test may have implications for patients, counselling before and after the test is essential. Counsellors advising AIDS sufferers, their contacts and other HTLV III antibody-positive persons are usually best placed within a Genitourinary Medicine/Sexually Transmitted Diseases Clinic. Support is also available from voluntary sector groups such as the Terrence Higgins Trust, the Haemophilia Society and Body Positive.

Counsellors can be from a variety of health care related disciplines. Counsellor training courses are available and the main centre for such courses is St Mary's Hospital, Paddington. DHSS is also negotiating with the RHAs to provide extra courses on an inter-regional basis.

Protection of health care staff

Methods for protecting health care and other staff possibly exposed to infection with HTLV III are essentially similar to the methods practised in the prevention of hepatitis B infection. Interim guidelines have been issued for staff coming into contact with patients with AIDS or their specimens.

Health education

Planning commenced in 1985 for a major national campaign of public information to begin in the Spring of 1986. An inter-departmental group has been formed and an AIDS and Education sub-group set up, jointly with the Department of Education and Science. The aim of the campaign is to provide information to the general public and to those in at-risk groups in order to increase understanding about HTLV III infection, and ways in which its spread can be controlled. £2.5 million has been set aside by the Government for this purpose (in addition to the special financial allocations set out below).

Research

Scientists around the world are searching for a vaccine and a cure. Research in the UK on AIDS is co-ordinated by the Medical Research Council (MRC). Projects are being funded at a total cost of £431,000. The UK Health Departments are contributing up to £300,000 per year for epidemiological research on AIDS and for a new co-ordinating centre to be set up by the MRC; the additional costs of this work will be met from the MRC's Grant-in-Aids — £125,000 has also been provided for the research co-ordinated by the Chief Scientist's Office in Scotland.

Resource allocation

Health Authorities in England have been asked to draw up plans to deal with AIDS on a comprehensive basis and to send these to the DHSS in the summer of 1986. Extra money has been allocated to North East, North West and South East Thames Regional Health Authorities, who at present treat the majority of AIDS cases in the UK: £680,000 in 1985–86 and £2.5 million in 1986–87. More money has also been allocated to the Haemophilia Reference Centres to provide specialist counselling services: £90,000 in 1985–86 and £270,000 in 1986–87. The Government has also provided £150,000 for the provision of counselling training courses for health care personnel.

Legal provisions

In March 1985 the Public Health (Infectious Disease) Regulations 1985 were drawn up to make available a number of provisions which could be used in exceptional circumstances to prevent the spread of AIDS. AIDS was not made a notifiable disease but certain public health legislation applies:

These provisions allow for

- Medical examination of a person suffering from AIDS
- Removal to hospital of a person with AIDS
- Detention in hospital for a person with AIDS
- Restrictions on the removal of the body of a patient dying from AIDS in hospital.

National policy

(i) *Expert Advisory Group on AIDS (EAG):* An Expert Group was set up by DHSS in January 1985 to advise the Chief Medical Officers of the UK Health departments on problems related to AIDS.
The terms of reference of the Group are as follows:

> "To provide advice on such matters relating to AIDS as may be referred to it by the Chief Medical Officers of the Health Departments of the United Kingdom"

The EAGA met seven times during 1985 and also set up several associated groups including:

1. Counselling Sub Group
2. Screening Test Sub Group

3. Resources Sub Group
4. Working Group on Health Education in relation to AIDS
5. Working Group on AIDS and Drug Abuse
6. Surgeons, Anaesthetists and Dentists Sub Group
7. Employment Sub Group
8. AIDS and Renal Units Sub Group
9. Artificial Insemination by Donor Sub Group
10. Sub Group on Immunoglobulin

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Much advice and guidance has been issued with the Department's help, directly from Government eg to health professions and to Local Education Authorities in relation to children at school, and some from organizations assisted by Government funds eg the Health Education Council, the Haemophilia Society, the Terrence Higgins Trust and the Scottish AIDS Monitor.

Government publications and guidelines

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(b) Creutzfeldt-Jakob disease

In the early 1920s Creutzfeldt and Jakob independently described 'a peculiar illness of the central nervous system'. This subacute dementia usually affects those over 50 years of age, is invariably fatal, and is characterized by spongiform cerebral degeneration. Some 45 years later Creutzfeldt-Jakob disease (CJD) was found to be transmissible[1], not only from man to animals but exceptionally from man to man. Until the discovery and investigation of Kuru, a similar spongiform encephalopathy, among New Guinea tribes in the late 1950s, the idea had not seriously been entertained that a cerebral degenerative condition could be transmissible and of infective origin.

The prolonged incubation period of Creutzfeldt-Jakob disease gave rise to the expression "slow virus" for the causative agent which lacks nucleic acid and bears similarity to that known to cause the animal disease Scrapie. This agent is extremely resistant to destruction, evokes no immune response in the host, and can only be detected reliably by successful transmission to animals by inoculation of infected brain tissue (after a very lengthy incubation period).

The condition is rare with a yearly incidence of around one per million. Ascertainment is particularly difficult and may have to be made retrospectively some time after death. Diagnosis is possible from the nature of the illness and changes in the brain apparent at post-mortem examination. Confirmation is obtained by transmission of the disease to monkeys through intracerebral inoculation with an extract from the brain of the victim. The unconventional nature of the infective organism and the difficulty of achieving adequate sterilization were brought home in 1974 by evidence of iatrogenic man-to-man transmission from a corneal transplant. Subsequently there were reports of transmission following neuorosurgery upon infected subjects.

In the winter of 1984–85, three people died in the USA with clinical signs of the disease[2]. They were unusually young — 21, 23 and 34 years of age. Autopsies had been carried out on two of these patients and these confirmed the diagnosis. Epidemiological study revealed that all three had received prolonged treatment with pituitary-derived human growth hormone for idiopathic deficiency (with no previous history of neurosurgery). Thirty-three batches of hormone were implicated, some having been used in two of the victims but none of them for all three. Samples of 26 of these batches are available and animal inoculation experiments have begun.

About 10,000 individuals received human growth hormone in the USA during the last 25 years. Its use was suspended in the USA in April 1985 and shortly afterwards in the UK.

In the UK 1,800 patients have received human growth hormone. Early in 1985 a 23-year-old woman died with the clinical features of CJD. The diagnosis was confirmed on post-mortem examination[3]. A craniopharyngioma had been resected when she was two years old and she was given human growth hormone for 4 years from the age of 10 years.

In 1981 a DHSS Advisory Group considered the management of patients with CJD and recommended precautions to be taken when neurosurgery was performed upon or specimens taken from those who may have the disease. In addition they advised that material from such patients should not be used for the

preparation of biological extracts such as growth hormone.

The development of Creutzfeldt-Jakob disease below the age of 30 years is very rare. Of 3,000 recorded patients worldwide, only nine were under 30 years of age, including three of the four known iatrogenic cases associated with the administration of human growth hormone. Of 48 registered deaths from the disease in the UK between 1971 and 1984, not one was known to have received human growth hormone and only one was below the age of 40 years.

Investigation continues. Death certificates arising from all people known to have received the hormone will be reviewed. Since October 1985 treatment of all growth hormone deficient children has been done with genetically engineered material.

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(c) Food poisoning

The four main data collecting systems particularly relevant to the surveillance of food-borne disease are: statutory notification of infectious disease, laboratory reports from medical microbiologists, outbreak reports from medical officers for environmental health and environmental health officers and hospital data. Reports of cases ascertained by means other than statutory notifications are also received from the Environmental Health Department of local authorities.

Notifications and cases ascertained by other means reported to the OPCS by Medical Officers for Environmental Health (MOsEH) in England and Wales are included in weekly, quarterly and annual OPCS publications. Table 1 gives extracts relating to England only, from the OPCS collations 1982–1985. The many factors influencing these statistics should be considered when interpreting these figures. The CDSC annually receives reports of food poisoning and salmonellosis collected from laboratories and MOsEH in England and Wales.

Table 3.4: Food poisoning cases in England 1982–85, corrected notifications to OPCS

	Year	Formally notified	Ascertained by other means	Totals
Presumed contracted abroad	1985	1,022	653	1,675
	1984	1,062	685	1,747
	1983	1,006	559	1,605
	1982	866	421	1,287
Presumed contracted in GB	1985	8,862	4,168	13,030
	1984	9,607	5,403	15,010
	1983	8,651	3,503	12,454
	1982	7,022	3,085	10,107
Not known where contracted	1985	2,078	1,101	3,179
	1984	1,776	1,211	2,987
	1983	1,954	1,008	2,962
	1982	1,468	714	2,182
Totals	1985	11,962	5,922	17,884
	1984	12,445	7,299	19,744
	1983	11,611	5,410	17,021
	1982	9,356	4,220	13,576

Cholera, typhoid fever and paratyphoid fever are now rare diseases usually acquired abroad. Specifically human infections, they have been controlled by improvements in the hygiene of water supplies and sanitation. Bovine tuberculosis, brucellosis, food-borne helminthiasis and major zoonotic food-borne diseases have been almost eliminated by eradication of the infection in animals.

Salmonellosis and campylobacter enteritis are now the most important food-borne infections in England. In 1985 over 11,900 notifications of salmonellas and more than 23,500 of campylobacter were reported by laboratories to the CDSC. *Clostridium perfringens* food poisoning, a major cause of institutional outbreaks, and giardiasis seem to be increasing.

The Report of the public enquiry into the outbreak at Stanley Royd Hospital, Wakefield was published in January 1986.[2] *Salmonella typhimurium* phage type

49, brought into hospital kitchens probably with raw poultry, contaminated cooked beef served to patients and staff. (See Introduction page 5). Other outbreaks were reported to the Department. One at St Bernard's Hospital, Ealing due to *Cl perfringens* was the subject of an internal enquiry by the Regional Health Authority.

Outbreaks of gastroenteritis occurred on ships cruising the Mediterranean during May[3] and increasing numbers of *Salmonella enteriditis* phage type 4 infections were recorded in tourists returning from the Iberian Peninsula.[4] The higher incidence of *S. typhimurium* DT141 reported from all regions was greatest in Yorkshire, Trent, SW Thames and the West Midlands. Laboratories isolated *S. typhimurium* from poultry and bulked liquid egg before and after pasteurization[5].

A DHSS Hazard Warning was issued on 29 August 1985 about 'Original' Westphalian Ham imported in 100g sealed vacuum packs. Some packs produced high counts of staphylococcus and the importers voluntarily agreed to withdraw the product. The Public Health Laboratory Service (PHLS) Food Hygiene Laboratory isolated two phage types of *S. typhimurium,* but the strains of *Staphylococcus aureus* found did not produce enterotoxin. The Hazard Warning was withdrawn on 13 December [6,7].

A serious incident of *Salmonella ealing* contamination of powdered baby food products occurred during the latter part of 1985. Thirty-nine persons, mainly babies under the age of one year, were infected. One baby died.[8]

S. ealing was discovered in the factory of the manufacturing company and in three packets from the same batch of products made in September 1985. Withdrawal of the implicated powders and other products manufactured by the same process caused the company to go into voluntary liquidation.

How salmonella entered the factory is unknown. Some months earlier the organism had been isolated from a cow in the catchment area of milk supplies used by the factory. However it is not certain that milk from this cow was used. If it was, it is difficult to understand how the organism survived the heat processes involved during manufacture, or was able to contaminate the factory environment. An alternative theory is that birds carrying the organism contaminated roof areas which then due to storm damage infected water in a storage tank which supplied a spray drier. *S. ealing* found in powder residue recovered from a small hole in the inner skin of the spray drier could have contaminated spray-dried products.

A thorough review of manufacturing processes producing spray-dried powders has been undertaken by the dairy and food manufacturing industries.

Shellfish

Approximately 300 incidents of gastroenteritis associated with the consumption of molluscan shellfish, particularly cockles and mussels, and less often, oysters, occurred during the 1985 Christmas period. Small round structured viruses and parvoviruses were found in stool specimens of affected persons, but no pathogens were isolated from shellfish samples. The outbreaks were similar to those reported in the 1976 Christmas period when low ambient and sea water

temperatures reduced the efficacy of purification and heat-treatment procedures for those molluscs.

In 1976 epidemiological evidence established that cockles from Leigh-on-Sea caused the outbreaks. Although the current epidemiological pattern was not so clear, samples from the same area produced above-normal levels of contamination after they had been subjected to required heat shucking and pasteurization procedures. Levels decreased after improved handling and heat processing methods were implemented in the cockle sheds.

Work commenced in 1985 on a voluntary code of practice for the mulluscan shellfish industry. Contributors include the UK Shellfish Industry, The Sea and Airport Health Authorities, The Fishmongers Company and the Government departments concerned — CDSC, PHLS, MAFF, DOE and DHSS. They aim to have an operating code of practice by 1987 which will reduce the risks of viral contamination of molloscan shellfish.

Gastrointestinal infections

Surveillance of common gastrointestinal infections by CDSC is based on laboratory reports received annually since 1977 for England and Wales.[9]

Campylobactor reports for 1985 were almost double the number of salmonella infections recorded. Shigella infections were less than in 1984, although outbreaks of Sonne dysentery in day nurseries, schools and the community were reported from the North of England and South Wales. The gradual decline in the incidence of *Escherichia coli* infections in children under three years of age continued. Rotavirus infections increased from 1,806 in 1977 to almost 8,000 in 1985.

Diarrhoeal diseases associated with protozoal infections have increased, but those due to *Entamoeba histolytica* declined from 830 in 1984 to 766 in 1985. Reports of Giardia infection increased from 4,510 in 1984 to 4,973 in 1985 and 1,847 reports of cryptosporidium infection were received.

The first water-borne outbreak of giardiasis in England associated with a municipal water supply was reported in July[10]. The Bristol PHL in the South Western Region confirmed 108 cases between 3 June and 12 August, Most patients had lived in or visited within the incubation period an area supplied by two water mains which had been repaired during the first week of July. The source of the contamination was not firmly established. Epidemiological investigation was undertaken by CDSC, the local authority environmental health department, the relevant water company and the Department of Environment[10]. Contingency plans for appropriate treatment were drawn up to combat further outbreaks of giardiasis in the area.

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(d) Lassa Fever

A 27-year-old British nurse working in a remote hospital in Sierra Leone under the auspices of Voluntary Service Overseas, developed Lassa fever in February 1985. Her condition deteriorated and she was transferred to a mission hospital in Segbwema where there was a research unit for the study of this disease (sponsored by the CDC, Atlanta). This hospital was situated some 200 miles from Freetown and did not have a continuous supply of electricity or a land telephone line. When the patient developed signs of brain damage an appeal was made for her repatriation to the UK.

In 1981 the Department had formulated a contingency plan for the repatriation of any individual thought or known to be suffering from a highly infectious communicable disease. Central to this plan was the co-operation of the RAF in arranging air evacuation using a transit isolator with subsequent admission to a High Security Infectious Disease Unit (HSIDU). The High Commission in Freetown initiated the repatriation request to the Foreign and Commonwealth Office which was backed-up by completion of a standard questionnaire describing the condition of the patient. In addition, a member of the UK panel (a consultant physician in infectious diseases) was able to speak by telephone with two members of the medical staff from Segbwema hospital (who had travelled to Freetown for this purpose). When the patient's condition improved arrangements were made for her evacuation.

The RAF repatriation team had been assembled and its leader (an anaesthetist) flew to Freetown and thence to Segbwema hospital to arrange for the repatriation. On the 26th day of her illness, the patient was transferred by helicopter to Freetown, placed in the transit isolator and flown to Filton Airport near Bristol.

A specially prepared vehicle transported the patient in the transit isolator to the HSIDU at Ham Green Hospital where she was transferred into a static isolator. The consultant in charge of this unit had flown to Freetown to supervise arrangements. By this time it was known that the patient still had a viraemia and was excreting the virus in her urine. The presence of virus persisted until the 40th day of her illness. She was removed from the isolator on the 51st day when three consecutive blood and urine samples had been shown to be free of virus. She was eventually discharged from hospital on the 93rd day of her illness, continued to make an excellent recovery, and was able to attend a PHLS Symposium on Lassa fever held five months after the onset of her illness.

This was the tenth known importation of a case of viral haemorrhagic fever into Britain but the first occasion on which the repatriation scheme for highly infectious diseases had been implemented.

(e) Legionellosis

In England, Wales and Northern Ireland in 1985, 209 cases of Legionnaires' Disease were reported to the CDSC during its continuing National Surveillance Programme.

These cases comprised 136 male and 71 female patients and two reported cases in whom the sex was not stated. There were 37 deaths. Sixty of the infections were acquired abroad. Whilst many of these reports were of sporadic infections, there was one major outbreak and several clusters of cases.

In England four small outbreaks were reported — from a hospital in Portsmouth (two probable cases with one death), from a geriatric ward in Luton Hospital (two cases), at an industrial estate in Ramsgate (five cases with one death) and at Police Headquarters in Lincoln (seven cases).

Several clusters of cases were associated with travel in other countries. Between July and October five cases occurred among British visitors to Paguera in Majorca. One had stayed in a hotel in the resort and the other in two nearby apartment blocks. The source of the infection is unknown.

The Stafford outbreak

The largest recorded outbreak of Legionnaires disease in the United Kingdom occurred in Staffordshire between late March and mid April. Of the 68 cases who were recognized, 22 died. A further 35 patients including six who died had clinical but no laboratory evidence of legionella infection. All the cases had attended clinics or visited Stafford District General Hospital during the ten days before the onset of symptoms. The epidemiological investigation and engineering studies suggested that a water spray cooling system was the reservoir of infection and that airborne transmission took place via the air-conditioning system. *Legionella pneumophila* serogroup 1, Pontiac 1A sub-group was isolated from 11 post-mortem lung specimens and from water in the pond of the suspected cooling tower, the drainpipe and insulation material in the chiller battery in the ventilation unit serving the outpatient department.

(f) Sexually transmitted disease

The number of new cases reported by clinics in England in 1984 was 569,928 (319,483 males and 250,455 females), an increase of 4.1% (Tables 3.4, 3.5, 3.6 and 3.7). The conditions showing an upward trend were genital warts, genital herpes simplex, candidiasis and non-specific genital infection. Molluscum contagiosum has also increased each year since 1971, as have cases of pubic lice, except for a slight reduction in 1983 (over 1982).

The problems produced by AIDS/HTLV III infection continued to add to the burdens of the heavily stressed clinics in North West London and spread to clinics in the rest of London, and to other clinics with a large proportion of homosexuals among their male patients. The number of cases and the resulting problems are likely to increase (see p 41).

The reported number of cases of syphilis and gonorrhoea continued to fall. In addition the number of gonococcal infections due to β -lactamase-producing strains fell for the first time since 1977.

The International Society for Sexually Transmitted Disease Research met in Britain in the summer of 1985 with 600 delegates from around the world. This was the first time the Society had met in the UK. There were 155 presentations and 178 posters covering all aspects of research into the Sexually Transmitted Diseases (STDs) and these illustrated the value of a multidisciplinary approach to research in this field.

Table 3.4: Cases of syphilis, gonorrhoea and chancroid reported in England for the year ended 31 December 1984 with the figures for the year ended 31 December 1983 in parentheses (for the incidence rate per 100,000 population see Table 3.6).

	Total	Male	Female
Syphilis			
Early	1,702 (1,934)	1,475 (1,721)	227 (213)
Primary and Secondary only	1,032 (1,149)	923 (1,039)	109 (110)
Late	1,167 (1,313)	815 (902)	352 (411)
Congenital	64 (80)	25 (39)	39 (41)
Gonorrhoea			
All forms	47,662 (48,393)	29,791 (30,464)	17,871 (17,929)
Post-pubertal gonorrhoea			
All ages	47,643 (48,367)	29,789 (30,455)	17,854 (17,912)
Under 16 years	360 (280)	94 (81)	266 (199)
16–19 years	10,295 (10,285)	4,398 (4,438)	5,897 (5,847)
20–24 years	18,285 (17,989)	11,188 (10,963)	7,097 (7,026)
25–34 years	13,343 (13,957)	9,709 (10,120)	3,634 (3,837)
35–44 years	3,952 (4,302)	3,187 (3,529)	765 (773)
45 years and over	1,408 (1,554)	1,213 (1,324)	195 (230)
Chancroid	40 (80)	31 (56)	9 (24)

Table 3.5: Other sexually transmitted diseases reported in England in year ended 31 December 1984 together with the figures for year ended 31 December 1983 in parentheses (for incidence per 100,000 population see Table 3.7).

	Total	Male	Female
Lymphogranuloma venereum	30 (36)	23 (27)	7 (9)
Granuloma inguinale	19 (21)	15 (14)	4 (7)
Non-specific genital Infection (NSGI)	139,352 (134,079)	99,497 (97,673)	39,855 (36,406)
NSGI with arthritis	428 (462)	407 (443)	21 (19)
Trichomoniasis	16,751 (18,274)	1,211 (1,317)	15,540 (16,957)
Candidiasis	59,668 (57,876)	12,133 (11,101)	47,535 (46,775)
Scabies	2,043 (2,192)	1,693 (1,818)	350 (374)
Pediculosis pubis	10,183 (9,093)	7,042 (6,194)	3,141 (2,899)
Genital herpes	18,301 (16,534)	9,663 (8,882)	8,638 (7,652)
Genital warts	44,050 (37,899)	26,899 (23,319)	17,151 (14,580)
Genital molluscum	1,928 (1,574)	1,230 (977)	698 (597)
Other treponemal diseases	658 (745)	425 (467)	233 (278)
Other conditions requiring treatment in a centre	100,213 (90,817)	47,817 (44,370)	52,396 (46,447)
Other conditions not requiring treatment in a centre	120,951 (121,900)	76,789 (77,026)	44,162 (44,874)
Other conditions referred elsewhere	4,718 (4,135)	2,502 (2,230)	2,216 (1,905)

Table 3.6: The venereal diseases — new cases per 100,000 population by age seen at hospital clinics in England, 1980–1984

	1980			1981			1982			1983			1984		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Early syphilis															
All ages	9.41	1.60	5.41	8.50	1.44	4.90	7.92	1.42	4.58	7.54	0.89	4.13	6.45	0.94	3.62
Primary & secondary only	5.92	0.87	3.33	5.53	0.80	3.10	5.21	0.62	2.86	4.55	0.46	2.45	4.03	0.45	2.20
Under 16 years	—	0.06*	0.03*	0.06*	—	0.03*	0.04*	0.08*	0.06*	—	—	—	0.06*	0.02*	0.04*
16–19 years	4.06	3.78	3.91	4.40	2.99	3.71	3.04	1.96	2.52	3.45	1.44	2.47	2.71	1.40	2.07
20–24 years	14.83	3.47	9.27	15.27	3.52	9.48	13.34	2.51	7.99	11.94	2.01	7.03	8.12	1.85	5.03
25 years and over	7.29	0.58	3.75	6.48	0.56	3.35	6.29	0.45	3.21	5.33	0.32	2.69	5.01	0.33	2.55
Late syphilis															
All ages	4.16	2.04	3.07	4.26	1.78	2.98	3.85	1.73	2.76	3.95	1.71	2.80	3.56	1.46	2.49
Congenital syphilis															
All ages	0.27	0.24	0.26	0.26	0.31	0.29	0.25	0.28	0.27	0.17	0.17	0.17	0.11	0.16	0.14
Gonorrhoea(post pubertal)															
All ages	150.49	85.26	117.04	146.96	77.94	111.52	145,06	79.46	111.39	133.48	74.54	103.25	130.18	74.17	101.46
Under 16 years	1.75	5.99	3.81	1.82	5.30	3.52	2.22	6.40	4.25	1.59	4.13	2.83	1.88	5.60	3.69
16–19 years	276.65	420.00	345.53	277.54	393.83	334.44	277.65	390.93	332.84	273.26	381.68	325.89	277.65	392.37	333.51
20–24 years	650.23	454.13	554.19	626.78	425.17	527.39	619.77	399.26	510.90	584.51	382.18	484.36	575.10	375.20	476.56
25 years and over	131.52	39.88	83.20	127.04	33.44	77.67	120.66	35.72	75.87	105.21	30.55	65.88	98.38	28.84	61.79
Chancroid															
All ages	0.17	0.07	0.12	0.28	0.11	0.19	0.39	0.15	0.27	0.25	0.10	0.17	0.14	0.04*	0.09

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

Table 3.7: Other sexually transmitted diseases and other conditions — new cases per 100,000 population at all ages seen at hospital clinics in England 1980–1984

	1980			1981			1982			1983			1984		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Lymphogranuloma venereum	0.10	0.03*	0.06	0.13	0.04	0.85	0.08	0.05	0.06	0.12	0.04	0.08	0.10	0.03*	0.06
Granuloma inguinale	0.07	0.02*	0.04	0.04	0.06	0.05	0.06	0.01*	0.03	0.06	0.03	0.04	0.07	0.02*	0.04
Non-specific genital infection	383.82	115.02	245.98	395.74	124.65	256.53	412.51	142.47	273.93	428.10	151.50	286.21	434.80	165.56	296.77
Non-specific genital infection with arthritis	2.27	0.13	1.17	2.40	0.15	1.25	2.09	0.10	1.07	1.94	0.08	0.99	1.78	0.09	0.91
Trichomoniasis	8.42	78.62	44.42	7.30	77.26	43.23	7.11	77.21	43.08	5.77	70.56	39.01	5.29	64.55	35.67
Candidiasis	40.68	148.53	95.98	41.72	155.88	100.34	45.33	175.20	11.98	48.66	194.65	123.55	53.02	197.46	127.07
Scabies	7.95	2.05	4.92	7.68	1.65	4.58	7.25	1.63	4.37	7.97	1.56	4.68	7.40	1.45	4.35
Pubic lice (pediculosis pubis)	24.10	10.53	17.14	26.22	11.44	18.63	29.06	13.24	20.94	27.15	12.06	19.41	30.77	13.05	21.69
Herpes simplex	27.16	16.34	21.61	29.13	18.80	23.85	34.28	24.33	29.17	38.93	31.84	35.29	42.23	35.88	38.97
Warts (condylomata acuminata)	79.20	43.00	60.63	82.63	45.36	63.49	90.59	52.90	71.25	102.21	60.67	80.90	117.55	71.25	93.81
Molluscum contagiosum	3.32	1.69	2.48	3.21	2.01	2.60	3.89	2.04	2.94	4.28	2.48	3.36	5.38	2.90	4.11
Other treponemal diseases	2.52	1.48	1.99	2.44	1.34	1.88	2.34	1.25	1.78	2.05	1.16	1.59	1.86	0.97	1.40
Other conditions requiring treatment in a centre	153.48	105.81	129.04	163.83	127.17	145.01	179.44	158.80	168.85	194.47	193.28	193.86	208.96	217.65	213.42
Other conditions not requiring treatment in a centre	295.54	168.75	230.52	305.84	173.97	238.12	332.63	181.64	250.28	337.61	186.84	260.21	335.57	183.45	257.58
Other conditions referred elsewhere	6.52	4.94	5.71	6.81	5.75	6.27	7.99	6.23	7.09	9.77	7.93	8.83	10.93	9.21	10.05

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

Genital herpes

Total cases rose by 11% to 18,301. The increase was 9% in males and 13% in females. Among females cases of genital herpes more than doubled between 1980 and 1984. Some of this increase may have been due to greater awareness or the condition among the public and the medical profession.

Genital warts

In 1984 cases of genital warts increased by 16% to 44,050, a 15% increase in males and 18% in females. There were 65% more cases in females between 1980 and 1984. This increase may be partly related to greater recognition of the importance of warts because of the possible aetiological link with cervical dysplasia and carcinoma. It is accepted that female patients with genital warts should be examined by colposcopy and more physicians are being trained in the techniques of colposcopy. More clinics are obtaining colposcopes, but it is difficult to provide an adequate colposcopy service.

Syphilis

In 1984 there was a fall of 12% in the number of cases of syphilis (2,933) compared with 1983. Primary and secondary syphilis decreased by 10% with an 11% decrease in males but only 1% in females. Late syphilis fell by 11% and cardiovascular and neurosyphilis returned to figures similar to those for 1982. Cases of congenital syphilis decreased from 80 in 1983 to 64 in 1984 with four cases of early infection (ie in children under two years of age) compared with one such case in 1983. There was a marginal increase in early latent syphilis in females from 103 cases in 1983 to 118 in 1984. This was the first year since 1980 when an increase occurred. This emphasizes the need to maintain control measures such as antenatal screening.

Gonorrhoea

Total cases of gonorrhoea (47,662) showed a 2% decrease in males and 0.3% in females, less than the decreases noted in 1983 compared with 1982. Cases rose among males and females under the age of 25 years. In those over 25 years the fall affected males and females to a similar degree. Isolates of penicillinase-producing totally penicillin resistant *Neisseria gonorrhoeae* were first reported in 1976 and showed an upward trend from 1977 to 1984. For the first time, the number fell from 1,277 in 1984 to 728 in 1985. Of the 611 isolates in 1985 in which the source of infection was stated, 26% were acquired abroad.

Non-specific genital infection

The upward trend in non-specific genital infection continued with a total of 139,780 cases (428 with arthritis) in 1984; the increase was more in females (9%) than in males (2%). Reasons for this may be related to the increased availability of investigations for *Chlamydia trachomatis* referred to in this Report for 1984 (p 49).

Trichomoniasis and candidiasis

Trichomoniasis fell by 8% in both males and in females to a total of 16,751 cases while candidiasis rose by 9% in males and 2% in females giving a total of 59,668 cases.

Other conditions

Other conditions requiring treatment (100,213 cases) increased by 8% in males and 13% in females. Much of the increase in females was probably due to anaerobic or bacterial vaginosis while some of the increase in males may have been due to HTLV III infection. "Conditions not requiring treatment" (120,951 cases) decreased by 1% showing that despite the pressure on clinics and long waiting times a substantial number of patients are seen who suspect infection or wish to exclude this possibility.

Conditions referred elsewhere (4,718 cases) rose by 14%.

Staffing of the clinics

The number of hospital medical staff working in clinics in England and Wales at 30 September 1985 was 433–252.6 whole-time equivalent (WTE) — compared with 418 (250.4 WTE) in September 1984. The figures for 1985 included 120 (113.0 WTE) consultants, 31 (29.3 WTE), senior registrars, 42 (39.0 WTE) registrars, and 21 (20.1 WTE) senior house officers compared with 121 (113.6 WTE) consultants, 30 (28.7 WTE) senior registrars, 41 (38.8 WTE) registrars, and 23 (22.1 WTE) senior house officers in September 1984. At 30 September 1985 there were 21 (5.6 WTE) hospital practitioners and 188 (4.5 WTE) part-time medical officers (clinical assistants).

(g) Smallpox

As part of the redevelopment of Christ Church at Spitalfields, it was planned to clear a crypt known to contain about 1,000 bodies that had been buried there between 1729 and 1858. From the bills of mortality for that period, it was estimated that some 9% of these were victims of smallpox. Although after 125 years the probability of viable (infectious) virus remaining seemed very low the agreement of the Health and Safety Executive was sought for this work to be done.

Although controlled studies have recorded the ability of the smallpox virus to survive in unfavourable conditions, considerable extrapolation was necessary from these results to estimate the risk in a crypt where conditions for survival may have been optimal. However, there is no recorded incident where smallpox may have been transmitted from an infected corpse and there is no doubt that disinterment, both intentional and otherwise, must have occurred on many occasions, some with minimal precautions and others with none at all.

Work commenced on clearing the crypt under guidelines prepared by the Health and Safety Executive, who had consulted the Advisory Committee on Dangerous Pathogens. In April 1985, examination of a plain wooden coffin exposed a body with some intact skin on which there appeared to be crusted small circular plaques. The crypt was evacuated in accordance with a pre-arranged procedure and the three archaeologists involved were placed under surveillance. After discussion between the Health and Safety Executive and the Department, these archaeologists were vaccinated as were two doctors who entered the crypt to examine the body and take specimens for laboratory examination. This work was carried out under stringent precautions and a specimen was sent to CDC in Atlanta for analysis. At Atlanta, although two particles resembling pox virus were found on electromicroscopy, attempts to culture a virus were negative on four separate occasions. Numerous other laboratory tests were conducted but

the specimens from Spitalfield were negative and it was thus not possible to substantiate the presence of smallpox virus in the specimens. There was no clear evidence that the tissue in the sample was skin.

Surveillance of the exposed individuals was uneventful and arrangements were made for work to recommence with emphasis on particular scrutiny of sample bodies within the leadlined coffins. The work gave rise to no further incident.

Since the world-wide eradication of smallpox, and by agreement with the World Health Organization, no laboratory work on smallpox is carried out in the UK and stocks of the virus are not maintained. Only two laboratories in the world (one in Atlanta and the other in Moscow) still have WHO authority to store and work with the virus and these laboratories carry out any necessary diagnostic work. In December 1985, technicians involved in emptying a fairly old refrigerator in a London laboratory found seven ampoules bearing a 1952 date and the label 'SP 22'. As this laboratory had maintained stocks of smallpox viruses in the past, the technicians loaded the box containing the ampoules into an autoclave and subjected it to two separate sterilization cycles. Later, under the supervision of inspectors from the Health and Safety Executive, the integrity of the ampoules was confirmed and they were transferred to a Category 4 laboratory at the PHLS Centre for Applied Microbiology and Research, Porton Down where they were opened and the contents carefully sterilized before incineration. In the meantime, the four technicians involved were placed under surveillance. The surveillance period passed uneventfully.

Although for reasons of safety, no attempt was made to identify the contents of the ampoules, the existence in a laboratory of historical material with inadequate or ambiguous labelling must be a matter for concern. The Department wrote to all laboratories that had handled smallpox and allied viruses seeking assurance that a careful check had been made and that no such material was held. The provisions of the Health and Safety (Dangerous Pathogens) Regulations 1981 require notification where certain scheduled pathogens, including smallpox virus, are kept or handled.

(h) Vaccination and immunization

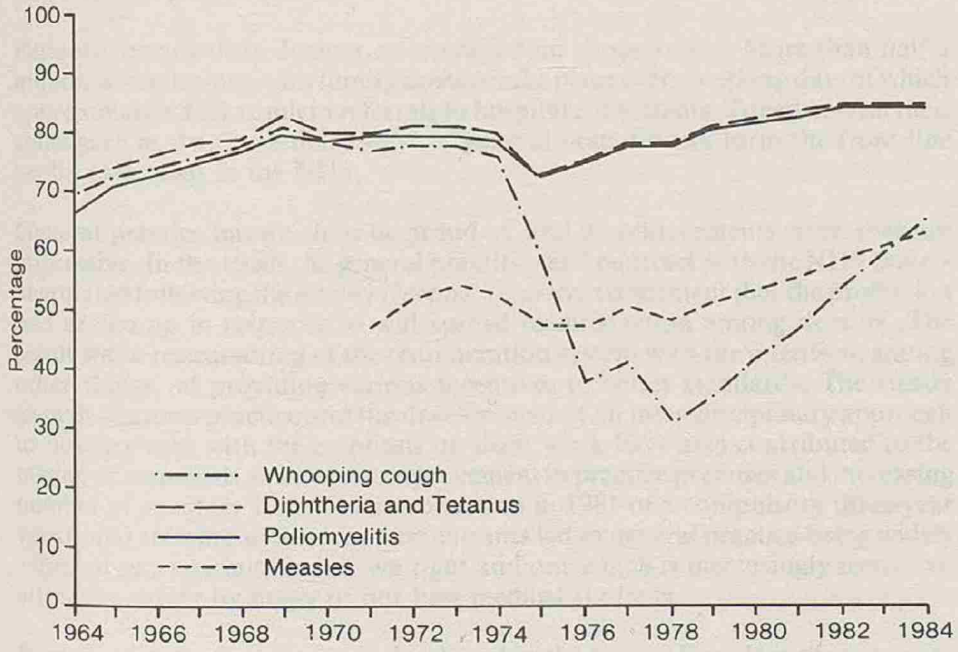
Figure 3.1 shows the acceptance rates for childhood immunization in England for the period 1964 to 1984.

In August 1985, the Department issued circulars to health authorities (HN(85)19 and HN(FP)(85)21) together with a CMO/CNO letter stressing the need for continuing efforts to improve the uptake of vaccination especially against rubella, measles and whooping cough.

With regard to rubella, attention was drawn to the target level for schoolgirls of at least 95% and an uptake of 90% in sero-negative women during the post-natal period. It was stressed for measles that a concerted effort was required to achieve an uptake level of 90% in the second year of life by the year 1990.

The circular announced a national publicity drive to promote whooping cough immunization which was to be mounted by the Health Education Council in the Autumn of 1985 to combat the expected onset of an epidemic of whooping cough which began in the latter half of the year. The publicity drive included a new

Figure 3.1:
Vaccination Acceptance Rates – England
Number vaccinated by end of stated year as a percentage of total born in second previous year.



poster and leaflet about whooping cough immunization together with material suitable for use in the press and on television.

Health authorities were asked, if they had not already done so, to designate a person or persons to take responsibility for the implementation of their immunization programmes.

4. PRIMARY CARE

(a) Facts and figures

By the end of 1984 there were 23,640 unrestricted principals engaged in general practice in England, an increase of 1.7% over 1983. In addition 2,169 assistants and trainee general practitioners were also employed. During the same year the average list size fell from 2,116 to 2,089. Most doctors now work within partnerships or groups; only 12% are single handed. Ancillary staff has increased proportionately remaining at 1.1 per principal.

During the year 83/84 the total expenditure on the NHS in England was £13,147 million. Roughly one quarter of this, £3,071 million, was spent on the Family Practitioner Services broken down as follows: £1,450 million on pharmaceutical services, £886 million on the general medical services, £592 million on general dental services and £163 million on general ophthalmic services.

The future of general practice

Patients consult their doctors on average four times a year. More than half a million consultations with family doctors take place every working day, of which approximately 10% result in referrals to hospital consultants. Together with their colleagues in the domiciliary services general practitioners form the front line health care team in the NHS.

General practice has much to be proud of, and its achievements since 1948 are impressive. In the 1960s the general practitioners' contract with the NHS was re-negotiated following the *Family Doctors' Charter*, a document that the profession had drawn up in response to widespread dissatisfaction among doctors. The result was a restructuring of the remuneration system with the intention, among other things, of providing various incentives to better standards. The steady growth of group practice and the development of an inter-disciplinary approach to primary care with the emphasis on team work have also contributed to the raising of standards as have the improvement in practice premises and increasing number of ancillary staff. The introduction in 1981 of a compulsory three-year vocational training scheme for new entrants led to general practice being widely accepted as a specialty in its own right and one which is increasingly seen as an attractive career by many of our best medical students.

Primary care services are more developed in the United Kingdom than in many other countries where patients have more direct access to expensive and sometimes possibly inappropriate specialist care. The unique nature of our primary care service lies in the fact that it is the first element in the continuing health care process and can therefore influence change or modification leading to improvements in the delivery of health care as a whole. Gps and their colleagues in the primary health care team are ideally placed to undertake certain types of screening, and other preventive or health education programmes which, especially with the growing use of computers, are increasingly being seen as important and integral parts of general practice.

In general these services are of a high standard and are well appreciated by the public. There is no doubt that such primary care arrangements have made an important contribution to the quality and cost effectiveness of the health care system. However, during the last few years there has been a growing body of

opinion within the medical profession and elsewhere which has felt that, despite past achievements, the time has come to examine critically the existing structures and arrangements in the hope that it may be possible to achieve a more effective service of a uniformly high standard whilst obtaining good value for money.

There are obvious examples of inequality in general practice especially within the inner cities as highlighted by the report *'Primary Health Care in Inner London'*[1] and the Royal College of General Practitioners' (RCGPs) recent policy statement *'Quality in General Practice'*[2]. The growing importance of community care, especially for the elderly, physically and mentally handicapped people and the mentally ill demands improvements in teamwork and the community services. Two other major factors are already having a significant impact on the health care services as a whole.

The first is the dramatic progress in new and often expensive medical technology with its resource implications and the second, partly as a consequence of this, is increased life expectancy.

The number of very elderly, those over 75 years of age, has risen by 13% from 1979 and between 1985 and 1987 there are likely to be a further 120,000 in this age group. The number of elderly and very elderly people is projected to rise even more dramatically by 17% between now and the next century. This is a result of improved social standards and the elimination of more causes of premature death. This is a fine testament to all that has been achieved over the last 20 years but elderly people naturally require more of the health service than perhaps any other group and consideration of the resource implications as well as implications for community and domiciliary care are urgently required if a universal high standard of care for this group of people is to be achieved.

The scope and role of primary care requires careful reassessment and evaluation in light of these and other developments. Many believe the time has come to build upon the existing strengths of the system by experimentation or initiative, the development of which will need much consideration and debate before a consensus emerges. This may be a slow and halting process, but without it little can usefully be achieved.

In order to structure the debate, the Government is undertaking a review of the Family Practitioner Services. Possible strategies for future development were outlined in a discussion document published in 1986[3]. At the same time the independent report on the future of the community nursing services which was commissioned by the Secretary of State and undertaken by a small working party under the Chairmanship of Mrs Julia Cumberledge was made available[4]. The Government hopes that the resulting discussions, in which the views of the professions and the public will be sought, will form the basis for a primary care service flexible enough to accommodate local demand and circumstance and one that will ensure the availability of a high quality, efficient and cost effective service for everyone.

The Government has not been alone in recognizing the vital and urgent impact of the need for change and adaptability. During the year the RCGP published *Quality in General Practice*[2], the Office of Health Economics held a discussion meeting on Health, Education and General Practice,[5] the Kings Fund College continued its important role in supporting the development of inner city primary care and some regional and district health authorities, notably the South East

Thames Regional Health Authority took a close look at the services currently available and provided far-ranging strategies for the future development of more closely integrated primary and secondary care in their areas. In many places localized experiments and research projects are under way, mainly to develop a concerted approach to cope with the increasing need for community care or for developing support systems for the most underprivileged members of society. The Lambeth community hospital, which enabled general practitioners to care for suitable patients in their local hospital and the firm proposal to employ a salaried gp by Camden and Islington Family Practitioner Committee (FPC) to care for the homeless and rootless population are two examples. There are many others.

The strategy outlined in the RCGP's policy statement[2] is not just concerned with the development of flexible, integrated community services and the professional development of the primary health care team but also addresses the problems of the disparity in the quality of care provided by individual doctors. It suggests that an assessment of the quality of the services provided by family doctors, through the setting of standards and the review of performance, should become an integral part of general practice. This theme had been echoed by many other professionals in recent years. The British Medical Association (BMA) and the RCGP recognize that in these times of ever-increasing costs the NHS must demonstrate that society is receiving value for money from each of its many services, not least primary care.

These issues and more will continue to be discussed throughout the coming year as the framework for a more responsive and integral primary care service emerges shaping the future pattern of these services for the foreseeable future.

Apart from enabling a wide-ranging discussion on the future of the service via the consultative document[3] there has been a number of Government initiatives during the year worthy of note:

(b) Prescribing

1. The selected list

For many years the profession and successive Governments have identified a need to contain the costs of the Drug Bill. There are many instances where a drug is marketed by different companies under different names, and for different cost or where effective less expensive alternatives exist. Hospitals, working within their financial budgets, were the first to recognize the possibility for savings and many took the lead by introducing their own drug formularies whereby the cheapest suitable preparations were automatically prescribed in each case. Many other countries have recognized the value of such systems and have already introduced their own lists of suitable prescribable drugs.

Many gps are also aware of the problem. Some have introduced their own practice formularies and others have audited their prescribing habits. However, unlike the cash limited hospital sector, gps have a greater freedom to prescribe drugs for their patients irrespective of cost and in some cases clinical need. Despite the achievements of some doctors, the cost of prescribed medicines has continued to grow. Some of this growth has resulted from medical advances or provision for the increased number of elderly people but it has become clear that, without harming patient care, significant savings could be made on the drug bill which could be used for essential developments in the NHS.

The Government introduced a Selected List of NHS drugs on 1 April 1985. The scheme aims to get best value for money by selecting for NHS prescribing a few of the following symptom-relieving drugs: analgesics for mild to moderate pain, antacids, tonics, vitamin preparations, cough and cold remedies, laxatives, benzodiazepines and tranquillizers.

The Selected List of drugs which continue to be prescribable at NHS expense contains approximately 120 drugs in the defined categories, this list being for guidance only and not comprehensive. Schedules 3A and 3B of the NHS (General Medical and Pharmaceutical Services) Amendment 1985 and the corresponding schedules to the regulations in Scotland and Northern Ireland contain a list of approximately 1,800 drugs which may not be prescribed at NHS expense. Schedule 3A also lists some borderline substances primarily foods and toiletries, which the Advisory Committee on Borderline Substances decided should not be regarded as drugs in the circumstances of general practice.

All drugs in therapeutic categories other than those already identified and which are not listed in Schedule 3A may continue to be prescribed on the NHS. Hospitals although not covered by the Regulations are required to follow the same practice as applies in Family Practitioner Services.

The Advisory Committee on NHS Drugs
Following the introduction of the Selected List Scheme the Advisory Committee on NHS Drugs was established with the responsibility to review the Selected List to ensure it continues to meet clinical needs at the lowest possible cost to the NHS. The Committee advises Ministers on the outcome of its reviews and on representations received from the medical profession and pharmaceutical industry. The Advisory Committee is a non-statutory body and its membership comprises representatives of all the specialist disciplines affected by the legislation including four general practitioners. Its recommendations are based on clinical need and cost and its functions therefore are completely separate from that of the Licensing Authority.

The introduction of the Selected List in April 1985 has in the event been a relatively smooth procedure which has achieved far wider recognition of the need for more economical and effective prescribing. In September 1985 the Department held a conference on prescribing which was attended by delegates of all the relevant branches of medicine and bodies representing patients. The conference agreed to an agenda for continued detailed discussion between the Department and the profession to identify further ways in which effective and economical prescribing can be promoted.

The Prescription Pricing Authority
The Prescription Pricing Authority (PPA) assists doctors to examine their prescribing habits with a view to introducing more effective and economical prescribing. It continues to provide many doctors with a detailed analysis of all the prescriptions issued by a practice in one month of the year. In 1985 the number of self-audit prescribing analyses provided by the PPA for individual doctors grew to 1,872, a reflection of the increasing importance general practitioners attach to their prescribing habits and the subsequent cost consequences. The PPA's ability to produce these audits has been enhanced by computerization and by the end of 1985 the prescriptions dispensed by pharmacists in 79 of the 90 Family Practitioner Areas were being priced by computer. In recognition of this, and the fact that the information provided to

doctors could be presented in a more immediately relevant form, a working party has been established to develop specifications for a new prescribing information computer programme. The working party's membership includes nominated representatives of the RCGP and the General Medical Services Committee of the BMA.

The Department's Regional Medical Officers (RMOs) continue to monitor gps prescribing habits and costs. Where a practice's prescribing costs appear to be substantially above the average a more detailed analysis can be provided by the PPA. During the year cost analyses were prepared in respect of 1,251 doctors. Whenever possible RMOs arrange to visit those practices where prescribing has been persistently high to discuss the subject with the doctors and to encourage them to audit their prescribing patterns more closely.

The Department has also continued to fund publications providing guidance on prescribing (*Prescribers' Journal, British National Formulary, Drug and Therapeutics Bulletin* and *Adverse Reactions Bulletin).*

(c) Oxygen concentrators in the domiciliary oxygen therapy service

In October 1984 the Minister for Health announced that oxygen concentrators would be introduced to replace cylinders for those patients requiring large quantities of oxygen for their treatment at home. These concentrators would be available through Family Practitioner Services and would be prescribed by general practitioners following consultant advice for suitable patients.

A working party was established to prepare guidelines for prescribing Long-Term Oxygen Therapy and these have been published in an appendix to the Domiciliary Oxygen Therapy Service Section (Part X) of the Drug Tariff[6]. These guidelines will assist gps to select those patients whose clinical condition is likely to be improved by the provision of oxygen for at least 15 hours a day for a prolonged period.

The Oxygen Concentrator Service came into operation on 1 December 1985.

(d) Family Practitioner Committees (FPCs)

On 1 April 1985 FPCs became free standing authorities, accountable to the Secretary of State for the provision and development of the Family Practitioner Services. This represents an important opportunity for the NHS to manage the contracts it holds with the independent contractors including family doctors more efficiently. It will also lead to an improved approach to local planning and operational matters with closer co-operation between FPCs, District Health Authorities (DHAs) and local authorities. Close inter-relationships and joint planning are essential if primary health care is to continue to develop its important role.

As part of the management planning and accountability process each FPC will prepare a five-year profile and strategy statement. In addition, similar to Health Authorities, each FPC will publish an annual programme reviewing progress made during the previous year and identifying planning priorities for the two years ahead. FPCs will be subject to periodic performance review. It is anticipated that 18 FPCs will be reviewed each year and between 1 April and the end of 1985 the first 11 reviews were undertaken.

e Computing

FPCs

Following the recommendations of the Arthur Andersen Report on the study of the role of computers within FPC administration further progress has been made in the computerization of FPC registers. So far, about one third of all FPCs have been computerized and it is intended that all FPCs will be fully computerized by April 1988. This will have benefits for not only the planning services according to demographic data and the easier transfer of medical records but in assisting gps to draw up age/sex registers for screening and preventive purposes. The computerized registers will enable the DHAs, in conjunction with general practitioners, to run cervical cytology call and recall schemes. The relationship between FPC and general practice computing is now under consideration so that the strategic use of computers may provide more effective co-ordination of health care information.

General practice

The use of computers in general practice is continuing to grow as more doctors recognize the benefits of computerized practice records for organization, planning, preventive medicine and monitoring of patients suffering from disorders such as diabetes, hypertension and epilepsy. The *Micros for gps scheme* sponsored by the Government provided assistance towards the installation of computers in 149 practices. The systems used offered facilities for registration, screening and recall of patients and the issue of repeat prescriptions. The final report of the project evaluation group, which described the practices' experiences over the first year of use, and assessed the value to gps of such computers in practice management and patient care was published in November 1985[7]. Despite initial organization difficulties and the fact that no significant saving of time was apparent, most doctors and staff thought the computer systems worthwhile and wished to maintain or expand their use. Moreover practices learnt from their own and others' experience how to introduce and use computers and how to specify their needs more effectively.

The Group reported a growing awareness that the main benefits of computers did not lie in the mimicry of manual procedures for the day-to-day routine of general practice administration, but in their ability to aggregate and analyse information. Computers demand a systematic approach to data gathering and provide more efficient ways of retrieving and analysing information. Practices had started to use these facilities to assess what they were doing, to plan and review their activities and to introduce change. A further one-year study of the longer term use of computers in practices commenced in October 1985 and will consider any innovative procedures that may have wider applications leading to improvements in the quality of health care.

The DHSS, in conjunction with the medical profession, also carried out an appraisal of a number of commercially available microcomputer systems designed for general practitioners. The aim of this study was to provide doctors with objective information which included both the technical performance of each of the systems and how gps and their staff used them. The intention was to increase doctors' awareness of microcomputer applications and enable them to make better informed decisions when choosing a system. The report of this study, *Micros in Practice*[8] was published in January 1986.

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5. DENTAL HEALTH

(a) General dental services

The number of estimates authorized for payment by the Dental Estimate Board in 1985 was 31,384,937, an increase of 1.3% compared with 1984. Decreases of 10% in the number of permanent teeth filled, of 3% in permanent teeth extracted and of nearly 10% in the number of permanent teeth either filled or extracted were observed. In contrast to trends noted in 1983 and 1984 6% fewer teeth were root-treated.

Courses of treatment (including providing crowns and restoring teeth by crowning) increased by more than 5% and the number of bridges provided by 7.3%.

General anaesthetics given by a doctor or by a dentist other than the operator decreased by more than 8%. Fees for administering analgesia or intravenous sedation were agreed during the year and introduced into the professional fee scale in October. Items relating to periodontal treatment were also altered. Prior approval from the Dental Estimates Board is required for a new item 5(a) — 'treatment of chronic peridontal disease including protracted scaling, marginal correction of fillings, oral hygiene instruction, and where required, root planing, sub-gingival curettage and gingival packing'. Item 3(a) — 'scaling, polishing and simple peridontal treatment, including oral hygiene instruction' is unchanged and a new item 3(b) has been introduced.

Peridontal treatments decreased by slightly more than 16%, but estimates, including the new item 5(a), would not all have been completed by the 31 December. Courses of treatment including peridontal surgery increased by 1.6%.

Courses of treatment for children declined by 3.5%, fillings for deciduous teeth by 4.3% and the number of extractions by 5.8%.

Dental officers in the reference service of the Department examined 20,690 patients for whom treatment (excluding orthodontic treatment) was planned or had been completed. They were broadly in agreement with the plans for treatment in 62.6% of cases. Among those patients for whom treatment had been completed they judged that it has not been entirely satisfactory in 41.8% of cases.

The reference service also examined 2,176 patients who had received orthodontic treatment. In 10.7% of these patients the dental examiner was unable to express an opinion because essential evidence was not available. The rate for adult patients who failed to complete their treatment rose from 40% in 1984 to 45% in 1985.

(b) Committee of Enquiry into unnecessary dental treatment

The Committee of Enquiry, chaired by Mr S G Schanschieff JP, FCA, was set up by the Minister of Health in December 1984 in response to concern that a small minority of dentists might be abusing the system of payments to dentists under the NHS. The terms of reference were:

> To enquire into the extent of unnecessary dental treatment in the General Dental Service; to consider methods of preventing and detecting such

treatment; to consider any amendments which may be necessary to the relevant legal provisions; and to make recommendations together with the estimated costs of those recommendations.

The Committee's Report was published in February 1986 and consultations are in progress on its 52 detailed recommendations. The Committee concluded that there was a significant amount of unnecessary dental treatment but that this was not so widespread that patients should lose confidence in their dentists, most of whom provided a thoroughly professional service. Ministers have endorsed the Committee's approach and, subject to consultation and detailed costing, intend to take action on most of the recommendations by the end of 1986.

(c) Water (Fluoridation) Act

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 antifluoridationists, 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. Given Lord Jauncey's confirmation of safety and efficacy the Government introduced the Water (Fluoridation) Act which came into effect on 30 October 1985. The Act gives specific legal powers for the arrangements under which fluoridation has been considered and implemented for over 30 years. Decisions on fluoridation schemes will continue to be taken locally by health authorities and statutory water undertakers. The Act also imposes a statutory duty on local health authorities to engage in public consultation before decisions on schemes are taken. The Act restores the option of fluoridation in Scotland and clarifies the legality of fluoridation in England and Wales. It is intended that parallel legislation will be introduced for Northern Ireland.

Health authorities in England and Wales have been given interim guidance explaining the effect of the Act, and definitive guidance on the procedures to be followed in developing schemes will be issued.

(d) Survey of dental services

In August 1985 the Office of Fair Trading made recommendations following a survey of dental services. Their report:

(a) advised against the introduction of 'denturism' (the supply of dentures directly to patients by dental technicians)

(b) concluded that dentists were unlikely to make monopoly profits on NHS work. The potential for dentists to make monopoly profits from private work was limited by the availability of NHS treatment and the scope for such profits would diminish if advertising restrictions were lifted.

(c) recommended that advertising restrictions should be lifted subject only to the usual requirements that advertising should be legal, honest and decent and have regard for professional propriety.

(d) recommended relaxation of the restrictions in the Dentists Act 1984 on laymen and bodies corporate carrying on the business of dentistry.

The General Dental Council revised their notice of Guide to Dentists in November 1985 to introduce relaxations in the rules governing advertising by dentists.

(e) Research

Women in dentistry

In 1975, the Department commissioned Mrs M E Seward to undertake a study of *The Provision of Dental Care by Women Dentists in England and Wales.* Since then the number of women in dentistry has increased so that about half all new entrants to dental school and one in five registered dentists are now women. This is an important development in respect of dental manpower planning, the economics of providing dental health care and undergraduate and post-graduate education. The Department has asked Mrs Seward to review the situation over the last ten years.

Assessment of dental materials

During 1984, the Department commissioned the University of Liverpool, School of Dental Surgery to undertake a three year study programme for the Assessment of Dental Materials. The aim of the study is to develop clinical and laboratory methodologies which will enable decisions to be taken about the suitability of new materials for use in the general dental services. The work began early in 1985 and is initially concerned with the evaluation of some commercially available resin based composite filling materials promoted for the restoration of cavities in posterior teeth. A conventional and a high copper amalgam are being used as reference materials.

Minimal intervention techniques

The decrease in dental caries noted over recent years, particularly in younger children, has emphasized the need to adopt a more cautious philosophy towards the restoration of the questionable or early lesion. This has been assisted by the advent of adhesive restorative materials which have allowed a more conservative approach to cavity preparation. Researchers in other countries have reported success with so called 'preventive fillings'. However, the Department recognized a need for research in this area before it could recommend the introduction of minimal intervention techniques. It is pleasing to note, therefore, that, following discussions with the Department, the Medical Research Council awarded a grant to Professor J J Murray and Dr J McCabe of the University of Newcastle-upon-Tyne for a controlled clinical trial to evaluate the use of minimal intervention techniques in the treatment of dental caries in children.

Hazards from dental amalgam

For more than a century, dental amalgam has been the most widely used material for the restoration of teeth where aesthetics is not a primary consideration. The risk to dentists and their staff from the mishandling of mercury is well recognized and can be minimized by taking adequate precautions. The mercury in finished amalgam restorations is not considered to be hazardous to patients though a very

small number are known to exhibit hypersensitivity to the material. Recent research has shown that amalgam fillings may continue to release mercury, particularly during prolonged heavy chewing, and it has been alleged that this may contribute to systematic mercury toxicity and be associated with neurological disorders. Scientific evidence does not support this contention but a comprehensive review is to be undertaken and the matter has been referred to the Committees on Toxicity and on Dental and Surgical Materials.

6. CLINICAL SERVICES

(a) Hospital services

(i) Supra-regional clinical services

The arrangements for selecting and funding of supra regional services were briefly set out in these Reports for 1982 (page 119) and 1984 (page 76). Since the introduction of these arrangements the Supra Regional Services Advisory Group has considered applications from 24 services. Nine of these applications were accepted, ten rejected, and five are still under consideration. The services accepted for designation were:

Spinal units
Paediatric end stage renal failure
Chorioncarcinoma
National Poisons Information Service
Neonatal and infant cardiac surgery
Liver transplantation
Cardiac transplantation
Specialized liver services
Endoprosthetic services for primary bone tumours

(ii) Heart transplantation

Future arrangements for funding heart transplantations were considered by the Supra Regional Services Advisory Group in the light of the Evaluation Report and the comments of the Standing Medical Advisory Committee, the Transplant Advisory Panel and the British Cardiac Society. The Group advised that heart transplantation should be recognized as a supra regional specialty and designated the existing units at Papworth and Harefield Hospitals. They also advised designating a new unit at Newcastle where a surgeon who had trained at Papworth and Stanford in the United States had recently been appointed. Ministers agreed to a total funding of £2.6 million for the heart transplant programme of which £0.9 million is "new money" for the 1986/87 programme. During 1985, 137 heart transplants and 37 heart-lung transplants were carried out.

(iii) Liver transplantation

Improved success rates were reported for the 81 liver transplants performed in 1985. On the advice of the Supra Regional Services Working Group it was decided that one of the three units should be de-designated. Ministers agreed a budget of £2.4 million for 1986–7 of which £0.75 million is 'new money'.

(iv) Paediatric end stage renal failure

The number of patients being treated for paediatric end stage renal failure has increased steadily and services are now virtually meeting the expected need for new patients. Ministers have approved the allocation of £3.6 million for 1986/87 of which £0.4 million is 'new money' to allow for the maintenance of the increased number of patients on treatment. It will be several years before a steady state is reached and increased funding is needed for several more years to cope with the greater number of patients receiving life-long treatment.

The Royal College of Physicians has set up a Working Party to advise on future developments in paediatric nephrology. A report is expected in 1986.

(v) Diabetic retinopathy

Serious sight-threatening diabetic retinopathy is characterized by macular or para macular hard exudates, macular oedema and reduced vision related to the formation of new blood vessels. The disease develops in an increasing proportion of diabetics some years after the onset of the condition. It is more common in diabetics requiring insulin but can be the first symptom in some diabetics who do not need insulin. It affects approximately 11% of a sample of diabetics and is the commonest cause of registered blindness in England and Wales for the age group 16–64 years. There are about 2,100 new registrations each year — 19% of the total. Treatment by laser photocoagulation has been shown to postpone, possibly prevent, the progress of the disease. Because damage cannot be reversed early diagnosis is most important. Research at three centres (Exeter, Oxford and Sheffield) is underway to evaluate different methods of screening for diabetic retinopathy. A report is expected at the end of 1988. The study will look at the cost effectiveness of different staff in carrying out direct ophthalmoscopy and in the use of retinal photography. Recently developed cameras that can be used without dilating the pupils will be evaluated.

(vi) Administration of radioactive substances

Regulations[2] require clinicians who administer radioactive substances to patients or to volunteers to be authorized by Ministers to do so. Ministers are advised by the Administration of Radioactive Substances Advisory Committee. Certificates for diagnostic and therapeutic purposes were issued for five years in the first instance, while those for research purposes were for two years. The procedure was introduced in 1980 so that the first certificates issued for diagnostic and therapeutic use were due to be renewed in 1985.

For this purpose a microcomputer was used for the 600 renewals required. The Department developed the software employing a commercially-available database language. The database consists of 1,600 clinicians and over 30,000 serials. The database has also been of value in answering *ad-hoc* questions from the Administration of Radioactive Substances Advisory Committee.

(vii) Breast cancer screening

After the randomized control trial of mammographic screening in Sweden was published Ministers set up a UK Working Party under the Chairmanship of Sir Patrick Forrest with the following terms of reference:

(i) To consider the information now available on breast cancer screening by mammography; the extent to which this suggests necessary changes in UK policy on provision of mammographic facilities and the screening of symptomless women;

(ii) To suggest a range of policy options and assess the benefits and costs associated with them; and set out the service planning, manpower, financial and other implications of implementing such options.

An Interim Report dealing with the first part of the Terms of Reference was

received by Ministers in February 1986. The Working Group concluded that the information available from the principal overseas studies demonstrated that screening by mammography could lead to the prolongation of the lives of women aged 50 years and over with breast cancer. The Working Group suggested that there is a convincing case, on clinical grounds, for a change in UK policy on the provision of mammographic facilities and the screening of symptomless women. However, the Working Group cautioned that it would not be sensible to introduce mammographic screening on a UK basis without providing the necessary back-up services to assess the abnormalities that would be detected.

The report on the second part of the Working Group's remit will be incorporated in the Final Report which is expected in 1986.

(viii) Cervical cancer screening

The DHSS issued revised guidance[3] to the NHS in 1984 which recommended regular screening every five years for women who were or who had been, sexually active. In April 1985 Ministers asked all health authorities to review the organization and effectiveness of their screening programmes; and to make plans, where they had not already done so, for computer-based call and recall of women so that all those who should be invited for screening would be sent invitations at the appropriate intervals. The principal aim was to achieve a much higher screening rate for women over the age of 35 years. They are the group most at risk of developing cancer of the cervix and least likely to have been examined.

During the year there was some public concern that patients with abnormal cervical smears were not being followed up properly. As a result the DHSS, assisted by an *ad hoc* working group drafted guidelines dealing with fail-safe arrangements which would be the subject of formal consultation with the medical profession. The Royal College of Obstetricians and Gynaecologists also set up a joint working group with the Royal College of Pathologists, Royal College of General Practitioners and the Faculty of Community Medicine. Among matters to be considered were whether greater standardization of cervical cytology reports would be helpful and whether measures could be recommended to improve the quality of smear-taking.

(ix) Data bank for cardiac valve replacement

In the NHS every year nearly 5,000 cardiac valve substitutions are carried out by 125 surgeons working in 50 centres. More than 20 prosthetic devices are at present marketed and no single centre has enough experience with the devices to be able to judge the relative merits of all of them.

The Department, with co-operation of the Society of Thoracic and Cardiovascular Surgeons has established a National Valve Registry at Hammersmith Hospital, London.

Data from all the centres will be made available to all participating surgeons at least once a year. The scheme commenced 1 January 1986.

It is hoped that this procedure will help surgeons to choose a device and enable DHSS to monitor the 'device behaviour' and operate an early warning system in case of device failure.

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(b) Aspects of human reproduction

(i) Exposure to ionizing radiation on women who are, or may be, pregnant

In 1983 the International Commission on Radiological Protection (ICRP) revised its advice on the hazards to the fetus of irradiation to the pelvis in the first two weeks following conception. The revised advice acknowledges that the risk to a fetus irradiated *in utero* in the first four weeks following the onset of the last menstruation is likely to be so small that there need be no special limitation on radiological exposures required within these four weeks. In March 1985 the National Radiological Protection Board endorsed the advice given by ICRP.

Following discussions with the Department's Radiological Advisory Committee, the Administration of Radioactive Substances Advisory Committee and professional organizations, the Department commended the National Radiological Protection Board's advice to doctors.

(ii) Contraception for the under 16's

In October the House of Lords gave judgement on the appeal by the DHSS in the Gillick case to which reference was made in *this Report* for 1984 (page 81). By a majority decision the Law Lords decided[2] that the DHSS guidelines [2,3] which said that it was proper in exceptional circumstances for doctors to give contraceptive advice and treatment to young people without the knowledge and consent of their parents were lawful. However, one of the Law Lords set out criteria which should be satisfied before a doctor prescribes a contraceptive to a girl under 16 years of age. These were that the girl should understand the doctor's advice; that he cannot persuade her to inform her parents or to allow him to inform parents that she is seeking contraceptive advice; that she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment; that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer; and, that her best interests require him to give her contraceptive advice, treatment or both without parental consent. The DHSS guidance has since been revised to take account of the Law Lord's judgement and other views expressed during the course of the case.

(iii) Report of the Committee of Enquiry into Human Fertilization and Embryology

This Report for 1984 (page 79) referred to the publication of the report of a committee chaired by Baroness Warnock and mentioned the deep public controversy about their recommendations on human embryo research[4]. This was shown in the results of the consultation exercise on the report and in opinion polls which suggested that the number of people who felt such research was ethically acceptable equalled the number who opposed it. A Private Member's Bill entitled *'The Unborn Children (Protection Bill)'* which sought to ban research on human embryos and to regulate the use of *in-vitro* fertilization (IVF) in treatment was introduced into the House of Commons. It did not get a third reading.

Early in the year the Medical Research Council and the Royal College of Obstetricians and Gynaecologists announced that they had established a Voluntary Licensing Authority for human *in-vitro* fertilization and embryology (VLA) to be chaired by Dame Mary Donaldson. They accepted the view of the

Warnock Committee that regulation was appropriate but recognized that Government legislation would not be introduced immediately. Centres engaged in, or proposing to undertake, the practice of, or research into, human IVF and pre-embryo insertion were invited to apply to the VLA for approval of their clinical work and/or research proposals. Centres would be inspected and be required to demonstrate that they were following the guidelines for both clinical and research applications of human IVF[5] prepared by the VLA.

The Warnock Committee had recommended that restrictions be placed on surrogacy agencies. In March the Government introduced a Bill to ban commercial surrogacy agencies and advertisements about surrogacy. The Surrogacy Arrangements Act 1985 received the Royal Assent in July[6].

(iv) Fetal viability and clinical practice

Termination of pregnancy after 24 completed weeks of gestation is uncommon and has usually been performed because of major fetal abnormality. Advances in neonatal care have posed an ethical dilemma with regard to termination at this stage where there is no major fetal abnormality incompatible with survival. With intensive care over 50% of babies born at 27 weeks of pregnancy and some 15% born at 24 weeks are alive 28 days later. The legal position is as set out in the Infant Life (Preservation) Act 1929[7], passed long before the era of neonatal intensive care. This made it an offence wilfully to destroy the life of any child capable of being born alive. For the purpose of the Act 28 weeks of gestation was regarded as prima facie proof that the fetus should be considered as viable.

Widespread concern led the Royal College of Obstetricians and Gynaecologists to establish a committee with other professional bodies and produce recommendations. Copies of their Report[8] were sent to all Fellows and members of the College. Its main recommendation was that the gestational age after which a fetus is considered as viable should be changed from the present limit of 28 weeks (196 days) to 24 weeks (168 days) of gestation. The DHSS discussed the Report with the proprietors of nursing homes approved for termination of pregnancy after the twentieth week of gestation. A voluntary agreement was reached that termination beyond the twenty-fourth week would cease. This has subsequently become a condition of approval for these homes.

(v) Maternal mortality

The future of Confidential Enquiries into Maternal Deaths
A Working Group of the Royal College of Obstetricians and Gynaecologists which was set up in 1984 to consider the future of the Confidential Enquiries into Maternal Deaths made its recommendations at the beginning of 1985. It concluded that the Enquiry should continue but that the form used to collect the case reports should be changed so that it would provide information on how much lack of resources contributed to sub-standard care. Improvements to the format of the published reports were recommended.

Probably the Working Group's most important recommendation for the future of the Confidential Enquiries was that England and Wales, Scotland and Northern Ireland should collaborate in producing a combined United Kingdom report. The first meetings between representatives of the four countries to discuss future collaboration were held in the summer and autumn of 1985. It is intended

that maternal deaths occurring after 1 January 1985 will be included in a joint United Kingdom report.

Confidential Enquiries into Maternal Deaths, 1979–81

The 1979–81 triennial Report on the Confidential Enquiries into Maternal Deaths in England and Wales was expected to be published in 1985 but delays in collecting data led to publication being postponed until April 1986.[9] The report was the tenth in the series which has now continued for 30 years.

The format of the report was changed. The Chapter on the place of booking for delivery was omitted and the term 'avoidable factors' replaced by 'substandard care'. The latter term was used to denote not only departures from acceptable standards of clinical care but also other factors such as shortage of resources or back-up facilities for the maternity services.

The present report shows that the maternal mortality rate for 1981 was 8.9 per 100,000 total births which is a fall of about 90% since 1951. The maternal mortality rate has roughly halved in each decade since the first report in 1951–54.

For the first time "late" deaths occurring more than 42 days after pregnancy or delivery have been extracted from the total and placed in a separate Chapter. Case reports were received for 365 deaths but when the 66 "late" deaths were excluded 299 deaths remained. Of these 176 were direct obstetric deaths and 123 associated deaths, of which 92 were classified as indirect and 31 as fortuitous. Only one known direct obstetric death was not reported to the Enquiry.

The six most common causes of maternal death were hypertensive disease of pregnancy, pulmonary embolism, deaths associated with anaesthesia and ectopic pregnancies, amniotic-fluid embolism and haemorrhage.

Hypertensive disease of pregnancy caused 36 deaths compared with 29 in 1976–78. The mortality rate also rose from 12.7 to 14.7 per million pregnancies. It was considered that management was substandard in 75% of these patients. Cerebral haemorrhage was the commonest complication causing death and probably resulted from a failure to control hypertension. The authors of the Report recommended expert teams should be set up in each Region to advise on the management of patients with severe hypertension in pregnancy.

Deaths from pulmonary embolism were reduced from 45 in 1976–78 to 23 in 1979–81, and the mortality rate per million pregnancies was halved from 18.9 to 9.4. It was hoped that this fall was due to better clinical management. The importance of pre-disposing factors was stressed.

Deaths directly associated with anaesthesia were reduced from 30 to 22. Many of these deaths were still associated with substandard care. Difficulties with endotracheal intubation led to the death of eight patients and failure in post-operative care was a factor in seven other deaths.

For the first time in the series of Reports haemorrhage, with 14 deaths, was not one of the four major causes of death. The death rate fell from 10.5 to 5.7 per million pregnancies. In 12 of the 14 cases the patient was considered to have had substandard care. However, if the deaths from all other causes where haemorrhage played a part were included, excessive blood loss played a part in a quarter of all the direct obstetric deaths. Suggested guidelines for the management of major obstetric haemorrhage were included in the Report.

Other causes of direct obstetric death were abortion and sepsis. The total of 14 deaths following abortion was the same as in 1976–78, when deaths associated with anaesthesia were excluded. There were five deaths after legal abortion, of which four were due to pulmonary embolism and one to sepsis. There was only one death from illegal abortion. The death rate from sepsis was halved in deaths unrelated to abortion from 6.6 to 3.3 per million pregnancies.

The death rate following Caesarean section fell from 0.7 to 0.5 per 1,000 operations between 1976–78 and 1979–81, but more operations were performed and more women died (87 compared with 81). Twenty-eight of the deaths were from associated disease not direct obstetric causes. One third of all obstetric deaths occurred in women delivered by Caesarean section and in these cases there was a much higher death rate associated with the operation performed as an emergency (0.6 per 1,000 operations compared with 0.1 per 1,000 for elective procedures).

Of the 66 "late" deaths, five were still considered to be due to direct obstetric causes. Two were cases of chorioncarcinoma, one of pulmonary embolism, one sepsis and one of postpartum cardiomyopathy.

An autopsy was not done in four of the 176 direct obstetric deaths. In 39 cases the autopsy appeared to have been unsatisfactory and in 85 cases histology reports were either incomplete or not available. The extended pathology Chapter in the report analyses the autopsy findings.

References

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[2] Department of Health and Social Security. *Family planning services for young people.* Heywood (Lancashire): Department of Health and Social Security, 1980. (Health Notice: Health Services Management: HN(80)4).

[3] Department of Health and Social Security. *Family planning Services for young people.* Heywood (Lancashire): Department of Health and Social Security, 1981. (Health Notice: Health Services Management: HN(81)5 (Local Authority Social Services Letter: LASL(81)2)

[4] Committee of Enquiry into Human Fertilization and Embryology. *Report.* London: HMSO, 1984. (Cmnd 9314). Chairman: Dame Mary Warnock.

[5] Medical Research Council, Royal College of Obstetricians and Gynaecologists Voluntary Licensing Authority for In Vitro Fertilization and Embryology. *Guidelines for both clinical and research application of human in vitro fertilization 1985:* MRC/RCOG, 1985.

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[7] *Infant Life (Preservation) Act 1929.* London: HMSO, 1929.

[8] Royal College of Obstetricians and Gynaecologists. *Report on fetal viability and clinical practice 1985.* London: Royal College of Obstetricians and Gynaecologists, 1985. Chairman: R W Beard.

[9] Department of Health and Social Security. *Report on Confidential Enquiries into Maternal Deaths in England and Wales, 1979–81.* London HMSO 1986 (Report on Health and Social Subjects;29).

(c) Mental health

(i) Joint Conference on Mental Health Service Planning

This lively conference held jointly between the Royal College of Psychiatrists and the DHSS was attended by professional representatives of the statutory services. Among the main themes discussed were an examination of the relationships between local and central governments, the adverse effects of inadequate funding on health services, and the need for better Departmental guidance on policies related to the development of community services.

Present services were generally considered to be under funded but disagreement arose over how the problem could be best solved. Some thought bridging loans were the solution for District-based services but others suggested that better financial strategies and more cost-effective working programmes could compensate for lack of financial resources.

The difficulties associated with working with multidisciplinary groups and the need to establish efficient information networks which kept everyone aware of current events were acknowledged. The diversity of views expressed — eg by opposing proponents of mental hospitals versus DGH units and community mental health centres — made clear the need for but difficulty of providing central guidance to policy makers in the mental health field.

(ii) Government response to Report on Community Care

The Report of the House of Commons Social Services on Committee Care published on 18 February 1985[1] contained 101 recommendations on community care for mentally ill and mentally handicapped people.

The Government's response (20 November 1985)[2] which summarized current policy on mental illness and mental handicap services, was sent to all Health and Social Services authorities. It welcomed the support given by the Committee and many witnesses to the philosophical and practical aspects of community care. The Government is giving priority to the development of an integrated network of local services capable of meeting the special needs of clients and ensuring them satisfying lifestyles within the community. This will lead to changes in the use of large hospitals with some contractures and closures.

Health and local authorities are spending more on mental illness and mental handicap services. The Government recognizes that community care is not a cheap option. It offers a better and more relevant use of community care resources.

Much is being achieved in the development of community care, but much remains to be done. Everyone concerned has a responsibility to make the most of available resources and develop a comprehensive range of local residential and other support services to meet the assessed needs of individual mentally ill and mentally handicapped people.

(iii) Psychiatric rehabilitation for the mentally ill

The Department promotes psychiatric rehabilitation by designating and promoting demonstration services. Two new centres were designated in 1985,

making a total of seven but it is hoped to have at least one in every Region. The broad criteria for designation as a demonstration service are:

1. A service must carry out good rehabilitation practice.

2. It must demonstrate that practice.

3. It must be supported by District and Region.

Good practice involves the provision of comprehensive rehabilitation for people of all ages and all forms of mental illness. This means determining each person's maximum potential and helping them to live as satisfying and fulfilling a lifestyle as possible.

Demonstration services provide treatment facilities and act as focal points for the development of services. Examples of good practice, advances in rehabilitation and what can be achieved in treating particular conditions or problems are presented.

(iv) Elderly people with psychiatric disorder

Previous reports have detailed information on the growing numbers of elderly people with psychiatric disorder and some of the responses to this both centrally and by professional bodies and other organizations. In February a further programme of centrally funded Care in the Community pilot projects was announced and this included three projects for elderly mentally ill people. In Hillingdon, places in five residential homes with extra care staff will be used to enable 40 elderly mentally ill people to leave hospital. An intensive home care scheme will be set up and people at present resident in these homes will be able to return to their own homes. In Camberwell a residential home staffed by Age Concern will enable 30 elderly mentally ill people in Cane Hill Hospital to move to community care closer to their families. A psychogeriatric support team from Maudsley Hospital will support this service. In St Helen's and Knowsley, 20 patients in Rainhill Hospital will move to a new 30-place purpose built home for highly dependent elderly mentally ill people. Day care will be provided. Each of these schemes represents a different approach to supporting elderly people in their own localities. They epitomize joint planning between different agencies and like other Care in the Community pilot schemes they will be evaluated by the Personal Social Services Research Unit at Kent University.

The Department is also funding three special medical development projects for elderly mentally ill people. These will provide homely care on a long-term residential basis for people with severe mental illness, usually dementia. The majority of such people now in hospital care are in mental illness hospitals and we are anxious to see how feasible it will be to care for them in smaller groups in local settings. There are to be three schemes, at Liverpool, Hertford and High Wycombe. High Wycombe, a product of a joint partnership between Buckinghamshire County Council and Wycombe Health Authority opened in February. It will provide for those residents whose needs cannot be met by existing local authority elderly mentally ill units or the Department of Mental Health for the Elderly. It will offer training courses for people working with the elderly in all settings; support for other residential homes, sheltered housing, hospitals and nursing homes; and services for local gps and elderly people living at home with their families. It will accommodate 16 full-time residents and have

four temporary relief beds. All three projects will be evaluated by a research team led by Professor Copeland of the Institute of Human Ageing in Liverpool.

(v) Care in the community pilot projects

The Government's Care in the Community scheme enables long-stay hospital patients to return to the community, where this is best for them and their families. Over £16 million of joint finance has been reserved in the four years up to 1988 to help fund 28 pilot projects. The Personal Social Services Research Unit, University of Kent will monitor and evaluate the programme and provide an information service.

The pilot projects cover a variety of services which cater for clients who need different degrees of support and care. Residential and day care facilities and support services for clients and their families are included. Eight of the projects are for mentally ill people; eleven for the mentally handicapped; seven for elderly or elderly mentally infirm; one for physically handicapped adults; and one for very handicapped children. The pilot project scheme is intended to launch the initiative, explore different approaches to moving people and resources into community care, and share experience.

(vi) Closure of Camberwell Resettlement Unit

Camberwell Resettlement Unit provided temporary board and lodging for people without a settled way of life. Alternative hostel bed spaces were made available and the unit closed on 27 September 1985. Those residents requiring hospital care were appropriately placed by the four Thames Regional Health Authorities.

(vii) Mental Health Act Commission

The Mental Health Act Commission's work is primarily concerned with patients detained under the Mental Health Act 1983 but extends into some aspects of the care of informal patients. Its first Biennial Report was published in October 1985[3].

The Commission's main functions are to monitor the use of powers of detention and procedures for consent to treatment and to examine complaints by and on behalf of detained patients.

The Report draws attention to difficulties such as coping with the needs of the mentally handicapped who are not detained, and the limited extent to which treatment is available for the violently disturbed. The extent to which the needs of non-detained patients are within the brief of the Commission is questioned.

The Consent to Treatment procedures set up under the Mental Health Act (1983) whereby, with certain safeguards and for certain treatments, mentally disordered people may be treated without their consent, have been accepted and are working well, including the appointment and use of doctors to provide second opinions.

Some areas relating to consent, where as yet no clearly defined or agreed clinical or legal answers exist, have been identified for the mentally handicapped, the elderly and informal patients.

In looking at the outcome for discharged patients the Commission has necessarily concerned itself with the need for the local development of community services, for active co-operation between Health and Local Authority services and for the development of plans for rehabilitation as part of a treatment plan. Compulsory treatment for detained patients on leave of absence in the community is a matter for debate and concern. At present they may not be treated compulsorily but clinicians may wish to treat them to prevent relapse or deterioration, thus avoiding recall to hospital.

Much of the Commission's work has been concerned with Special Hospitals and with the long delays that occur before a patient is transferred to a local mental hospital after their treatment in a Special Hospital.

References

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[2] Department of Health and Social Security. *Government response to the second report from the Social Services committee. 1984–85 session: community care: with special reference to adult mentally ill and mentally handicapped people.* London: HMSO, 1985. (Cmnd. 9674).

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7. ARTIFICIAL LIMB, VEHICLE AND APPLIANCE SERVICES (ALAC)

(a) The Artificial Limb Service

The review of the Artificial Limb and Appliance Service is now complete (see this Report for 1984 — page 94). The draft recommendations of Professor McColl's Working Party were submitted to the Minister for the Disabled, Mr Tony Newton, in August, 1985.

The Working Party received over 1,000 written submissions and heard many personal presentations during the 18 months it took to prepare its report which was published early in 1986.[1] Interested parties, individuals, and organizations for the disabled have been invited to comment upon the Report before the Minister decides what to do.

(b) Computerization of ALAC services

A Steering Group was arranged during the year to study how to set up a computer network to meet ALAC Service requirements and to store relevant data (including clinical information on amputees). It is hoped that this programme will be completed during 1988.

(c) The Thalidomide review

At the request of the Thalidomide Trust, a team consisting of a Senior Prosthetist, a Senior Medical Officer and an experienced Technical Officer was set up to review many of the patients with thalidomide-induced limb malformations. Thirty-six patients accepted the invitation to be assessed. They are now all in their early twenties and are largely independent and able to enjoy most normal social, leisure or vocational pursuits. Their prosthetic and wheelchair prescriptions were upgraded where necessary in order to take advantage of the latest development in lightweight materials and fitting techniques. A report was compiled and may be published in 1986.

(d) Above-knee stump casting technique

As mentioned in this Report for 1984 (page 95) a satisfactory casting technique of the above-knee stump is essential for the introduction of modern prosthetic materials.

Above-knee sockets have hitherto been prepared by measurement of the stump. Methods for taking a plaster cast of the stump have not been developed. In 1985 clinical trials comparing the techniques for above-knee casting favoured by two lower limb contractors began. It is pleasing to record that so far both systems appear to have provided sockets that fit better and this has led to greater satisfaction for the patient. Although both techniques are more time-consuming than the previous method of measuring the stump, the prosthetists preferred the new techniques and introduced them at Centres where they worked. The long-term objective will be to select one preferred technique (or possibly an amalgam of the better features of each technique). This will then be officially approved and become the standard practice for teaching to all student prosthetists.

(e) New range of wheelchairs

Two new models of wheelchair were introduced during 1985. One of these has

been designed for the young active user ("The Sprint"), and the other for the growing child of 10–13 years. The latter fills a gap in the present DHSS range.

Three "New Look" models of the standard range were also introduced. These are available in various colours and are attractively upholstered.

In an attempt to provide a more cost effective service to elderly patients steps were taken to encourage wheelchair manufacturers to introduce a low cost maintenance-free chair. ("The Grannie Chair").

(f) The invalid three wheeler (ITW)

With the introduction of the Mobility Allowance in 1975 there was an opportunity for ITW users to convert on a cash allowance. Since then the fleet of ITWs on issue has steadily declined. However, a programme to encourage the remaining users to convert to the cash allowance more rapidly will reduce the growing difficulty and disproportionate cost of maintaining this ageing fleet on the road.

(g) Cambridge symposium

The annual DHSS/RCS Symposium took place in Cambridge on 25 October.

(h) Statistics

In 1985 there were 5,394 new patients (24 more than 1984—Table 7.1). The overall ratio of arm amputations to leg amputations was 1:29.8.) There were 180 non-amputation cases and a further 135 with congenital deficiencies or malformations.

Table 7.1: First attendances at Artificial Limb Centres, England 1985 (Total first attendance for 1984 in parentheses).

	Male	*Female*	*Total*	
Single arm amputations	128	36	164	(155)
Single arm non-amputations +	83	49	132	(116)
Single leg amputations	2961	1579	4540	(4552)
Single leg non-amputations +	21	10	31	(25)
*Double arm amputations	3	2	5	(3)
Double arm non-amputations +	2	6	8	(3)
**Double leg amputations	365	129	494	(493)
**Double leg non-amputations +	2	—	2	(5)
Other multiple amputations	6	5	11	(15)
Other multiple non-amputations	5	2	7	(3)
	3576	1818	5394	(5370)

(+ e.g. congenital shortening, polio, etc)
* Includes double arm previously single
** Includes double leg previously single

The overall ratio of male to female was 1.97:1 (2.02:1 in 1984). The male to female ratio for the 0–9, 10–59, 40–79, 60–79 and 80 and over age groups were

respectively 1.28:1, 3.69:1, 2.25:1, 2.03:1, and 0.84:1. The corresponding ratios for 1984 were — 1.2:1, 3.35:1, 2.32:1, 2.13:1 and 0.9:1.

The ratio of arm to leg amputations following trauma (Table 7.2) was 1:2.3 (1:2.93 in 1984). The corresponding ratio of arm to leg amputations due to disease was 1:78.4 (1:71 in 1984).

Table 7.2: Number of first attendances for injuries resulting from trauma, 1985 (Figures for 1984 in parentheses).

	1985	
Traumatic injuries-total (amp and non amp)	484	(448)
Arm trauma (amp and non amp)	145	(132)
Leg trauma	335	(312)

Prostheses for non-amputees

Table 7.3 lists the reasons for providing a prosthesis to non-amputees — as for the last two years 75% were for congenital defects.

Table 7.3: Reason for providing a prosthesis to non-amputees

	Male	*Female*	*Total*	*% total non-amputations**
Trauma	39	1	40	22.2
Congenital	72	63	135	75.0
Disease †	2	3	5	2.8

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

Reasons for amputations

In 1985 a total of 3,332 (63.9%) of all leg amputations were performed for peripheral vascular disease (PVD). This is identical to the figure for 1984. Of all amputations, 20.7% were recorded as being undertaken for diabetes, mainly because of vascular complications, but the true percentage is probably much higher. As mentioned in this Report for 1984 (page 95) there is a proven association between these two conditions which has yet to be reflected in our figures.

Even using present data, peripheral vascular disease and diabetes now account for 86.6% of all lower limb amputations. The benefits nationally of a reduction in smoking and dietary intake of saturated fats may not become apparent for several years.

If other levels of amputation are excluded, the overall percentage of above-knee amputations (including through-knee procedures) to below-knee amputations (including Symes) was 53.0%:47.0%. Last year's trend away from a reduction in above-knee operations has now been reversed. A resumption of the more usual

pattern may mean that either more vascular reconstructive procedures are proving successful, or that more amputations of the failed cases are being undertaken at below-knee level.

Road traffic accident (RTAs) — pedestrians, riders or occupants of road vehicles — accounted for 223 attendances (i.e. amputations and non-amputations). This is an increase of four cases from 1984. The number of two-wheeler drivers seen has slightly increased this year as compared with 1984; 113 to 109. There was a modest reduction in pillion passengers involved.

Table 7.4: Patients seen for the first time at Artificial Limb Centres in England 1985 (Amputees and non-amputees)

(i) Age distribution	*Male*	*Female*	*Total*	*% Total*
Age range				
0–9	78	61	139	2.6
10–19	74	31	105	1.9
20–39	271	57	328	6.1
40–59	611	171	782	14.5
60–79	2183	1073	3256	60.4
Over 80	359	425	784	14.5
Total	3576	1818	5394	100.0
(ii) Reasons for amputations				
Vascular	2244	1088	3332	63.9
Metabolic				
i Diabetes	663	417	1080	20.7
ii Other	1	3	4	0.1
Trauma	336	78	444	8.5
Malignancy	101	90	191	3.7
Neurogenic deformity				
(i) Acquired	9	7	16	0.3
(ii) Congenital	21	22	43	0.8
Infection (including gas gangrene)	58	46	104	2.0
Total	3463	1751	5214	100.0

Table 7.5: Analysis of main reasons for amputation and details of road accident cases, England 1985

	Male	*Female*	*Total*	*% total of vascular cases*
(a) Breakdown of vascular aetiology				
Arteriosclerosis	2027	950	2977	89.3
Embolism	129	77	206	6.2
Thromboangiitis	26	3	29	0.9
Varicose ulceration	21	38	59	1.8
Others	41	20	61	1.8
				100.0
(b) Breakdown of trauma aetiology				
(Amputation and non-amputation*)				% of Trauma Aetiology
Total	405	79	484	
Industrial	106	5	111	22.9
RTA	164	20	184	38.0
Pedestrian	41	21	62	12.8
Home	35	19	54	11.1
Recreation	10	2	12	2.5
Armed forces	12	—	12	12.5
Rail	23	2	25	5.2
Other	14	10	24	5.0
				100.0
(c) Breakdown of RTA and pedestrian cases				% of total RTA
Total	182	41	223	
Pedestrian	41	21	62	27.8
2-Wheeler driver	108	5	113	50.7
2-Wheeler passenger	6	3	9	4.0
Other vehicles				
Driver	19	1	20	9.0
Passenger	8	11	19	8.5
				100.0

(* See footnote to Table 7.3 for explanatory example on non-amputation following road accidents).

(i) The vehicle service

An analysis of the motor vehicles and wheelchairs on issue is shown at Table 7.6. As in recent years, the increasing number of disabled drivers opting for the cash benefit of the Mobility Allowance or the War Pensioner's Mobility Supplement has meant a continued decline in the powered vehicles and private car allowances on issue.

Table 7.6: Analysis of vehicle and chairs on issue in England at 31 December 1985 (Figures for 1984 in parentheses)

(a)	Powered vehicles and private allowances		
	Motor cars	2263	(2894)
	Petrol propelled three wheelers	4847	(6606)
	Electrical propelled three wheelers	93	(123)
	Private car allowance (PCA's)	45	(357)
(b)	Non-powered wheelchairs (including spinal carriages, pedal and hand tricycles)	432,013	393,361
(c)	Powered wheelchairs		
	Indoor electric chairs	10,548	(10,380)
	Outdoor electric chairs	7,966	(7890)
	Total	457,775	424,611

Table 7.7: Patients using the Artificial Limb, Vehicle and Appliance Service in England in 1985. (Figures for 1984 in parentheses)

Artificial Limb Service	61,891	(66,230†)
Vehicle Service*	429,663	(376,093††)
Appliance Service	13,406	(13,804)

* Figures in Table 7.7 refer to patients whereas Figures in Table 7.6 refer to numbers of vehicles on issue. A patient may have a motor vehicle or private car allowance, a powered chair and one or more wheelchairs.

(† The 1984 total included figures for Wales) (†† did not include powered chairs).

The total number of motor vehicles on issue at 31 December 1985 was 7,203 a decrease of 2,420 on 1984.

(j) The appliance service

Charged under Royal Warrant with the prescription and supply of orthoses to War Pensioners, the service is responsible for 13,406 pensioners, a decrease of 398 on the number for 1984.

Reference

[1] Department of Health and Social Security, *Review of Artificial Limb and Appliance Centre Services.* Report of an independent Working Party (Chairman: Professor Ian McColl). DHSS, 1986.

8. NATIONAL HEALTH SERVICE (NHS) ORGANIZATION AND MANAGEMENT

(a) Implementation of the NHS Management Enquiry Report

The year saw rapid progress made with the implementation of the recommendations of the NHS Management Enquiry. At the centre the NHS Supervisory Board and the NHS Management Boards came into being and began work. At District level the appointment of general managers was completed, and the majority of health authorities reviewed their internal management arrangements. The appointment of general managers at unit level also proceeded and at the end of the year about two thirds of the expected total number of appointments had been made. It is hoped that all appointments will have been made by the summer of 1986, and that more than 800 general managers will be in post at various levels within the NHS.

Concern was expressed during the year about the role in the new arrangement of specialists in community medicine. There is no doubt that the provision of a medical overview in planning and service development will continue to be crucial, as will the co-ordination of medical advice to health authorities and their managers. All health authorities have identified sources of community medical advice, but in many the range of work undertaken by medical chief officers has been expanded. Some have become unit general managers and many have taken on responsibility for identified tasks such as the oversight of planning.

(b) Körner and performance indicators

Health Service Information

In 1985, the Steering Group on Health Services Information (the "Körner" Committee) published a supplement to its First and Fourth Reports, providing the remainder of the minimum data set items on maternity services. This completed the Steering Group's work to identify the minimum information requirements of management in the NHS.

The Dental Services Statistics Group, sponsored by the Steering Group, produced its interim report on the information requirements for the dental services. They expect to produce their final report during 1986.

In October 1985, a programme for the early implementation of the Steering Group's proposals was confirmed by Ministers and Regional Chairmen and the Management Board was asked to monitor progress. The feedback from the fourteen Regional Health Authorities (RHAs) indicated that the Service is committed to the implementation of the Körner requirements and are planning to do so within the national timetable.

The Steering Group wound up and was superseded by the Information Advisory Group which met for the first time on 25 September under the chairmanship of Mr Fairey. A non-executive body, set up to advise the Management Board on Hospital and Community Health Services information and Information Technology matters, it has a membership of nine consisting of four representatives of RHAs, four from District Health Authorities (DHAs) and one from the Department. One of its first aims is to produce a national strategic framework for information management in the HCHS for consideration by the Management Board. This is currently being drafted.

Performance indicators

The Joint NHS/DHSS Group on Performance Indicators presented their report to the Secretary of State in January 1985[1]. Work was immediately put in hand to produce a computer-based package of performance indicators, with an emphasis on the geographical presentation of values in order to highlight areas of unusual performance and to stimulate users to enquire further into the aspect they had chosen to investigate. A package based on 1983 data was produced in a remarkably short time, and was issued to all health authorities in England in July 1985, under cover of HC(85)23[2].

The package was designed to be much more convenient than the previous Indicators. The specially written computer programme operates on equipment readily available to potential users throughout the health service, the same equipment that is required for the Körner training package and for the complementary performance indicators developed by John Yates, of the Health Services Management Centre, Birmingham[3].

Topics covered by the performance indicator computer package include a much wider range of services than those previously published in book form by the DHSS in 1983. Although there has been a threefold increase in the number of indicators, the computer presentation enables inexperienced users to have rapid access. In all there are now some 450 performance indicators available which are divided into eight groups, acute services, services for children, elderly, mentally ill, mentally handicapped, support services, manpower and estate management. These cover the subjects dealt with by the eight working groups who reported to the joint NHS/DHSS Group of Performance Indicators[4]. The groups of performance indicators are not presented as being mutually exclusive. Manpower performance indicators, for example, also feature in the client-based groups such as acute services, but they are represented separately for users with a special interest in the subject.

As the 1983/84 package was well received by users, every effort was then made to assemble a second package of performance indicators based on 1984 data. This was achieved, again very quickly, and indicators covering 1984/85 data were all issued to all health authorities in December 1985, under cover of Circular HN(85)32[5].

The latest package updates the first set by incorporating further facilities for viewing performance indicator values for individual districts. For example, a district can now compare itself with other districts considered to be similar as a group; a separate grouping of teaching districts can also be shown. In addition there is provision for a time series which will show how performance indicator values change over successive years within a given district; a manager, from his own data, can also enter locally calculated performance indicators, thus providing an extended time series.

Towards the end of 1985 attention was being focussed on the effect that implementation of the recommendations of the Körner Committee will have on the performance indicator package developed so far. It is likely that the performance indicator package as it stands will have to be amended, both to incorporate the new and better quality Körner-based information, and to build upon the experience of users.

(c) Confidentiality of personal health information

During the year the Department completed its consultation on the proposed code on the confidentiality of personal health information and continued to work closely with the Interprofessional Working Group on Access to Personal Health Information, chaired by Sir Douglas Black, to amend the code in the light of the comments received. It is expected that the final code, will be promulgated in a direction from the Secretary of State, under the 1977 NHS Act in 1986.

In September 1985, the Department issued a consultation document (DA(85)23) to all the major health professional and consumer bodies seeking views on the possible content of an order under section 29(1) of the Data Protection Act 1984. The consultation period ended in February 1986. An order which, from November 1987, will govern the right of access by data subjects to automatically processed personal health data relating to them, will be drawn up to take account of the comments received.

(d) Regional strategic planning — medical manpower

An important consideration in relation to hospital and community health services is that the responsibility for their provision is delegated as far as possible to local health authorities. At the same time the health service remains a national service in which national policies and priorities are set. The key to linking these two apparently disparate principles is planning. Following restructuring in 1982 a simplified and revised NHS planning system was introduced (HC(82)6[6]). The new system asked health authorities to produce 10-year strategic plans which would be updated every five years and short-term operational plans based on a two-year rolling programme through which strategic objectives would be achieved.

The new system became operational in 1984 with the issue of HC(84)2[7]. RHAs were given long-term resource assumptions and asked to prepare outline strategies which provided a policy framework and more detailed resource assumptions within which DHAs were required to produce their strategic plans.

The planning cycle was completed by the regions modifying, confirming and consolidating districts strategic plans into a definitive regional strategic plan.

Regional strategic plans have all been submitted to the Department and the majority have been approved by Ministers. Examination of the plans so far shows that they have followed the principles laid down in '*Care in Action*'[8]. There is a continued commitment to resource equalization both between and within regions. The previous major differences in available resources between districts are projected largely to disappear by the end of the planning period. Much effort will be going into the continued rationalization of acute services to provide, as far as possible, the most effective provision of services according to the needs of the population. Particular attention has been paid by health authorities to developments in the priority services. A major change to district based services with the emphasis on community care is planned for mentally ill patients and mentally handicapped people. Similarly considerable improvements are projected in services for care of the elderly.

Such evaluation of strategic plans plays an important role in ensuring that health authorities provide necessary services in the most appropriate way. Gaps in plans

are being identified for further work. The other element of the planning cycle is annual production of short-term programmes through which the progress of regions towards their strategic objectives will be monitored. In addition, annual ministerial reviews provide an opportunity for key strategic issues to be addressed.

Medical manpower planning

It is essential that health authorities should estimate the number of doctors required for the effective delivery of services, both existing and planned. They should also look ahead, considering whether the number of doctors under training (ie mainly in the senior registrar and registrar grades) in the various specialties is sufficient to ensure the filling of consultant vacancies — or whether more are in training than are needed for that purpose. A major problem in many acute specialties is the balance between the numbers in consultant and training grade posts. It is desirable that more patient services should be provided by fully trained doctors. It would follow that health authorities should promote the expansion of the consultant grade, consistent with service requirements, and limit the number of training grade posts in line with career grade opportunities expected to arise.

Of course local and regional medical manpower planning both take place within a national framework. It is for the Department to consider plans affecting the medical student intake on a time-scale much longer than the 10 year horizon of regions' strategic plans. In 1985, it was announced that a further review of long-term trends would be conducted and preparations were made to begin this in 1986. A national perspective is also required on the number of training posts required to fill the expected number of consultant vacancies in various specialties. A Joint Planning Advisory Committee has been set up therefore initially to agree the regional quotas for senior registrar posts including equivalents in the academic and research sectors. It is envisaged that the work may be extended to registrar posts in the future. The combined effects of these initiatives are aimed at enabling substantial progress in meeting service needs and achieving a career balance. They should be strengthened by health authority planning stemming from the lessons of this round.

(e) Immigration of doctors and dentists

Changes in the immigration rules effective from 1 April 1985 ended the permit-free entry to and employment in the UK of overseas doctors and dentists, but permit free entry for a period of four years was preserved for doctors seeking postgraduate training in the UK (HC(FP)(85)149).

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9. SOCIAL SECURITY

(a) Statutory sick pay

Extension of statutory sick pay

In 1985 the Government announced its intention to extend the period for which employers are responsible for paying Statutory Sick Pay (SSP) to their employees. The period is to be increased from 8 weeks in a tax year to 28 weeks in any one period of entitlement. This means that SSP generally will replace completely the employee's entitlement to state sickness benefit. An employee sick for more than 28 weeks in a period will claim state invalidity benefit. These arrangements are due to start on 6 April 1986. As in the existing scheme, employers may require their employees to provide reasonable evidence of incapacity for work to support their claim to SSP. This evidence is likely to consist of a self-certificate, or, where a spell of sickness has lasted over seven days, a doctor's statement of incapacity for work.

Statutory Sick Pay (Medical Evidence) Regulations 1985
6 April 1986 is also the date on which the Statutory Sick Pay (Medical Evidence) Regulations 1985 will come into force. These Regulations were made in 1985 after consultation with representatives of the medical profession, and they stipulate the rules for the issue of doctors' statements for SSP purposes. When a patient requests a doctor's statement for SSP purposes under the NHS, the doctor should issue Form Med 3 free of charge after the spell of incapacity has lasted seven days. When the patient consults the doctor during the first week of incapacity it may be clear that the incapacity is likely to last more than one week. On such occasions the doctor may choose to issue form Med 3 at the time of that consultation (though he or she is not obliged to do so).

The rules also make provision for the diagnosis given on a doctor's statement to be entered less precisely where, in the doctor's opinion, the disclosure of the precise diagnosis would be prejudicial to the patient's well being, or to the patient's position with his employer.

Control of sickness absence for SSP

As a result of the extension of the SSP scheme, additional control procedures have been agreed to help employers to check that their payment of SSP is justified in individual cases. It is of course for employers to control and monitor sickness absence while they retain responsibility for the payment of SSP, and the methods used will depend on each employer's particular circumstance and requirements.

Employers will not have direct access to the Government's Regional Medical Services (RMS). However, local Social Security offices will continue to be able to refer cases to the RMS under existing arrangements. In addition, from 6 April 1986, the local offices may also refer SSP cases where an employer asks for a second medical opinion on an employee's incapacity for work. Such references will be limited to cases where the sickness absence has lasted longer than would normally be expected for the specified diagnosis. When a reference of this kind has been made, the RMS will send the doctor a form RM2 (SSP(EMP)) asking for a confidential medical report on his patient's condition. The completed form will be retained by the RMS and not passed on to the local office or to the employer.

Information to doctors about all these matters is to be issued in a revised edition of the booklet *Medical Evidence for Social Security and Statutory Sick Pay Purposes*[1]. All doctors in clinical practice should receive a copy of the booklet in the Spring of 1986.

(b) Prescribed industrial diseases

From 1 April 1985, Vibration White Finger was added to the schedule of prescribed industrial diseases as PD A11. It is defined as:

> "Episodic blanching, occurring throughout the year, affecting the middle or proximal phalanges, or in the case of the thumb the proximal phalanx, of:
>
> (a) in the case of a person with 5 fingers (including thumb) one hand, any 3 of those fingers, or
>
> (b) in the case of a person with only 4 such fingers, any 2 of those fingers, or
>
> (c) in the case of a person with less than 4 such fingers, any one of those fingers or, as the case may be, the one remaining finger. (Vibration White Finger)"

The condition is prescribed in relation to any person whose occupation involves:

"a. The use of hand-held chain saws in forestry; or

b. the use of hand-held rotary tools in grinding or in the sanding or polishing of metal, or the holding of material being ground, or metal being sanded or polished, by rotary tools; or

c. the use of hand-held percussive metal-working tools, or the holding of metal being worked upon by percussive tools, in riveting, caulking, chipping, hammering, fettling or swaging; or

d. the use of hand-held powered percussive drills or hand-held powered percussive hammers in mining, quarrying, demolition, or on roads or footpaths, including road construction; or

e. the holding of material being worked upon by pounding machines in shoe manufacturers."

From the relatively small number of claims decided since the addition of the disease to the schedule, it would appear that about one third fail to satisfy the diagnostic criteria. Of those that do, the vast majority (86%) are given assessments of between 1% and 5% for life.

Two new occupational respiratory diseases were also prescribed with effect from 1 April 1985. These are

1. Prescribed disease D8: primary carcinoma of the lung where there is accompanying evidence of one or both of the following

   (a) asbestosis

   (b) bilateral diffuse pleural thickening.

2. Prescribed Disease D9: bilateral diffuse pleural thickening.

One case of PD D8 and thirteen cases of PD D9 were diagnosed between 1 April 1985 and 23 January 1986. The figures relating to D8 are an underestimate, as lung cancer complicating previously diagnosed asbestosis is treated as being due to the asbestosis, since this procedure could be more advantageous to the claimant.

(c) New procedures for industrial injuries

Disablement benefit adjudication

As a consequence of a decision by a Social Security Commissioner in one instance, and arising from Counsel's opinion in a case which proceeded to the Court of Appeal in another, it became necessary to reconsider the form of report made by the Adjudicating Medical Authorities in connection with claims to Industrial Injuries Disablement Benefit, and to re-design the form in order to comply with legal requirements.

The Commissioner's decision pointed out that the existing form did not require, or allow for, the Authority to describe adequately the loss of faculty arising from an Industrial Accident or a Prescribed Disease. The omission led to difficulty in adjudication of additional benefits, notably Special Hardship Allowance. Counsel's advice was to the effect that, on the form as it stood, the law relating to offsets and additions was not being correctly applied.

The forms were therefore re-designed to take account of these developments. However, before they could be put into use on a statutory basis it was necessary to produce specimen models, which were legally approved, and then to conduct a pilot study to determine whether, in their new layout, they were intelligible in all respects to the adjudicating medical practitioners who will be required to complete them, and would fulfil all the requirements of the law. On completion of the pilot study, and following such minor further amendments for which a need was demonstrated, an exercise was planned in which all members of Departmental Medical Boarding Panels were introduced to the new forms, and the legal implications were explained to them. It is intended that the amended forms should be introduced for general use in 1986.

(d) Attendance allowance and mobility allowance examinations

Decisions on claims to these two allowances are based on the outcome of a medical examination and report. The majority of these examinations are carried out by doctors, known as examining medical officers (EMOs), employed by DHSS on a part-time basis. For administrative reasons, processing of the claims follows different routes in different locations. Hence if a disabled person applies for both benefits simultaneously it can happen that two separate examinations by two different doctors are carried out within a few days of each other. A procedure has been introduced to assist with identification of such cases and this has greatly reduced the number of such double examinations.

A more intractable problem arises if a disabled person applies for both benefits but the applications are separated by a short period of time; or if an application for only one of the benefits is made and it becomes apparent during the examination that an application for the other benefit might succeed, either in

addition to or instead of the benefit applied for. A pilot experiment was therefore initiated in one geographical area to try to reduce this problem. Clerical staff identified applications where there might be such a "sequential" claim and notified the examining medical officer when asking him to carry out the examination. The EMO then asked the claimant at examination whether the other benefit had been claimed, and, if so, the result. If the other benefit was not in payment, and the EMO considered that there was a reasonable prospect of the claimant being entitled to it, he invited the claimant to complete a claim form, carried out an examination sufficiently detailed to cover the needs of both benefits and completed two report forms.

After a six month trial period, which ended in January 1985, the results were analysed. In practice a small number of claimants were able to receive a benefit for which they had not applied, thus obviating the need for an application and a separate examination at a later date. There was however an administrative cost. Considerable clerical effort was required to sift all claims to identify potential sequential claims and notify the EMOs accordingly. In arranging a visit or series of visits the EMO had to allow himself time to carry out the second examination and complete the second report form and, as this was not required in every case, he was unable to make the best use of the time available to him. Both these factors tended to delay the handling of all cases, the great majority of which would not gain from the sequential examination procedure.

The conclusion drawn from the trial was that the disadvantages of introducing the scheme throughout the country would outweigh the advantages.

(e) Mobility allowance

Use of claimant's own doctor in obtaining reports
Following a claim for Mobility Allowance, the present arrangements involve the claimant being referred to an examining medical practitioner (EMP). The EMP is appointed and trained in examining, reporting and advising as to whether an award is appropriate and if so, for how long. On the basis of this advice and any other medical evidence which is necessary, an adjudication officer (formerly insurance officer) awards benefits or rejects the claim.

In 1983 a review of Attendance Allowance and Mobility Allowance Procedures and of Medical Adjudication, known as the Oglesby Report, recommended that steps be taken to enable greater use to be made of the claimant's own doctor in obtaining medical reports related to Mobility Allowance claims. The report recommended a pilot experiment using a revised and simplified report form which was suitable for completion by the claimant's own doctor.

As a result, DHSS Central Management Support were asked to undertake a pilot study in the North Western Social Security Region under the following terms of reference:

(a) to design a pilot study (including the medical report form to be used) to evaluate the benefits to be gained from making greater use of the claimant's own doctor in obtaining medical reports for Mobility Allowance;

(b) to supervise and co-ordinate the carrying out of the pilot study on the basis of (a) and,

(c) to evaluate the outcome of the study in relation to efficiency, economy and service to the public, and to make recommendations.

The study commenced on 6 January 1986 and will last for six months. Claimants with a Mobility Allowance reference number ending with an even number will be examined and reported on by an examining medical practitioner as at present and those with odd numbers will be reported on by their own doctor, who in most cases would be the general practitioner.

EMPs and general practitioners in the North Western Region were informed of the nature of the study. The general practitioners were also given the opportunity to refuse to take part, or if willing to participate to decline to report on any particular claimant. Initial soundings show that of the general practitioners approached, 450 (12%) have decided not to participate.

A new and simplified medical report form has been designed for the pilot study. Scrutiny of reports will follow the normal pattern, initial claims being seen by non-medical scrutineers, with medical back-up, and renewal claims being seen by Departmental medical officers.

All variables will be compared. These include

(a) delays in processing claims,

(b) the quality of the medical reports,

(c) the extent to which further evidence was required,

(d) whether the adjudication officer was able to accept the reporting doctor's advice entirely or his decision on the medical questions differed from the doctor's recommendations,

(e) the number of cases requiring reference to a statutory Medical Board for decision.

Consideration will also be given as to whether the reports completed by the claimant's own doctor indicated any bias for or against the claimant and whether the new, simplified medical report form is an improvement on the existing standard version. The final percentage of claimants' own doctors unwilling to participate will also be established.

Only after these and many other factors have been considered and evaluated, will a decision be taken about the possible implementation of these arrangements on a national scale.

(f) Severe disablement allowance

A description of severe disablement allowance (SDA) was given in this Report for 1984 (p 102). People aged 35–49 years became eligible from 28 November 1985, and an extensive publicity campaign was launched in September 1985 to ensure that as many potential claimants as possible were made aware of the benefit.

Detailed information on the type and number of new beneficiaries will not

become available until the results of the annual statistical exercise for the year ending March 1986 are published. By this time new claims received during the first year of take-on will have been processed, and it is hoped that similar information for the second phase will be available after the completion of the 1987 statistical exercise. The latest available figures (those for the year ending March 1985) show 251,900 people in receipt of SDA.

(g) Statistics

The following figures show a continued increase in Social Security medical activity during 1985. On this occasion the increase is in all the main disablement benefits.

	1985	(1984)
Industrial injuries		
Cases boarded	185,918	(177,695)
Attendance allowance		
Decisions made	353,350	(325,529)
Examinations performed	321,778	(311,170)
Reviews	41,995	(33,474)
Allowances in payment (31.3.85) Estimated		
Higher rate	222,000	(192,000)
Lower rate	321,000	(277,000)
War Pensions		
Cases boarded (including treatment examinations)	13,127	(12,271)
Mobility allowance		
All claims	176,072	(152,687)

Occupational respiratory disease

The figures for the number of cases of pneumoconiosis and related diseases are not available at the time of preparation of this Report. However, for the period 18.12.84 to 17.12.85, 24,603 cases of all types were cleared by the Medical Boarding Centres (Respiratory Diseases). Of these 8,192 were new claims.

123 cases of occupational asthma were diagnosed in the 9-month period from 1.1.85 to 24.9.85. The relevant sensitizing agents were as follows:

	1.1.85 24.9.85	Total number diagnosed 29.3.82 to 24.9.85
Isocynates	34	198
Platinum salts	6	22
Hardening agents	16	47
Soldering flux	17	89
Proteolytic enzymes	4	12
Animals/insects (mainly in laboratories)	6	25
Dusts arising from flour and grains	40	145
	123	538

10. INTERNATIONAL HEALTH

(a) The World Health Assembly

Delegations from 159 Member States attended the 38th World Health Assembly in Geneva from 6 to 20 May. The United Kingdom (UK) delegation was led by Mr John Patten the then Parliamentary Secretary for Health.

Addressing the Assembly Mr Patten made an appeal for firm international action to halt the spread of drug abuse and drug trafficking. He underlined the role which Health Ministries have in relation to the misuse of drugs, proposed a five-point plan covering prevention, treatment and rehabilitation, and urged health authorities to work towards the adoption of internationally agreed guidelines. As a result a conference jointly funded by the World Health Organization (WHO) and the UK was held in London in March 1986.

The Assembly approved a working budget of $543.3 million for 1986–87 which, with the addition of extra budgetary funds, will be raised to one billion dollars. To ensure that the best use is made of these resources each of the Organization's six regions is to introduce programme budget policies.

In reviewing the programme for 1986–87 the Assembly felt that there should be greater concern for the protection of women's health. Member States were also requested to increase opportunities for the participation of disabled persons in community life, and to promote studies on population behaviour with the aim of controlling cardiovascular diseases, lung cancer, diabetes mellitus and chronic respiratory and other noncommunicable diseases. Notable contributions from the United Kingdom delegation dealt with the need to rationalize the use of WHO fellowships, to support the Action Programme on Essential Drugs and to take more positive action to reduce smoking.

In the course of the Assembly a resolution was adopted recommending an increase in the total number of Executive Board members from 31 to 32. The UK is currently a member of the Executive Board.

A decision was taken that Israel should henceforth form part of the WHO European Region.

(b) WHO European Regional Committee

The 35th session of the European Regional Committee was held in Amsterdam from 17–21 September 1985.

While most WHO global targets for health for all have already been reached there are still many regional shortcomings. Disparities exist between countries in respect of life expectancy and infant mortality. Increasing trends in specific mortality rates such as cardiovascular diseases, cancer and accidents cause concern as do negative trends in smoking, alcohol abuse and drug abuse.

The Committee proposed a Regional programme budget policy which would identify criteria for allocating resources and would ensure that the best use was made of them.

The UK delegation made contributions on a number of key issues including a

statement by the Chief Medical Officer on the need for more international co-operation on the control of AIDS.

(c) WHO regional strategy and targets for health for all

In September 1980 the member states of the WHO European Region agreed a strategy for improving the health situation in Europe. The strategy urges that priority be given to health promotion and disease prevention; that all sectors with an impact on health should take steps to maintain and improve it; that greater stress should be placed on the role that individuals, families and communities can play in health development; and finally that primary health care should be the major approach used to bring about these changes.

In order to give form to strategy a set of 38 targets were developed, and later endorsed by the Regional Committee in September 1984, together with a number of indicators to measure progress in achieving the targets.

The Regional targets[1] can be subdivided roughly into five groups.

The first group deals with reduction of inequalities in health status between countries and between groups within countries; the elimination of specific diseases and the reduction of conditions leading to premature death. Thus, for example, it is proposed that by the year 2000 the European region should be free of indigenous measles, poliomyelitis, neonatal tetanus, congenital rubella, diphtheria and congenital syphilis. Targets include the lowering of infant and maternal mortality rates and reducing diseases of the circulatory system in people under 65 years of age by 15%. The same applies to mortality from cancer. Deaths from accidents should fall by at least 25% through an intensified effort to reduce traffic, home and occupational accidents. The relevant target for suicide aims to reverse the current rising trend.

The second group of targets is directed at lifestyles. These are to provide better opportunities for choosing and living a healthy life and to promote healthy behaviour. By 1995 a 50% reduction in national tobacco consumption with a minimum of 80% of the population being non-smokers is sought. Sports and physical activity programmes should be promoted and made more accessible, and health-damaging behaviour such as the overuse of alcohol and pharmaceutical products, the use of illicit drugs and dangerous chemicals, dangerous driving and violent behaviour should be reduced by at least 25%.

The third group is concerned with monitoring, assessment and control of environmental hazards. Targets relate to housing and to lessening health risks from water and air pollution, food contamination, the disposal of hazardous wastes and the working environment.

The fourth group of objectives seek to develop health care systems based on primary health care supported by secondary and tertiary care. Primary health care should provide health promoting, curative, rehabilitative and supported services to meet the basic health needs of the population. They concentrate upon high risk, vulnerable and underserved individuals and groups.

The fifth group aims to formulate strategies linking research to health policies and to the political, managerial, technological and informative support required to meet the targets.

Table 13.1 WHO and Council of Europe fellowships in UK, 1985

	WHO fellowships commenced in UK during 1985									
	Europe	Eastern Mediterranean	Africa	South East Asia	West Pacific	Americas	Total	Average duration in months	Council of Europe fellowships commenced in 1985	Total fellowships commencing in 1985
Public health and administration	8	8	12	10	16	4	58	4½	3	61
Environmental health	16	3	9	5	4	5	42	2½	1	43
Nursing	4	12	5	1	4	3	29	7½	6	35
Maternal and child health	2	2	3	—	5	—	12	2	1	13
Communicable diseases	4	6	5	13	5	2	35	4½	2	37
Clinical medicine	7	18	13	9	4	5	56	10	6	62
Basic sciences	25	17	17	9	3	5	76	6	9	85
Other health services	3	20	17	9	4	6	59	6½	5	64
Total	69	86	81	56	45	30	367		33	400
Average duration in months	1½	7½	12	4	4	4		6		
WHO Fellowships programmes requested during 1985 but cancelled							65			
WHO Fellowships programmes already in progress at 1.1.85							144			
Other programmes arranged during 1985							48			

(d) The programme for WHO and Council of Europe Medical Fellowships in the United Kingdom

During 1985 the Department was involved in 576 programmes for WHO fellows visiting the United Kingdom and 367 of them started, the average duration being six months. Sixty-five programmes were initiated but cancelled either by the WHO or the Department before studies began. On 1 January 1985 144 programmes were in progress. Thirty-six Council of Europe medical fellows came to the United Kingdom for periods ranging from 2–12 weeks. Details of both programmes are shown in Table 13.1.

Five United Kingdom candidates were awarded fellowships by the World Health Organization and five by the Council of Europe for study overseas during 1986.

Reference:

[1] World Health Organization. Regional Office for Europe. *Targets for health for all: targets in support of the European regional strategy for health for all.* Copenhagen: Regional Office for Europe, WHO, 1985.

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