DEPARTMENT OF HEALTH AND SOCIAL SECURITY

On the State of THE PUBLIC HEALTH for the year 1980

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DEPARTMENT OF HEALTH AND SOCIAL SECURITY

On the State of
THE PUBLIC HEALTH

THE ANNUAL REPORT OF
THE CHIEF MEDICAL OFFICER OF
THE DEPARTMENT OF HEALTH AND SOCIAL SECURITY
FOR THE YEAR 1980

LONDON
HER MAJESTY'S STATIONERY OFFICE

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REPORT OF THE CHIEF MEDICAL OFFICER ON THE STATE OF THE PUBLIC HEALTH FOR THE YEAR ENDED 31 DECEMBER 1980

INTRODUCTION

To the Rt Hon. Norman Fowler, MP
Secretary of State for Social Services

Sir

This report follows a pattern similar to those of previous years and aims to provide a general appreciation of the state of the public health and the functioning of the National Health Service. The first thirteen chapters cover the subjects traditional to this report and this year the last chapter which deals with special subjects that vary from year to year features contributions on organization and management of the NHS, safety of medicines, prevention of accidents, smoking and health, nutrition and scientific services supplies and equipment. Following the precedent set last year I shall not attempt in this introduction to cover every subject included in the report but will draw attention to some of the more significant events, thoughts and deliberations that characterized the year.

Preventive medicine

The role of prevention in the promotion of health again featured prominently in the Department's thinking during 1980 and a number of reports and papers dealing with the subject have been published during the year. Three of the six special subjects chosen for Chapter 14 of this Report are specifically concerned with preventive medicine (Prevention of Accidents, Smoking and Health and Safety of Medicines). In addition the importance of the role of prevention is stressed in several of the other chapters: particularly in Chapters 3, 4 and 9.

(i) Chapter 3 which deals with the work of the Division concerned with Environmental Health refers to the important, if unspectacular work on the setting of safety standards in, for example, the quality of water and the use of industrial chemicals. The safety aspects of food additives, pesticides and microwave radiations are discussed in this chapter. Further work is also reported on assessing the extent of the hazard of lead in the environment and of the significance of soil contamination by cadmium.

(ii) The chapter on Communicable Diseases (Chapter 4) notes that rates for vaccination and immunization show a slight improvement compared with those of previous years although there can be no room for complacency. Important reports from the Committee on Safety of Medicines and the Joint Committee on Vaccination and Immunization on the safety of pertussis vaccine were completed in 1980 and submitted to Ministers. The reports were both included in a Departmental publication entitled *Whooping Cough* which was published in May 1981. All concerned must be very grateful to the members of both committees and to the panels which were set up to examine and evaluate the evidence for the painstaking work which has led to the authoritative advice that is now available. It must be stressed that no vaccines

can be guaranteed to be free from all possible side effects, and that decisions on their use must therefore be made in the light of their potential benefit compared with the severity and frequency of any adverse effects. Taking all points into consideration the Joint Committee on Vaccination and Immunization have reaffirmed their advice that the benefits of vaccination against whooping cough outweigh the risks and that, with due attention to contraindications, whooping cough vaccine should continue to be recommended as part of the basic course of immunization in childhood.

(iii) The Mental Health chapter (Chapter 9) reports the publication of a national survey of drinking habits and draws attention to valuable guidance from the British Medical Association, the Faculty of Community Medicine, the Royal College of Psychiatrists and the British Association of Psychopharmacology on the medical implications of unwise alcohol consumption and the upper safe level of daily consumption if harm is to be avoided.

Vital statistics

Chapter 1 has been prepared by the staff of the Office of Population Censuses and Surveys and it is a source of continuing pleasure to me to be able to acknowledge the invaluable work involved in the preparation of this chapter.

The resident population increased by 0.2% compared with the previous year. There was a small increase (the first since 1967) in the number of children aged 0-4 but the number of children of school age declined by 2.1%. In contrast the number of persons of pensionable age increased by 1.5%. In the higher age groups there was a marked difference between the numbers of men and women; over twice as many women are aged 75 and over. Tables and commentaries on population changes, birth rates and death rates will be found in this chapter, which also includes tables showing mortality trends for the major forms of circulatory disorder over the past 30 years and a detailed examination of death rates from the various forms of cancer: a notable feature of the latter is that the reduction in male deaths (45) from lung cancer is greatly outweighed by the increase in the number of female deaths (482) which is the largest annual increment on record. Unfortunately it has not been possible to include any international comparison tables this year due to the late publication of the United Nations Demographic Yearbook.

Perinatal and neonatal mortality

Perinatal mortality is discussed in Chapter 7. In July 1980 the House of Commons Social Services Committee published its report on perinatal and neonatal mortality. The enquiry had been mounted because of public concern about perinatal mortality and because recorded mortality rates in England and Wales were falling less quickly than in some other developed countries. The report included a large number of recommendations and towards the end of the year the Government published its reply in the form of a Command Paper. It was acknowledged that in spite of the steady improvement in perinatal mortality over the years there is still plenty of room for improvement in services which are themselves rapidly developing. Most of the Committee's recommendations are the concern of health authorities and professional and other bodies but of the 40

or so recommendations that apply to central Government over two-thirds have been accepted or are under consideration.

Mental health and mental handicap

There is a continuing need to foster improvement in the day to day running of large mental illness hospitals in the context of developing District Psychiatric Services, and a departmental working group on Organization and Management Problems of Mental Illness Hospitals (The Nodder Report) was published, covering different aspects of the management of such organizations. A number of other important reports have been published during 1980. The use of behaviour modification in the treatment of groups of patients rather than individuals was the subject of a Report of a Joint Working Party chaired by Professor O L Zangwill.

The Rampton Management Review Team set up in July 1979 by the Secretary of State, under the Chairmanship of Sir John Boynton, published its Report in November 1980. The terms of reference of the Team were to review the organization, management and functioning of Rampton Hospital, and to recommend changes.

The Government has accepted in principle the model of care recommended for patients with mental handicap in the Report of the Committee on Mental Handicap Nursing and Care (Jay Committee). The National Development Group for the Mentally Handicapped was wound up in April 1980 on completion of its final exercise on accreditation. A review of mental handicap services in England undertaken by DHSS officials and Professor Peter Mittler was completed and their report *Mental Handicap Progress, Problems and Priorities* was published in December 1980.

These various reports coincide with a continuing discussion on the review of the 1959 Mental Health Act and provide some indication of the increased emphasis which has rightly been placed on the importance of mental health, mental illness and mental handicap in recent years.

Blood Products Laboratory

Among the subjects covered in Chapter 14 is a brief resume of some of the more important developments in scientific services, supplies and equipment. Foremost among these is the upgrading of the Blood Products Laboratory at Elstree. Work has started on improvements to the laboratory which should permit some increase in production. Longer term plans for large scale redevelopment of the laboratory have also been started.

National Health Service

As the scope of traditional public health problems has contracted the Department has become more active in fields directly concerned with matters relating to the NHS. Chapter 6 on Primary Health Care includes a description of the work of the Regional Medical Service and provides information about fresh initiatives to encourage responsible prescribing by NHS general practitioners.

Other significant developments affecting the service appear elsewhere in the Report.

(i) An up-dated report on organization and management of the NHS is included in Chapter 14.

(ii) Chapter 12 describes some preoccupations of the Division concerned with medical manpower and postgraduate medical education. Since the mid-1960s members of the medical profession and others who are concerned with patient services, with medical education, and with medical manpower planning, have become increasingly concerned that the imbalance in the hospital medical staffing structure was adversely affecting the care given to patients and the career prospects of the doctors themselves. There was considerable discussion of the subject during 1980 and the proposal now is to double the number of consultants over a fifteen year period, and to relate more closely the number of doctors in training posts to career outlets. This would have the following effects:

i. An increase in the total number of doctors by 6,000 — a substantially smaller increase than the last decade has seen.

ii. An increase in the number of doctors with security of tenure and the higher salary level.

iii. A decrease of 7,000 in the number of juniors in training posts.

The Department accepts that progress towards a more balanced grade mix of medical staff can only be *gradual* and must be carefully observed so that any effects on the work of other professions or on costs can be identified at an early stage.

Among other matters affecting medical staffing were:

(a) *The implications of the 1978 Medical Act.* Further provisions of this Act came into force on 1 August 1980. These concern professional conduct and fitness to practice and required the General Medical Council to establish preliminary proceedings and professional conduct committees and a new health committee.

(b) *The effect of the European Communities Medical Directives.* On 3 September 1980 the Government announced its decision to introduce amending legislation so that European Community doctors and dentists and nurses would no longer have to satisfy the registering bodies for these profession as to their knowledge of the English language. Instead those wishing to work in the NHS would be subject to language requirements imposed by the employing and contracting authorities relating to the post concerned.

(c) *Community health doctors.* Discussions continued in a Joint Working Group which had been set up with the profession to consider a career structure and training for community health doctors. It was agreed that there would continue to be a need for two grades of doctors working in the community health service and that the profession's representatives would explore with the appropriate bodies the whole question of postgraduate training for these doctors. Further details will be found in Chapter 7.

Acknowledgements

In carrying out their function of advising ministers and assisting in the development of departmental policies the main contributions of the medical

staff of the Department is the application of knowledge derived from wide contact with professional colleagues working in all branches of the service. It gives me great pleasure to acknowledge not only the support of my own colleagues in DHSS but also the unfailing help of many members of the health professions engaged in clinical administrative work who have been associated with the Department in the development of policy throughout the Health Services. I should like particularly to pay tribute to the contributions of Lord Richardson who in 1980 retired as President of the General Medical Council and as Chairman of the Council for Postgraudate Medical Education. I wish to record my deepest gratitude for all the help he has given to the Department over the years and for his unvarying friendship and support. 1980 also saw the retirement of Sir Eric Scowen as Chairman of the Committee on Safety of Medicines as well as the retirement of three prominent members of the Committee on Medical Aspects of Food Policy, Sir Frank Young, Dr Elsie Widdowson and Professor Angus Thomson. Also Lord Hunter of Newington retired as Chairman of the Independent Committee on Smoking and Health. To all these I should like to express my greatest thanks for the generous help they have given to the Department in the important areas of work with which they are concerned.

This report has been put together from contributions provided by the heads of Medical Divisions in DHSS and colleagues in OPCS. Once again the drafting and compilation has been done by Dr R M Shaw and the report is edited by Dr J L Hunt. I am grateful to all who have helped particularly to Dr Hunt and Dr Shaw who have worked so hard and so effectively to produce once more the report "On the State of the Public Health".

I am, Sir,
Your obedient servant,
H. YELLOWLEES

December 1981.

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VITAL STATISTICS

Population size (England)

The resident population of England at mid-1980 was estimated to be 46,467 thousand, some 71 thousand (0.2 per cent) persons more than at mid-1979. When final figures from the 1981 Census are available it will be possible to compare the estimated population figures with those from the Census. To date only a very rough comparison has been made (Office of Population Censuses and Surveys, 1981a) showing that the mid-1980 population estimate up-dated to census day 1981 was a little higher (0.2 per cent) than the preliminary census count. However, this calculation was only provisional and later, more definitive, comparisons may modify it.

On the basis of the currently available estimated population figures, the increase shown between mid-1978 and mid-1979 was repeated and, as a result, the numbers in the population have recovered from the small decline seen between 1973 and 1978 to exceed the previous high point of 46,405 thousand attained at mid-1973. Table 1.1 shows that the main reasons were a significant recovery in numbers of births in 1978-79 and 1979-80 from the low point reached in 1977 (numbers were declining from 1964 to 1977), coupled with a turn-round in migration from the usual position of net loss to small net gains between mid-1978 and mid-1980.

Table 1.1 Components of population change, England (thousands)

Mid-year to mid-year	Population at start of period	Components of population change (mid-year to mid-year)					
		Births	Deaths	Natural increase	Net migration	Other changes*	Total change
1973-74	46,405	616	547	+69	-73	- 1	- 5
1974-75	46,400	590	554	+36	-50	+ 6	- 8
1975-76	46,391	561	563	- 2	-14	- 1	-17
1976-77	46,374	536	544	- 9	- 8	- 5	-22
1977-78	46,351	543	548	- 4	-10	+12	- 2
1978-79	46,349	591	555	+36	+ 9	+ 2	+47
1979-80	46,396	610	542	+68	+ 1	+ 2	+71
1980-81	46,467	—	—	—	—	—	—

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

Age and sex structure of the population (England)

The age and sex structure of the estimated mid-1980 population of England is shown in Table 1.2. As a result of the increase in the annual numbers of births between 1977 and 1980, between mid-1979 and mid-1980 the number of children aged 0-4 showed a small increase; this was the first time since 1967 that such an increase had occurred. The pre-1977 pattern of declining numbers of annual births continued to affect the population of school age and the total fell by 2.1 per cent. In contrast, the number of persons older than the pensionable age increased by 1.6 per cent. A marked feature of the distribution of the population by sex is the large difference between the numbers of men and women in the

higher age-groups; there were over twice as many women as men aged 75 years or more in 1980. The increase between 1979 and 1980 in this age-group was almost 3 per cent for both sexes, substantially higher than the equivalent change in any other age-group.

Table 1.2 Population age and sex structure, England, 1980

Age group	Home population						% change between mid-1979 and mid-1980		
	Persons		Males		Females				
	Number (000's)	Percent distribution	Number (000's)	Percent distribution	Number (000's)	Percent distribution	Persons	Males	Females
0-4	2,793	6	1,434	6	1,360	6	+0.8	+0.8	+0.9
5-16	8,470	18	4,348	19	4,122	17	-2.1	-2.0	-2.1
17-29	8,809	19	4,492	20	4,318	18	+1.3	+1.3	+1.2
30-44	8,990	19	4,530	20	4,459	19	+1.4	+1.2	+1.6
45-64/59*	9,162	20	5,087	22	4,075	17	-1.5	-0.8	-2.4
65/60±74*	5,590	12	1,894	8	3,696	16	+1.1	+0.7	+1.3
75+	2,652	6	853	4	1,799	8	+2.7	+3.2	+2.5
All ages	46,467	100	22,638	100	23,828	100	+0.2	+0.1	+0.2

*45-64 For males
45-59 For females
+65-74 For males
60-74 For females

Live births (England and Wales)

The number of live births in England and Wales during 1980 was 656 thousand. This was 18 thousand more than in 1979, but the rate of increase, of around 3 per cent, was lower than the 7 per cent increase between 1978 and 1979. An increase in the general fertility rate (live births per 1000 women aged 15-44 years) accounted for about half of the increase in the number of births in 1980; the other half of the increase was accounted for by an increase in the number of women of child-bearing age. During 1980, after allowing for seasonal factors, the trend in the fertility rate was fairly flat.

Differences between the rates of change in the numbers of births in particular age-groups were greater than changes in the equivalent fertility rate because of population differences (Table 1.3). For example, although the fertility rate for women aged 25-29 went up by 2.2 per cent, the number of births increased by only 0.6 per cent owing to the fall in the population in the age-group (caused by a lower level of births during the early 1950s than in the late 1940s). Between ages 20 and 34 birth rates increased by around 2 per cent between 1979 and 1980; the increase was much smaller for teenagers (0.4 per cent), and for women aged 40-44 (0.9 per cent), and greater for women aged 35-39 (5.2 per cent).

The total period fertility rate for a given year shows the average number of liveborn children that would be born to each woman who survived to the end of her reproductive period if the age-specific fertility rates of the year in question persisted indefinitely. The figure of 1.9 in 1980 was some 10 per cent below replacement level (2.1), the level which in the long run would imply a stationary population; the 1980 figure was only a little higher than that for 1979 but represented a substantial recovery from the low point reached in 1977 (under 1.7).

Table 1.3 Age specific female population, numbers of live births and fertility rates, England and Wales, 1980

Age/Age of mother at birth							
15-44 [1]	15-19 [1]	20-24	25-29	30-34	35-39	40-44	
Mid-year female home population (thousands)							
10,094.9	1,965.1	1,766.3	1,645.4	1,822.9	1,499.2	1,397.0	
Percentage change from 1979							
1.4	2.3	2.5	–1.6	1.5	2.6	0.7	
Numbers of live births (thousands)							
656.2	60.8	201.5	223.4	129.9	33.9	6.1	
Percentage change from 1979							
2.9	2.9	4.3	0.6	3.3	8.0	1.7	
Rates: all live births per 1,000 women in the age-group							TPFR [2]
65.0	30.9	114.2	135.8	71.3	22.6	4.3	1.90
Percentage change from 1979							
1.5	0.4	1.7	2.2	1.8	5.2	0.9	0.5

[1] Births to women aged under 15 and over 45 are included in the 15-44 year age-group and births to women aged under 15 in the 15-19 year age-group.
[2] The total period fertility rate (TPFR) is derived by summing the fertility rates for a given year (live births per woman) by single years of age up to the age by which the childbearing life-span of women is effectively finished, taken to be age 50.

The numbers of first and second births to women in their first marriage under age 35 changed comparatively little in 1980, though their third and higher order births increased significantly; births of all orders to women over age 35 increased sharply, and births to re-married women aged 25 and over increased substantially (Table 1.4). The most marked rates of increase in all age-groups were shown in the numbers of illegitimate births, the greatest change (14.7 per cent) occurring in the group of women aged 35 and over. These figures reflect the continuing trend towards the occurrence of a higher proportion of births outside marriage, and during 1980 almost 12 per cent of all births were illegitimate.

For births within marriage the median intervals between marriage and first birth and between subsequent births decreased slightly between 1979 and 1980: between marriage and first birth from 30 to 29 months, between first and second birth from 33 to 31 months and between second and third births from 44 to 40 months. In terms of birth spacing, therefore, 1980 showed a slight reversal of the general trend towards longer intervals between births which had been a general feature of the 1970s. The proportion of first births occurring three years or more after marriage fell in 1980 from the peak level of 43 per cent seen in 1978 and 1979 to 41 per cent, close to the 1976 figure.

The mean age at maternity in 1980 was 26.7 years showing no change compared with 1979 (the lowest figure was 26.1 in 1974), the mean age at bearing the first child in marriage was also unchanged between 1979 and 1980 at 25.0 years (compared to the lowest figure of 23.8, last seen in 1970).

Table 1.4 Live births by legitimacy, birth order in marriage and age of mother, England & Wales (thousands), 1980

Age of mother at child's birth	Illegitimate	Remarried women	Women married once only					Total live births
			All birth orders	First birth	Second birth	Third birth	Fourth or higher order births	
All ages								
	77.4	38.5	540.4	231.3	197.1	76.8	35.2	656.2
Percentage change from 1979	11.4	4.3	1.6	0.7	1.1	4.3	5.4	2.9
Mother aged under 25								
	52.5	3.7	206.1	123.3	65.3	14.5	3.0	262.3
Percentage change from 1979	11.9	2.8	2.1	1.5	2.5	4.3	7.1	3.9
Mother aged 25-34								
	21.1	27.8	304.5	102.9	123.8	54.7	23.1	353.3
Percentage change from 1979	9.9	4.1	0.9	−0.5	0.0	3.6	6.0	1.6
Mother aged 35 and over								
	3.9	7.0	29.8	5.0	8.0	7.6	9.1	40.6
Percentage change from 1979	14.7	6.1	6.8	6.4	6.7	10.1	3.4	7.1

Social class differences in the timing of the first birth within marriage still existed in 1980 although, against the general trends of the 1970s, the gap seemed to have closed a little. Between 1971 and 1979 the median intervals from marriage to first birth increased from 32 to 44 months for women with husbands in Social Class 1 (professional occupations) but only increased from 9 to 14 months for women with husbands in Social Class V (unskilled manual occupations). In 1980, however, the median interval for Social Class 1 fell to 40 months whereas that for Social Class V remained unchanged (revision of the Social Class categories in 1979 led to a revised median interval of 13 months for Social Class V in both 1979 and 1980). The equivalent median intervals for other social class groupings stayed at roughly the same level or fell slightly between 1979 and 1980.

One factor affecting the increases in median interval between marriage and first birth during the 1970s was the decline in all social classes in the numbers of pre-maritally conceived first births. The total numbers fell from 69.4 thousand to 34.7 thousand over the period. In 1980 about half the pre-maritally conceived births were to teenage mothers, although in this group also the numbers had fallen substantially compared with 1970 (from 34.0 thousand to 17.2 thousand). The numbers of pre-maritally conceived births to teenage mothers in all social classes showed large decreases between 1970 and 1980, but the rate of decline was most marked for women whose husbands were in skilled non-manual occupations (Social Class III(N)), for whom the numbers of such births in 1980 were at only about one third of the 1970 level (0.9 thousand compared with 2.7 thousand).

Marriages and divorces (England and Wales)

A falling trend in marriage rates was seen throughout the 1970s. However, in 1979 a small increase occurred in the marriage rate for spinsters aged 25 to 39. Median ages at first marriage continued to increase slowly in 1979, reaching 23.9 years for men and 21.6 years for women (the comparable figures in 1970 were 23.2 years and 21.3 years respectively).

Between 1970 and 1980 divorce rates (number of divorces per thousand married population) for both men and women increased in every age-group, doubling for those aged 25 and above and trebling for those aged under 25. The increase in the rate was very sharp in the first half of the decade, but slowed down in the second half. The overall divorce rate in 1980 was 12 divorces per 1000 married couples. Although the great majority of divorces continued to involve couples both of whom were in their first marriage, the number of divorces among couples in which at least one partner had been married previously continued to increase; the 1980 figure of over 25 thousand such divorces was 13 per cent higher than in the preceding year.

The large increases in divorce rates during the 1970s have led to larger numbers of divorced persons eligible to remarry than in previous decades. However, although the numbers of such remarriages increased considerably, remarriage rates for men and women declined since 1973 both overall and in most age-groups. Median ages at remarriage for men and women in 1979 were 35.7 and 32.8 years respectively. The distribution of womens' ages at remarriage was such that one quarter of remarried divorced women had a potential 17 years or more before reaching the end of their childbearing period at the age of 45 (and one-half had a potential of 12 years). The tendency during the 1970s has been for this potential to be increasingly realized, and the numbers of births to remarried women have gone up considerably. In 1980, the figure reached over 38 thousand (4 per cent above the 1979 level) accounting for almost 6 per cent of all live births.

Deaths

The number of deaths in England in 1980 was 544,349, a decrease of 1.9 per cent from the total for 1979 (554,840). These figures represent a fall in the crude death rate per 1,000 of the population from 12.0 to 11.7. This rate is the third lowest of the past decade and compares favourably with the average crude death rate over that period of 11.82. However, comparisons of mortality over time should take account of changes in the age and sex structure of the population. This is done in the Standardized Mortality Ratio (SMR) which compares the observed number of deaths with the number that would have occurred if the sex/age specific death rates of a standard year had applied to the current population structure. The SMR for 1980 is 87 (1968=100). After a period of three years in which the SMR has remained more or less stationary at 90 this represents a return to the overall trend of a steady improvement in mortality experience.

The only two factors which are liable to produce major short-term changes in mortality rates are epidemics of influenza and abnormal weather conditions especially severe cold. In the event influenza was largely confined to a small outbreak in late spring and a recurrence of activity towards the end of the year. Neither episode produced much impact on the mortality indices of influenza activity and the net result was an annual total of deaths ascribed to influenza which is the lowest this century. As regards the weather, the winter was generally mild, the summer cool and wet and the early autumn unusually cold. These patterns are reflected in Table 1.5 which shows that the death rate in the March quarter of the year was distinctly better than the average of the last 5 years for that quarter, whereas mortality in the December quarter was a little worse than average.

Table 1.5 Quarterly death rate per thousand home population (England), average 1975-79 and 1980

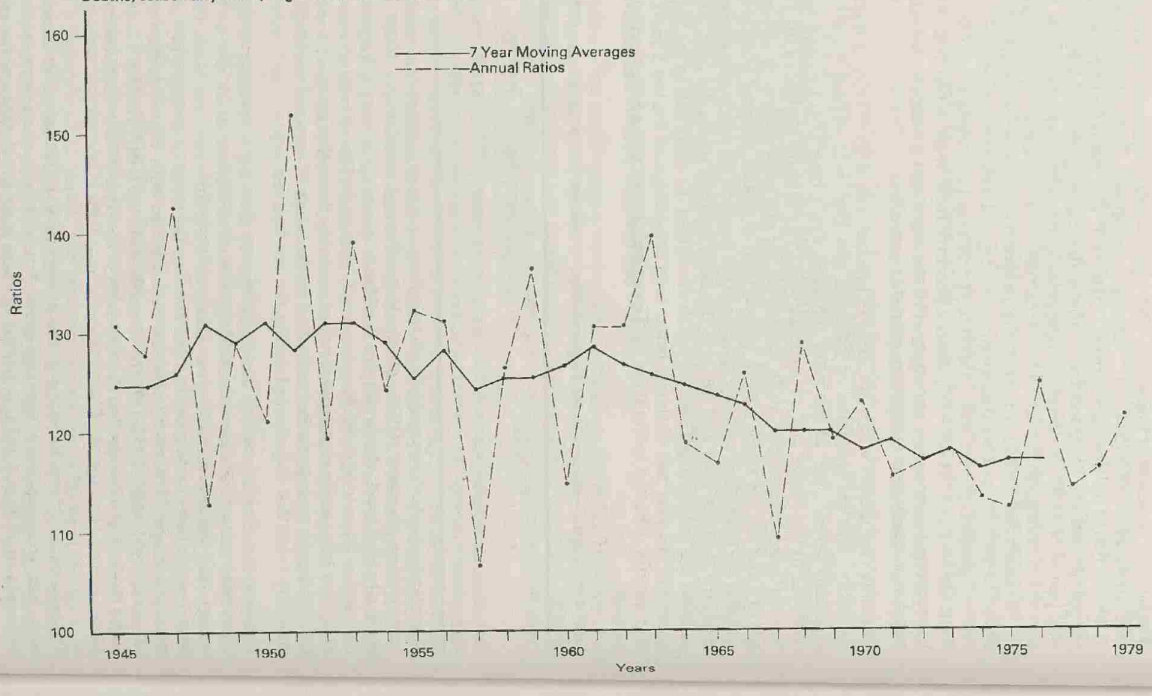
	March	June	September	December
England average 1975-79	13.9	11.6	10.2	11.7
England 1980	13.1	11.4	10.3	12.0

The relationship between mortality in the March and June quarters of a year, has recently been discussed (Office of Population Cenuses and Surveys, 1979). An unusually high level of mortality in the March quarter of a year is frequently followed by a low level in the June quarter. Although the March (winter) quarter invariably has a somewhat higher level of mortality than other quarters, the last few years have seen a marked reduction in the range of seasonal variation in mortality from that experienced during the last half century.

Figure 1 is a diagram which illustrates this by showing a specially derived seasonality ratio (the ratio of each March quarter's crude death rate to the annual rate for the calendar year taken as 100), for each year since 1945. Superimposed on the diagram is a line showing the trend of the ratios (a 7 year moving average). The peak years can be associated with winter epidemics of influenza (1951, 1953, 1959, 1976) or very severe winters (1947, 1963) or a little of both (1968). A distinct decline in seasonality is however evident from the early 1960s.

The reasons for this decline are not immediately clear. Influenza epidemics have been less common since the mid-1960s but although there were serious outbreaks in 1970 and 1976, in neither of these years did the seasonality ratio

Figure 1
Deaths, seasonality ratios, England and Wales, 1945-1979.



reach the levels previously associated with them. Similarly the winter of 1979 was very nearly as severe as that of 1963 but the seasonality ratio for the two years is very different. A statistical analysis of the figures tends to confirm that the influence of influenza epidemics and severe winters in raising winter mortality has declined since around 1970. For further discussion, see McDowall M, *Long term trends in seasonal mortality, Population Trends* (Office of Population Censuses and Surveys 1981b). An international study of seasonality in mortality (Momiyama, M, 1977) has associated central heating with lower winter mortality although causality is difficult to determine. In England and Wales the proportion of households having central heating is estimated to have risen from around 7 per cent in 1964 to over 50 per cent in the late 1970s (Department of Employment, 1964 et seq).

The principal causes of death are identified in Table 1.6. Circulatory disorders account for one half of all deaths, the main components being ischaemic heart disease (26 per cent) and cerebrovascular disease (12 per cent). The second biggest broad group of causes of death is the malignant neoplasms which account for over one fifth of all deaths, the most important site being the trachea, lung and bronchus (6 per cent). Respiratory conditions are responsible for about one in seven of all deaths, the main element being deaths attributed to pneumonia (9 per cent). This is only the second year for which data are available since the introduction of the 9th revision of the International Classification of Diseases and the examination of recent time trends is complicated by issues of comparability with earlier years. However, among the larger individual causes of death hypertension, atherosclerosis, bronchitis, emphysema and asthma and hyperplasia of the prostate showed reductions of over 10 per cent in their crude death rate compared with the previous year. There were no proportional increases on a corresponding scale.

The mortality trends for the major forms of circulatory disorder over the past 30 years are presented in Table 1.7. Mortality rates from ischaemic heart disease have fallen fairly steadily throughout the period for men over 74 years of age and women over 64. For men below 70 the rates have risen over most of the period, but at 55-64 years the rate of increase has slowed considerably in the last 20 years and in the other age groups there has been a fall in the latest quinquennium. Indeed at 35-39 the rate has been falling for 20 years. Among women under the age of 60 the emphasis is on rising rates over the period although in the latest quinquennium the rates have tended to stabilize. Mortality rates for cerebrovascular diseases, the second commonest cause of death among the circulatory disorders, have fallen substantially in all age groups for both sexes. Below age 80 the rates fell throughout the period so that for males the final rates were as much as 42 per cent below the initial level (at ages 60-64) while for females falls of 48 to 51 per cent were achieved in the age range 50-69. Over the age of 80 the downturn in the rates for both sexes was progressively more recent and the degree of improvement correspondingly reduced. Thirty years ago hypertensive disease accounted for almost 4 per cent of all deaths; but as Table 1.6 indicates this proportion has now fallen below 1 per cent. This striking improvement is seen to have affected both sexes and all the age groups in Table 1.7. There is a tendency for the extent of the improvement to increase with age except in the oldest age groups. From 50-69 years the proportional reduction in the rates for women has outpaced that of men with the result that the ratio of male to female rates in this age range has risen from about 1.5 to about 2.

Death rates from the various forms of cancer are examined in more detail in Table 1.8. The trachea, bronchus and lung constitute the commonest site for

cancer mortality in men (39 per cent) and the second commonest site (14 per cent), after cancer of the breast (20 per cent), for women. Last year the death rate for men from cancer of this site fell slightly although the number of deaths was marginally higher. This year the rate has fallen again and the number of deaths has also fallen slightly for the first time since 1975. On that occasion the reduction in male deaths exceeded the rise in female deaths to give an overall reduction in lung cancer mortality; this time the reduction in male deaths (45) is greatly outweighed by the increase in female deaths (482) which is the largest annual increment on record. There is little change from last year in the figures for cancer of the breast. The second commonest site among cancer deaths in men and the fourth commonest in women is the stomach. Deaths from this cause have been declining for over 30 years, more for females than males, and comparison with the figures for 1979 indicates that this trend is continuing. Cancer of the intestine (except rectum) which ranks fourth among men and third among women as a cause of cancer deaths has shown little change over the past decade. The incidence and mortality of cancer of the prostate, which is the third commonest cause of death from cancer among men, rise steeply with age. Although the number of deaths and the crude death rate from this cause show an annual increase, age-standardization reveals a stable position and indicates that the increase is largely attributable to the increase in the proportion of elderly males in the population.

Almost 2,000 deaths were ascribed to cancer of the cervix uteri in 1980. The latest figure represents a fall of only just over 10 per cent since 1971 in spite of evidence that screening for this condition is capable of leading to a substantial reduction in mortality. Data on mortality from cancer of the cervix uteri are presented in Table 1.9. In the latest quinquennium death rates rise with age to a plateau of about 200 per million at ages 55 to 74 years and thereafter rise gradually through the remaining age groups. Against a background of general improvement in age-specific death rates exemplified by the fall throughout the period at ages 70-79, there are three cohorts which, moving diagonally across the table, produce increases in age-specific rates. The oldest appears among those aged 80 and over in 1956-60. The most extensive in the table is that which involves those aged about 35 to 49 years in 1956-60. These women would have been about 20-30 years of age at the time of World War II, a finding which contributed to the evidence that early and promiscuous sexual activity is associated with this condition (Hill and Adelstein, 1967) and with a possible infective agent (Beral, 1974). The latest wave of increased age-specific mortality appears in those aged under 35 in 1971-75, an age group which contributed 5.5 per cent to the total burden of mortality from this condition in 1980.

Stillbirths and infant mortality

Although 1980 saw a further increase over the previous year in the number of live births, the number of stillbirths fell from 4,811 to 4,523 and the stillbirth rate improved from 7.9 to 7.3 per 1,000 total births (Table 1.10). This represents a rate of improvement that is better than the average of the last five years. After rising slightly in 1979 as a result of the increase in the birth rate the number of early neonatal deaths (in the first week of life) fell from 4,028 to 3,793 and the early neonatal death rate improved from 6.7 to 6.1 per 1,000 live births. These two sets of figures (stillbirths and first week deaths) are combined in the perinatal mortality rate which fell from 14.6 in 1979 to 13.4 per 1,000 total births. Though not as big in absolute terms this constitutes a marginally greater rate of improvement than the striking reductions of 1975/6 and 1977/8. Although the

postneonatal mortality rate fell from 4.6 to 4.4 per 1,000 live births this represents no more than a return to the level recorded in 1978. After falling relatively rapidly in the early 1970s there has been little further reduction in the postneonatal mortality rate since 1976. Although it covers the age range from one month to one year, deaths in this period (2,706 in 1980) are substantially fewer than those in the first week of life. Accordingly the reduction of the infant mortality rate from 12.8 to 12.0, the biggest improvement since 1975/6, largely reflects the increased survival at the start of life.

Birthweight

OPCS has routinely collected birthweight information for stillbirths for more than 20 years. A scheme for the transfer of birthweight data from birth notification into the vital statistical system in respect of live births was started in 1975. There has been a gradual increase in the success of the transfer process and by 1979 birthweight was available in the vital registration system for two thirds of live births. In 1980, this rose to 87 per cent as a result of various improvements made during late 1979 and 1980. It is hoped that birthweight information will become available for almost all births occurring in 1981 and subsequent years.

This information will be used to provide perinatal and infant mortality statistics by birthweight and to analyse and monitor the distribution of birthweight in relation to a wide range of social and biological factors. Estimated perinatal and infant mortality rates for 1978 infant deaths have been issued in OPCS Monitor DH3 81/2.

Notifications in 1980 of babies born in England weighing 2,500g or less at birth showed that low birth weight live births represented 6.9 per cent of live births; and low birth weight live and stillbirths together represented 7.3 per cent of live and stillbirths. (See Table 7.5). Table 1.11 gives an analysis of low birth weight babies by birth weight groups showing stillbirths and neonatal mortality. 48 per cent of all low birth weight *live births* were just below the limit in the heaviest 2500g group while 30 per cent were 2,000g or less and 3.6 per cent 1,000g or less. The table clearly shows the increase in mortality with the decline in birthweights as does Table 1.12 which shows the perinatal mortality rates for each of the low weight groups. Over the last six years the rates have fallen in each group with a tendency for a smaller decline in the lightest group.

Congenital malformations

The number of babies notified at birth with congenital malformations discovered within seven days of birth rose again in 1980 (Table 1.13). This was partly due to the increased number of births; the rate of malformed children per 1,000 total births increased from 21.2 in 1979 to 21.6 in 1980 (Table 1.14).

Quarterly tabulations of the main groups of malformations are published and commented on in OPCS Monitor MB3 series and the results of the monthly monitoring program are published annually in this series. During the last year notification rates of central nervous system malformations have continued to decrease, maintaining the downward trend seen since 1973. The increasing trend in notifications of cardiovascular malformations noted from 1973 (10.9 per 10,000 total births) has continued in 1980 (13.2 per 10,000 total births). Since about 80 per cent of the children with cardiovascular malformations are not diagnosed till later in infancy, this increase of 21 per cent in the reporting rate may reflect only increased ascertainment in the perinatal period.

Table 1.6 Mortality: Principal causes — England 1980

ICD No (9th Revision)	Causes	Deaths	Rate per million	Percentage of deaths from all causes
010-012	Tuberculosis of the respiratory system	435	9.4	0.08
013-018, 137	Tuberculosis, other forms	399	8.6	0.07
036	Meningococcal infection	64	1.4	0.01
090-097	Syphilis and its sequelae	56	1.2	0.01
Rem. 000-139	All other infective and parasitic diseases	1,118	24.1	0.21
	Malignant neoplasms:			
140-149	Buccal cavity and pharynx	1,495	32.2	0.27
150	Oesophagus	3,572	76.9	0.66
151	Stomach	10,140	218.2	1.86
152-154	Intestine and rectum	15,770	339.4	2.90
157	Pancreas	5,564	119.7	1.02
161	Larynx	755	16.2	0.14
162	Trachea, bronchus and lung	33,327	717.2	6.12
174-175	Breast	11,489	247.3	2.11
179-182	Uterus (female)	3,358	140.9	0.62
185	Prostate (male)	4,732	209.0	0.87
204-208	Leukaemia	3,120	67.1	0.57
Rem. 140-208	Other malignant neoplasms	28,224	607.4	5.18
250	Diabetes mellitus	4,457	95.9	0.82
290-319	Mental disorders	3,150	67.8	0.58
332	Parkinson's disease	1,474	31.7	0.27
340	Multiple sclerosis	675	14.5	0.12
401-405	Hypertensive disease	5,155	110.9	0.95
410-414	Ischaemic heart disease	144,080	3,100.7	26.47
393-398 415-429	Other forms of heart disease	35,524	764.5	6.53
430-438	Cerebrovascular disease	66,675	1434.9	12.25
440	Atherosclerosis	7,464	160.6	1.37
441	Aortic aneurysm (non-syphilitic)	6,141	132.2	1.13
451-453	Venous thrombosis and embolism	3,958	85.2	0.73
480-486	Pneumonia	50,601	1089.0	9.30
487	Influenza	478	10.3	0.09
490-493	Bronchitis, emphysema and asthma	19,329	416.0	3.55
531-533	Peptic ulcer	4,187	90.1	0.77
571	Cirrhosis of liver	2,060	44.3	0.38
580-589	Nephritis and nephrosis	4,174	89.8	0.77
600	Hyperplasia of prostate (male)	666	29.4	0.12
630-676	Complications of pregnancy, childbirth, and the peurperium (female)	68	2.9	0.01
740-759	Congenital anomalies	3,119	67.1	0.57
Rem. 000-799	All other diseases	38,450	827.5	7.06
E810-E825	Motor vehicle accidents	5,481	118.0	1.01
E880-E888	Accidental falls	3,841	82.7	0.71
E800-E807 Rem. E826-E949	All other accidents	3,649	78.5	0.68
E950-E959	Suicide and self inflicted injuries	4,070	87.6	0.75
E960-E999	All other external causes	1,805	38.8	0.33
	All causes	544,349	11,714.8	100.00

Table 1.7 Deaths from circulatory disease per 100,000 population, England and Wales, 1951-1980

Age-group (years)	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
Males											
Hypertension											
1951-55	3	6	14	27	57	104	187	300	486	716	891
1956-60	4	7	13	25	49	87	152	257	405	610	715
1961-65	3	6	10	20	35	64	107	179	291	412	577
1966-70	3	5	10	17	28	48	77	125	189	275	363
1971-75	2	4	8	14	22	37	62	91	142	187	252
1976-80	1	2	5	9	15	28	47	71	102	143	195
Ischaemic heart disease											
1951-55	21	50	114	239	421	737	1,237	2,057	3,479	5,780	10,286
1956-60	28	63	133	265	482	775	1,250	2,020	3,181	5,205	8,269
1961-65	37	82	166	302	529	879	1,346	2,057	3,073	4,801	8,006
1966-70	35	94	187	329	548	876	1,379	2,042	2,936	4,109	7,332
1971-75	35	96	207	365	569	891	1,404	2,081	2,957	4,151	6,604
1976-80	32	85	187	358	579	903	1,365	2,045	2,928	4,040	6,169
Cerebrovascular disease											
1951-55	8	15	33	72	138	284	532	954	1,675	2,564	3,630
1956-60	8	16	31	65	135	266	506	928	1,635	2,657	3,662
1961-65	8	15	30	59	122	247	482	891	1,570	2,574	4,106
1966-70	8	15	29	57	111	223	444	834	1,466	2,444	4,270
1971-75	8	14	29	53	100	195	397	759	1,334	2,258	3,859
1976-80	7	13	25	48	85	166	337	646	1,166	1,896	3,259

Females											
Hypertension											
1951-55	2	4	9	18	34	68	132	236	402	590	752
1956-60	2	4	7	14	26	56	112	211	365	559	734
1961-65	2	5	8	15	27	49	78	130	210	302	382
1966-70	1	2	5	8	13	26	52	100	179	277	399
1971-75	1	2	4	6	11	19	36	68	122	201	283
1976-80	1	1	3	5	7	15	26	49	86	139	214
Ischaemic heart disease											
1951-55	5	10	25	56	124	280	602	1,212	2,391	4,559	9,111
1956-60	4	10	23	51	119	268	557	1,107	2,087	3,813	7,598
1961-65	5	13	27	55	125	278	563	1,087	1,927	3,490	6,798
1966-70	6	15	28	60	123	270	536	999	1,742	2,896	5,999
1971-75	6	16	34	67	136	274	526	968	1,676	2,802	5,342
1976-80	5	15	32	69	139	280	510	923	1,567	2,624	4,954
Cerebrovascular disease											
1951-55	8	17	38	79	134	241	456	853	1,493	2,358	3,452
1956-60	9	17	33	66	116	215	411	801	1,470	2,413	3,738
1961-65	8	15	31	56	97	189	364	737	1,362	2,389	3,975
1966-70	9	15	30	52	84	164	323	655	1,254	2,237	4,171
1971-75	8	15	27	46	75	139	280	589	1,156	2,144	4,022
1976-80	7	13	23	40	65	122	237	494	978	1,833	3,618

ICD 6th and 7th Revisions	440-447	Hypertension
	420-422	Ischaemic heart disease
	330-334	Cerebrovascular disease
ICD 8th Revision	400-404	
	410-414,428	
	430-438	
ICD 9th Revision	401-405	
	410-414, 429.0, 429.1	
	430-438	

Table 1.8 Deaths from cancer of certain sites, England 1980

Table 1.8 Deaths from cancer of certain sites, England 1980

ICD No (9th Revision)	Sites	Number of deaths		Rates per million living		Proportion per 1,000 total cancer deaths	
		Male	Female	Male	Female	Male	Female
140-159	Total digestive system	20,216	18,729	893	786	312	330
141	Tongue	218	134	10	6	3	2
140-149	Lip, oral cavity and pharynx	912	583	40	24	14	10
150	Oesophagus	2,054	1,518	91	64	32	27
151	Stomach	5,940	4,200	262	176	92	74
152-153	Intestine (except rectum)	4,108	5,774	181	242	63	102
154	Rectum rectosigmoid junction and anus	3,139	2,749	139	115	48	48
157	Pancreas	2,923	2,641	129	111	45	46
160-165	Respiratory and intrathoracic organs	26,220	8,383	1,158	352	405	148
161	Larynx	571	184	25	8	9	3
162	Trachea, bronchus and lung	25,306	8,021	1,118	337	391	141
163-165	Other and unspecified	237	88	10	4	4	2
170-175	Total bone, connective tissue, skin and breast	949	12,341	42	518	15	217
170-171	Bone, connective tissue and other tissue	367	337	16	14	6	6
172-173	Skin	510	587	23	25	8	10
174-175	Breast	72	11,417	3	479	1	201
179-187	Total genital organs	5,050	7,371	223	309	78	130
180	Cervix uteri	—	1,939	—	81	—	34
182	Uterus (other and unspecified)	—	1,105	—	46	—	19
183	Ovary, fallopian tube and broad ligament	—	3,524	—	148	—	62
184	Other and unspecified female genital organs	—	489	—	21	—	9
185	Prostate	4,732	—	209	—	73	—
188-189	Total urinary system	3,787	1,908	167	80	59	34
188	Bladder	2,796	1,217	124	51	43	21
189.0, 189.1	Kidney	950	656	42	28	15	12
190-192	Eye, brain and other parts of nervous system	1,352	1,015	60	43	21	18
193	Thyroid	92	228	4	10	1	4
200-208	Total lymphatic and haematopoietic tissue	3,923	3,368	173	141	61	59
201	Hodgkin's disease	317	218	14	9	5	4
204-208	Leukaemia	1,713	1,407	76	59	26	25
140-208	Total cancer	64,734	56,812	2,859	2,384	1,000	1,000

Table 1.9 Deaths from cancer of cervix uteri per million population, England and Wales, 1951-80

Years	*Age groups* (years)													
	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
1951-55	1	10	30	58	93	136	203	254	285	304	315	361	327	315
1956-60	1	9	37	74	119	154	181	197	246	284	313	336	366	361
1961-65	1	5	18	67	134	180	187	178	221	232	274	301	332	357
1966-70	2	7	15	44	106	176	204	201	193	217	247	271	290	351
1971-75	3	10	22	38	67	130	190	199	199	193	206	247	257	262
1976-80	3	15	33	53	59	92	157	192	214	203	201	217	238	246

Table 1.10 Live births, still births and infant mortality, England 1960-80

Year	Live births	Stillbirths		Early neonatal mortality (deaths under 1 week)		Perinatal mortality (stillbirths plus deaths under 1 week)	Post-neonatal mortality (deaths 4 weeks to under 1 year)	Infant mortality (deaths under 1 year)
	No.	No.	Rate*	No.	Rate†	Rate*	Rate†	Rate†
1960	740,858	14,753	19.5	9,772	13.2	32.5	6.3	21.6
1970	741,999	9,708	12.9	7,864	10.6	23.4	5.9	18.2
1976	550,383	5,339	9.6	4,468	8.1	17.6	4.6	14.2
1977	536,953	5,087	9.4	4,070	7.6	16.9	4.5	13.7
1978	562,589	4,791	8.4	3,975	7.1	15.4	4.4	13.1
1979	601,316	4,811	7.9	4,028	6.7	14.6	4.6	12.8
1980	618,371	4,523	7.3	3,793	6.1	13.4	4.4	12.0

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

Table 1.11 Low birth weight live and stillbirths by weight and mortality for the year ending 31 December 1980. England.

Birth weight group	Low weight live births	Deaths within 24 hours of birth	Deaths within 28 days of birth	Deaths within 28 days per 1,000 low weight live births	Low weight stillbirths	Low weight stillbirths per 1,000 low weight live and still births
— 1000 g (— 2lbs 3 ozs)	1,519	693	1,062	699.1	638	295.8
— 1500 g (— 3lbs 4 ozs)	3,306	379	744	225.0	881	210.4
— 2000 g (— 4lbs 6 ozs)	7,905	284	546	69.1	765	88.2
— 2250 g (— 4lbs 15 ozs)	9,453	111	208	22.0	326	33.6
— 2500 g (— 5lbs 8 ozs)	20,191	114	255	12.6	362	17.6
All babies 2500 g (5lbs 8ozs) or less	42,374	1,581	2,815	66.4	2,975	65.6

These figures exclude 100 live births and 24 stillbirths where birthweight was not specified.
Of the live births 26 died within 24 hours and 57 died within 28 days.

Table 1.12 Low weight births — perinatal mortality rates, England 1980

Birth weight group	Stillbirths and deaths in first 7 days per 1000 live and stillbirths					
	1975	1976	1977	1978	1979	1980
— 1000 g	857	819	811	792	772	742
— 1500 g	544	491	499	437	415	362
— 2000 g	216	195	187	173	152	144
— 2250 g	86	71	71	64	56	51
— 2500 g	42	37	38	31	30	27
All of 2500 g or less	172	156	154	142	132	121

Table 1.13 Notified congenital malformations in live and stillborn babies, and percentage with one or more malformations, England 1974-1980

Year	Number of malformations notified	Number of babies involved	Percentage with one or more malformations			
			One	Two	Three	Four or more
1974	15,254	12,143	81.8	13.4	3.1	1.7
1975	14,592	11,740	82.4	13.3	2.9	1.4
1976	14,615	11,803	83.6	12.0	2.6	1.7
1977	14,378	11,851	84.9	11.2	2.4	1.4
1978	14,715	12,197	85.1	11.4	2.2	1.4
1979	15,573	12,858	85.3	11.0	2.2	1.5
1980	16,417	13,457	84.7	11.6	2.2	1.6

Table 1.14 Notified congenital malformations among live and stillborn babies, showing rates for live born and for all babies, England 1974-1980

Year	Live born babies with malformations		Number of stillborn babies with malformations	All babies with malformations*	
	Number	Rate per 1,000 total births		Number	Rate per 1,000 total births
1974	9,967	16.3	2,145	12,143	19.9
1975	10,556	18.4	1,140	11,740	20.4
1976	10,812	19.5	957	11,803	21.2
1977	10,892	20.1	928	11,851	21.9
1978	11,318	19.9	857	12,197	21.5
1979	12,048	19.9	773	12,858	21.2
1980	12,704	20.4	697	13,457	21.6

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

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2

INCAPACITY AND DISABLEMENT

An account of the social security aspects of the Department's activities that are of medical interest appears in this chapter. It remains the same format as in last year's Report, but complete figures for 1980 are not yet available for all tables.

Changes in legislation have affected the significance of the tables concerned with incapacity statistics and the effect will be even more marked in future years. This has been the result of the Social Security (No 2) Act 1980, whereby, since 14 September 1980, a spell of incapacity for work lasting three days or less has not formed a period of interruption of employment for incapacity benefit purposes. Thus these periods do not now attract incapacity benefit; and they do not count for linking purposes. As a consequence doctors' statements are no longer required to support claims where incapacity has lasted for three days or less and general practitioners can refuse to issue them. It is estimated that the number of claims to benefit, and therefore the number of recorded spells of incapacity, will be reduced by approximately half a million in a full year. The number of doctors' statements issued should be correspondingly reduced. Arrangements have, however, been made so that benefit may continue in payment to those who are incapacitated regularly for 2 or 3 days each week by reason of haemodialysis for chronic renal failure and certain other forms of treatment.

On 2 April 1980 the Secretary of State presented to Parliament a Green Paper (Department of Health and Social Security, 1980a) that set out for discussion the Government's proposals for an employers' statutory sick pay scheme. It stressed that 60% of those who qualified for sickness benefit were back at work by the end of a fortnight, 80% within a month and 90% within six weeks. The scheme would entail employers, rather than the State, being responsible for sick-pay for up to eight weeks in a tax-year. Widespread consultations were held during 1980 with, among others, the BMA; matters discussed included the provision of medical evidence to employers in respect of claims to statutory sick pay.

A consultative document, *A Fresh Look at Maternity Benefits* (Department of Health and Social Security, 1980b), was issued in October. The review was carried out because of the need to determine how cash provision for maternity would be provided once the Government's proposals for statutory sick-pay had been implemented. It was given further impetus by the recommendation of the Select Committee on Social Services that the Government should consider whether the large sums of money for maternity provision could be better spent.

The estimated annual cost of social security benefits in Great Britain at December 1979 rates is shown in Table 2.1. It amounted to £19,656 million. This was an increase of 21.3% compared with the cost at the end of 1978 which was in turn 19.3% higher than the cost at the end of 1977. The costs of benefits paid in respect of incapacity and disablement from the Consolidated Fund amounted to £839 million; this showed an increase of 25.4% over 1978. The cost of industrial injury benefits, paid from the National Insurance fund, rose by 18.5% to £385 million. The figure given for "Other National Insurance Benefits" includes the cost of sickness and invalidity benefits and also maternity benefit, widows benefit, death grant and unemployment benefit.

Table 2.1 Annual cost of social security benefits (at December rates) Great Britain 1969, 1978, and 1979

	£ million		
	1969	1978	1979
From the Consolidated Fund			
In respect of incapacity and disablement			
War pensions	129	360	414
Attendance allowance	—	180	240
Non-contributory invalidity pension	—	70	90
Invalid care allowance	—	4	5
Mobility allowance	—	55	90
In other respects			
Supplementary pensions	230	670	780
Supplementary allowances	230	1,300	1,420
Child benefit & child benefit increase†*	339	2,138	2,833
Old persons' pensions	—	37	36
Family income supplement*	—	23	38
Lump sum payments*	—	101	5
From the National Insurance Fund			
Retirement pensions	1,740	8,018	9,790
Industrial injuries benefits	880‡	325	385
Other National Insurance benefits	—	2,919	3,432
Lump sum payments	—	—	98
Total	3,548	16,200	19,656

Where dashes are shown, the benefit was not payable in that year.
*Revised figure for December 1978.
†Net figures after deducting receipts, eg rent/rate rebates from local authorities.
‡Includes industrial injuries benefits and "Other National Insurance benefits".

Tables 2.2 and 2.3 show respectively the numbers of people receiving certain benefits on a given day in 1969 and in recent years; and the annual number of claims to those benefits. When 1980 is compared with 1979 the following changes are apparent: for attendance allowance the number of claims showed an increase of 8.9%; the number in receipt of injury benefit showed only a slight fall, but for the number of claims for industrial injuries benefits there was a decrease of 12%; mobility allowance claims have fallen from the peak in 1979 but the number in payment continues to rise; the combined figures for sickness and invalidity benefits and non-contributory invalidity pension (only sickness benefit was payable in 1969) show a decrease of 3.0% in the number receiving the benefits, and there was in 1980 a 13% fall in the number of new claims on that for the previous year. It is not at present clear how big a contribution to these changes has been made by the generally lower level of employment and how much by the legislative change in September 1980.

Information about the war pensions scheme is available from the Department's Report for War Pensioners for 1980.

Decisions on claims

Claims to disability-related benefits are determined by various independent statutory authorities. Their constitution and functions were dealt with in this Report for 1979 (page 30), except for medical appeal tribunals described in the Report for 1977 (page 29). This section does not deal with decisions made by

medical boards and appeal tribunals, which are given in the section on the industrial injuries scheme; claims in respect of attendance allowance, mobility allowance and vaccine damage also are given in their own respective sections.

Table 2.2 Number of people receiving certain benefits on a given day, Great Britain, 1969, 1978, 1979, and 1980

	1969	1978	1979	1980
Attendance allowance*				
Higher rate	—	122,000	123,000	126,000
Lower rate	—	149,000	163,000	169,000
Child benefit (formerly family allowance)	4,189,000	7,183,000	7,180,000	7,174,000
Child benefit increase (formerly child interim benefit)	—	311,000	380,000	438,000
Child's special allowance	400	800	800	878
Family income supplement	—	81,000	81,000	97,000
Guardian's allowance*	5,000	3,900	4,000	3,499
Industrial injuries benefits				
Injury benefit	**	45,000	39,000	37,000
Disablement benefit	208,000	200,000*	198,000*	195,000
Widow's pension	28,500	31,000	31,000	31,000
Invalid care allowance	—	6,000	6,000	6,600
Invalidity allowance				
Lower rate	—	268,000	235,000	232,000
Middle rate	—	94,000	120,000	126,000
Higher rate	—	99,000	150,000	154,000
Maternity allowance	81,000	92,000	106,000	116,000
Mobility allowance	—	101,000†	137,000†	185,000†
Retirement pension	7,189,000	8,667,000‡	8,806,000‡	8,970,510‡
Sickness & invalidity benefits, non-contributory invalidity pension	923,000§	1,180,000	1,203,000	1,169,000
Supplementary benefit				
Supplementary allowance	810,000	1,190,000	1,130,000	1,923,000
Supplementary pension	1,870,000	1,740,000	1,720,000	1,694,000
Unemployment benefit	279,000	429,000	467,000	940,000
War pensions				
Disablement pension	397,000	287,000	276,000	266,000
Widow's pension	109,000	82,000	79,000	77,000
Other dependants' pension	32,000	14,000	12,000	10,000
Widow's pensions and widowed mother's allowance	551,000	458,000	425,000	**

Where dashes are shown, the benefit was not payable in that year

*Estimated from a basic count of all live cases, adjusted by an annual sampling exercise.

**Figures not available.

†Figures include Special Mobility Allowance which was introduced in November 1977.

‡Include non-contributory retirement pension for people over 80.

§Sickness benefit only.

Insurance Officers

In 1980 Insurance Officers decided 547,000 industrial injuries claims, 9,387,000 sickness and invalidity benefit claims and 813,000 child benefit (formerly family allowance) claims. The previous year's corresponding figures were not available for the 1979 Report: they were respectively 632,000, 10,791,000 and 789,000. Claims to the non-contributory invalidity pension for married women numbered approximately 11,500; 7,000 awards were made.

Table 2.3 Number of claims to benefit, Great Britain 1969, 1979 and 1980

	1969	1979	1980
Attendance allowance	—	135,000	147,000
Child benefit (formerly family allowance)	**	789,000	813,000
Child benefit increase (formerly child interim benefit)	—	115,000	123,000
Child's special allowance	100	300	300
Death grant	508,000	623,000	613,000
Family income supplement	—	180,000	180,000
Guardian's allowance	1,100	1,500	1,500
Industrial injuries benefits			
Injury benefit	928,000	632,000‡	547,000
Disablement benefit	202,000	135,000	126,000
Invalid care allowance	—	6,000	6,000
Maternity benefit	913,000	652,000	675,000
Mobility allowance	—	66,000*	53,000*
Retirement pension	662,000	670,000	687,000
Sickness & invalidity benefits, non-contributory invalidity pension	11,411,000†	10,800,000‡	9,387,000
Supplementary benefit			
Supplementary allowance	6,320,000	4,930,000	5,440,000
Supplementary pension	370,000	270,000	290,000
Unemployment benefit	3,098,000	4,271,000	5,132,000
War pensions			
Disablement pensions	8,000	5,000	6,000
Widow's pension	4,000	3,000	4,000
Other dependants' pension	500	100	50
Widow's pension and widowed mother's allowance	69,000	53,000	**

Where dashes are shown benefit was not payable in that year.
*These figures include claims for Special Mobility Allowance which became payable in November 1977.
†Sickness benefit only
‡Revised
**Figures not available

National Insurance Local Tribunals

The number of appeals by claimants and references by insurance officers dealt with by local tribunals in 1979 were not available for last year's Report. They amounted to 39,304 and in 1980 to only a few less, ie 39,198. Decisions were given in claimants' favour in 21% and 23% of cases respectively. The figures included the following:

Cases	1979	1980
Sickness and invalidity benefit	12,790	‡2,298
Non-contributory invalidity pensions (NCIP)	2,039	2,011
NCIP for married women (HNCIP)	1,870	1,949
Industrial injury benefit	3,912	3,805

Of the appeals on claims to HNCIP, 41% in 1979 and 40% in 1980 were decided in claimants' favour.

Social Security Commissioners

The title of National Insurance Commissioners was changed by the Social Security Act 1980 to that of Social Security Commissioners. The cases dealt with in 1979 and 1980 and their outcome were as follows:

	1979	1980
Appeals from decisions of local appeal tribunals in national insurance cases	2,156	2,186
Cases decided in claimant's favour	36%	29%
Industrial injuries cases	453	485
Cases decided in claimant's favour	40%	35%

In 1979 and 1980 the commissioners granted 45 and 236 applications respectively for leave to appeal on a point of law on decisions of medical appeal tribunals. They allowed in 1979 33 and in 1980 34 of these appeals. Nearly 200 HNCIP appeals were also considered in 1979 but only 83 in 1980; of these 70 and 43 respectively resulted in awards to claimants.

Sickness and Invalidity benefits; and Non-contributory invalidity pension

The circumstances under which incapacity benefits are payable were described briefly in this Report for 1979.

New Claims

As is shown in Table 2.3, new claims for the calendar year 1980 numbered 9,387,000. Between 1970 and 1980 the number of claims, averaged over five-year periods, have been as follows:

Period	No of claims (million)
1970-74	9.8
1971-75	9.7
1972-76	10.0
1973-77	10.1
1974-78	10.3
1975-79	10.5
1976-80	10.4

Table 2.4 shows the average weekly intake of new claims in 1962 and from 1972 to 1980 inclusive.

Numbers incapacitated

Table 2.5 shows the number of claimants incapacitated from working on a given day in each month for the same years as is used in Table 2.4.

Table 2.4 Sickness and invalidity benefits* and NCIP. Average weekly intake of new claims†, Great Britain 1962 and 1972-1980

	Number (thousands)				Index: 1962=100			
	Jan-Mar	April-June	July-Sept	Oct-Dec	Jan-Mar	April-June	July-Sept	Oct-Dec
1962	252	154	121	172	100	100	100	100
1972	224	153	146	212	89	99	121	123
1973	243	169	164	194	96	110	136	113
1974	230	174	159	195	91	113	131	113
1975	225	175	156	183	89	114	129	106
1976	291	172	161	202	115	112	133	117
1977	220	191	170	199	87	124	140	116
1978	259	200	182	217	103	130	150	126
1979	266	196	171	197	106	127	141	115
1980	212	179	157	161	84	116	130	94

*Invalidity benefit was introduced on 23 September 1971 and from 20 November 1975 includes non-contributory invalidity pension.

†A 'new claim' means a claim submitted at the beginning of a spell of incapacity for work. If a person has several separate spells of incapacity for work during the year, each spell is counted as a 'new claim'. The figures include a relatively small number of claims that did not result in the payment of benefit.

Table 2.5 Sickness and invalidity benefits*. Number of claimants incapacitated on first Tuesday of month†.
Great Britain 1972-1980. 1962 figures are for the third Tuesday.

Number (thousands)

	1962	1972	1973	1974	1975	1976	1977	1978	1979	1980
Jan	1,352	1,100	1,293	1,046	1,047	—	1,030	1,113	1,278	1,113
Feb	1,034	1,146	1,107	1,089	1,060	—	1,097	1,241	1,281	1,197
Mar	1,034	1,043	1,051	1,118	1,042	—	1,113	1,223	1,256	1,163
Apr	960	973	1,000	1,052	978	—	1,081	1,123	1,202	1,153
May	889	939	970	974	943		1,035	1,084	1,124	1,076
Jun	860	929	945	924	—	—	1,052	1,096	1,112	
Jul	810	922	939	918	—	944	1,040	1,100	1,115	
Aug	802	914	940	908	—	932	1,045	1,107	1,109	
Sep	833	942	947	921	—	951	1,073	1,103	1,120	
Oct	899	968	1,014	991	—	1,005	1,126	1,151	1,154	
Nov	911	989	1,008	998	—	1,009	1,123	1,165	1,163	
Dec	923	1,090	1,009	982	—	1,039	1,101	1,164	1,122	

*Invalidity benefit was introduced on 23 September 1971.

†In this Report for 1976 the figures given for the period June 1975 to June 1976 were provisional. Due to the difficulties experienced generally in respect of statistics for the year 1975-76, following the change in sample size from 2½ to 2%, it has not been possible to correct the figures. They are therefore now omitted.

Certified Incapacity by cause

The numbers of spells and numbers of days of certified incapacity in 1962-63 compared to the years 1972-73 to 1979-80 are shown in Table 2.6.

Table 2.6 Sickness and invalidity benefits: new spells* and days † of certified incapacity, Great Britain 1962-63 and 1972-73 to 1979-80

Millions

Period‡	Sex	New spells*					Days†		
		All causes	Influenza	Other causes	All incapacity	Long incapacity§	All causes		
							Other incapacity	Influenza	Other causes
1962-63	M	6.3	0.9	5.3	213	65	147	11	202
	F	2.2	0.3	1.9	76	28	48	3	73
1972-73	M	7.0	1.0	6.0	250	88	162	11	239
	F	2.4	0.3	2.1	70	23	47	3	67
1973-74	M	6.8	0.7	6.1	251	89	162	7	244
	F	2.4	0.2	2.2	68	22	46	2	66
1974-75	M	6.6	0.7	5.9	244	90	153	7	236
	F	2.3	0.2	2.1	66	22	45	2	64
1975-76	††	—	—	—	—	—	—	—	—
1976-77	M	6.7	0.5	6.2	256	99	157	5	251
	F	2.5	0.2	2.3	65	21	45	2	64
1977-78	M	7.1	0.7	6.4	274	110	164	7	266
	F	2.9	0.3	2.6	80	24	56	2	77
1978-79	M	7.3	0.7	6.6	288	122	166	6	282
	F	3.2	0.3	2.9	83	26	57	2	81
1979-80	M	6.2	0.4	5.8	276	130	146	4	272
	F	3.0	0.2	2.9	83	27	56	2	81

*Spells commencing in period
†days in spells current at some time in period
‡starting on first Monday in June
§Incapacity lasting throughout period
††Not available for 1975-76

This table specifically singles out new spells and days of incapacity caused by influenza. Table 2.7 shows the contribution of diseases of the various systems to the total spells and days of incapacity in 1978-79 & 1979-80. The commonest individual causes of incapacity are also shown, and bronchitis (excluding acute bronchitis) is again second to influenza. The number of spells for bronchitis among males averaged over 5 year periods since 1970 have been as follows:

Period	No. of Spells (thousands)
1970-74	575
1971-75	535
1972-76	525*
1973-77	507*
1974-78	477*
1975-79	448*
1976-80	407*

*Estimated, as a result of incomplete sample in 1975/76.

Table 2.7 Sickness and invalidity benefits: new spells* and days† of certified incapacity, analysed by cause of incapacity. Great Britain, 1978-79 and 1979-80.

Cause	New spells*				Days†			
	Males		Females		Males		Females	
	thousands				millions			
	1978-1979	1979-1980	1978-1979	1979-1980	1978-1979	1979-1980	1978-1979	1979-1980
All causes	7,279	6,165	3,210	3,043	288.0	275.6	83.0	83.0
All causes except influenza	6,606	5,753	2,941	2,864	281.7	271.9	80.6	81.5
Infective & parasitic diseases	746	654	380	374	9.5	8.3	4.3	4.2
Tuberculosis of respiratory system	2	4	1	1	1.4	1.5	0.3	0.3
Neoplasms	12	14	6	7	1.7	2.1	0.4	0.5
Endocrine, nutritional and metabolic diseases	39	34	7	9	4.2	4.2	1.5	1.3
Diseases of blood and blood-forming organs	11	9	19	17	0.7	0.7	0.6	0.7
Mental disorders	206	244	134	186	22.7	29.6	10.4	14.6
Diseases of nervous system and sense organs	204	143	83	75	19.6	17.0	5.0	5.0
Diseases of circulatory system	254	224	45	43	51.5	53.6	5.2	5.3
Hypertensive disease	55	42	16	14	9.4	9.0	1.5	1.3
Ischaemic heart disease	97	76	6	5	24.0	24.6	1.3	1.4
Diseases of respiratory system	2,456	1,826	1,187	1,000	53.7	46.5	13.7	11.5
Influenza	674	412	270	179	6.3	3.7	2.5	1.6
Bronchitis excluding acute bronchitis	429	367	128	123	26.1	28.2	3.2	3.2
Emphysema	2	—	—	—	2.0		0.1	—
Disease of digestive system	469	427	161	163	15.4	14.4	3.4	3.7
Diseases of genito-urinary system	78	79	159	170	3.1	3.1	3.8	4.3
Complications of pregnancy, childbirth & puerperium	—	—	83	88	—	—	4.3	4.1
Diseases of skin and subcutaneous tissue	163	151	65	58	3.9	3.7	1.2	1.4
Diseases of musculoskeletal system & connective tissue	707	785	180	226	38.9	42.8	9.5	11.4
Arthritis & rheumatism except rheumatic fever	332	264	81	85	24.0	19.3	6.0	5.8
Congenital anomalies	2	2	1	0	0.3	0.3	0.1	0.2
Symptoms & ill-defined conditions	753	515	448	362	30.5	19.2	12.9	8.6
Accidents, poisoning & violence	1,173	1,049	250	253	32.3	29.9	6.6	6.1

*Spells commencing in period
†Day in spells current at time in period

Non-contributory Invalidity Pension for Married Women

This pension — the so-called housewives non-contributory invalidity pension or HNCIP — was described in this Report for 1979. A report presented to Parliament (National Insurance Advisory Committee, 1980) dealt with the question of the household duties for HNCIP. The Committee favoured either removing the test in the case of claimants who had been in employment, or had been seeking employment, during the majority of the previous five years; or alternatively gradually phasing it out altogether.

Reference of claims for sickness, invalidity and injury benefit to Regional Medical Services 1980

Before an award of benefit can be made, the claimant has to satisfy the insurance officer that the conditions for entitlement are met. Normally a doctor's statement is regarded as sufficient evidence of incapacity. Control action may be exercised by reference to the Regional Medical Services of the Department of Health and Social Security, the Scottish Home and Health Department, or the Welsh Office. The number of references cleared in 1980 amounted to 682,713. The results are shown in Table 2.8.

Table 2.8 Incapacity for work: decisions on claims referred to Regional Medical Services, Great Britain 1980

	Number of references (thousands)	Claimant not examined			Opinion after examination of claimant		
		considered incapable of work after receipt of further medical evidence	claim ended after receipt of notice to attend for examination	failed to attend for examination	incapable of work	not incapable of work	incapable of work at normal occupation but capable of suitable alternative work
Sickness and invalidity benefit	655.9	43%	4%	14%	27%	8%	4%
Injury benefit	26.8	19%	9.5%	26%	34%	11%	0.5%
Total	682.7	42%	4%	15%	27%	8%	4%

The industrial injuries scheme

General

Preferential contributory benefits are payable in the event of incapacity or disablement occurring as a result of industrial injuries and diseases. The circumstances under which disablement and injury benefits are payable were described in this Report for 1979.

In February 1980 the Department issued a discussion document on Industrial Injuries Compensation (Department of Health and Social Security, 1980c). It consisted of a general review of the scheme in the light of the relevant recommendations of the Royal Commission on Civil Liability and Compensation for Personal Injury (the Pearson Commission) and invited views and suggestions from interested parties on the issues and particular questions raised in the document.

Disablement benefit

Disablement is assessed by comparison with a normal person of the same age and sex. The benefit may be payable even if there is no loss of earning power.

There was a 0.3% decrease (520) in the number of disablement pensions for industrial accidents only (including pensions in lieu of gratuities) in payment on

30 September 1979 by comparison with 1978. The figure for 1980 was 155,370 an increase of 1.5% on 1978.

There was a small decrease in the number of industrial injuries medical board examinations in 1980 compared with the previous year. They numbered 226,876, mainly to assess disablement or to diagnose prescribed diseases. Of these, 103,771 were first examinations, 110,082 were for reassessment and review, and 13,023 were miscellaneous in nature.

If dissatisfied with a medical board's decision a claimant may, subject to some restrictions, appeal to a medical appeal tribunal. Alternatively the Secretary of State, often in the claimant's interests, may refer a decision to the tribunal. Like the medical board, the tribunal is an independent body. It consists of a legally qualified chairman and two consultants.

In 1980 medical appeal tribunals dealt with 9,809 appeals made by claimants and 2,617 references made by the Secretary of State on disablement questions; these were respectively 75 and 76 fewer than in 1979. Tribunals decided about 38% and 34% respectively in the claimant's favour. Tribunals also dealt with 385 appeals and 197 references on diagnosis and recrudescence questions as against 386 and 222 the previous year, varying or reversing the decisions of medical boards in about 32% and 57% of cases respectively.

Industrial injury benefit

Table 2.9 (Table 2.8 in this Report for 1979) shows the number of new claims for injury benefit for accidents and prescribed diseases for each year from 1971 to 1980. The fall in the number of claims experienced in 1979 was even more marked in 1980.

Table 2.9 Injury benefit (accidents and prescribed diseases): new claims, Great Britain 1971-1980.

Year	Thousands
1971*	729
1972	709
1973	741
1974	688
1975	648
1976	641
1977	657
1978	673
1979	633
1980*	547

*53 weeks

Table 2.10 (table 2.9 in this Report for 1979) shows new spells and days of incapacity as a result of industrial accidents each year from 1970-71 to 1979-80. Despite the marked fall in the number of claims for accidents and prescribed diseases, there was in 1979-80 only a slight decrease in new spells and in days of incapacity in the case of men. However a slight increase in both was recorded where women were concerned.

Table 2.10 Injury benefit (accidents): Great Britain 1970-80. New spells* and days † of certified incapacity

Period‡	New Spells* Thousands		Days† Millions	
	Men	Women	Men	Women
1970-71**	612	73	16.6	2.5
1971-72	556	66	15.3	2.1
1972-73	562	68	14.6	2.0
1973-74	555	68	14.1	2.2
1974-75	509	68	12.9	2.0
1975-76§	—	—	—	—
1976-77	478	75	12.2	2.3
1977-78	499	80	12.9	2.4
1978-79	496	84	12.6	2.6
1979-80	425	84	10.4	2.4

*Spells arising in period from fresh accidents
†Days in all spells current at some time in period
‡Starting on first Monday in June
**53 weeks
§Not available

Table 2.11 (table 2.10 in this Report for 1979) shows the principal causes of incapacity and the average length of each spell for men and women during the years 1978-80. Compared with 1977-78, there has been a marked decrease in the total number of spells of incapacity for men. "Sprains and strains of joints and adjacent muscle" were in 1979-80 the commonest cause of incapacity.

Table 2.11 Injury benefit (accidents) Great Britain: spells of certified incapacity from main causes terminated in period with average duration June 1978-June 1980.

	Men				Women			
	Spells		Average Duration		Spells		Average Duration	
	Thousands		Days		Thousands		Days	
	1978-1979	1979-1980	1978-1979	1979-1980	1978-1979	1979-1980	1978-1979	1979-1980
All causes	520.3	444.6	24	23	90.0	84.7	29	28
Fracture of limb(s)								
Upper limb(s)	24.6	20.3	47	42	5.0	5.3	56	62
Lower limb(s)	19.3	18.0	55	53	4.4	1.9	49	84
Sprains and strains of joints and adjacent muscles	88.0	117.3	19	20	16.3	21.1	27	26
Lacerations and open wounds of upper limb	30.7	48.5	15	16	5.0	7.6	13	14
Other lacerations and open wounds and superficial injuries	11.2	10.2	16	16	1.0	1.6	12	32
Contusion and crushing with intact skin surface	26.6	38.6	19	18	4.4	6.9	15	21
Injury of unspecified nature								
Upper limb(s)	83.0	39.6	23	20	14.2	8.7	29	18
Lower limb(s)	74.7	46.4	21	22	9.8	9.3	26	22
Face, neck and trunk	43.9	28.4	23	24	8.6	6.0	27	31

Prescribed industrial diseases

Table 2.12 (table 2.11 in this Report for 1979) gives the yearly figure of new spells of certified incapacity for work due to prescribed diseases for the period 1972-79. The total number of spells continues to fall, including those in respect of dermatitis, the condition which accounts for some 62% of spells of incapacity in respect of prescribed diseases. Occupational deafness is dealt with in the next section.

Table 2.12 Injury benefit (Prescribed Diseases). New Spells* of certified incapacity, Great Britain 1973-1979

	PD No	Period† 1973-1974	1974-1975‡	1975-1976‡	1976-1977‡	1977-1978‡	1978-1979
All prescribed diseases	—	14,813	13,775	13,080	12,797	12,329	10,936
Lead poisoning	1	62	44	51	25	27	24
Squamous-celled carcinoma of skin	23c	14	13	9	6	7	5
Beat hand	31	39	37	28	36	24	15
Beat knee	32	945	906	903	818	751	597
Beat elbow	33	213	188	190	196	171	140
Inflammation of tendons of hand, forearm etc	34	3,498	3,309	3,244	3,341	3,503	3,178
Tuberculosis	38	62	61	68	49	64	32
Inflammation of upper respiratory passages	41	53	36	42	55	90	48
Dermatitis	42	9,754	9,030	8,371	8,119	7,538	6,798
Farmer's lung	43	9	17	8	4	2	5
Other diseases		153	125	166	148	152	94

*Spells arising from fresh developments
†Starting on first Monday in June
‡Revised to include all late notifications available to date

Occupational vitiligo was added to the list of Prescribed Diseases from 15 December 1980 (Statutory Instruments, 1980). The disease, PD No 52, is prescribed in relation to those whose work involves:—

> "The use or handling of, or exposure to, para-tertiary-butylphenol, para-tertiary-butylcatechol, para-amylphenol, hydroquinone or the monobenzyl or monobutyl ether of hydroquinone".

Occupational deafness – prescribed disease No 48

The extension of the occupational deafness scheme was described in this Report for 1979 (page 39). It brought an increase in the number of new claims and increased otologists' workload. The break-down from the inception of the scheme on 3 February 1975 up to 23 December 1980 is as follows:

Claims received	21,308
Disallowed on prescription	8,922
Sent for otologist's examination	12,502
Sent for medical boarding	5,884
Claims allowed	5,058
Disallowed — hearing threshold level less than 50 dB	4,944

The load on ENT consultants was further added to during 1980. This was because the period to be taken into account by medical boards is, by Regulation, not less than five years. Those patients, therefore, who had received five-year assessments in 1975, had reached the stage at which reassessments were necessary. These cases required evaluation and further audiological testing to determine the current hearing levels.

Pneumoconiosis and byssinosis

Medical questions arise from claims to cash benefits for pneumoconiosis (including asbestosis), byssinosis and for certain other occupational disorders that may affect the chest. These are dealt with by full-time and part-time staff on the pneumoconiosis medical panels, experienced in the speciality. Their responsibilities in connection with disablement benefit were described in this Report for 1979 (pages 39 and 40). In claims for death benefit, pneumoconiosis medical panel doctors provide the independent statutory adjudicators, lay authorities, with medical opinions on the relevance to the cause of death of the disease in question.

For pneumoconiosis and byssinosis examinations medical boards carried out 3,211 diagnosis boards in 1980, an increase of 12% on the previous year's figure. Re-assessment boards, however, were slightly fewer with 11,962 examinations.

Initial radiological examinations undertaken for diagnostic purposes in pneumoconiosis claims amounted to 6,921. Panel doctors carried out 4,415 autopsy examinations of thoracic organs in connection with possible claims to death benefit for pneumoconiosis.

There were 461 cases of coal-workers pneumoconiosis newly diagnosed by medical boards, a fall of 14% on 1979. The number of asbestosis cases newly diagnosed came to 144, an increase, as it happened, also of 14%. Byssinosis cases newly diagnosed (148) were 97% more than in 1979: this was the result of the publicity associated with the compensation scheme recently introduced by the Department of Employment. The boards found 123 new cases of pneumoconiosis in other industries. They were located in the following industries: slate 47, pottery 18, steel dressing 3, iron foundry work 17, steel foundry work 4, refractories 6, and other industries 28. A total of 33 cases of pneumoconiosis (all industries) and byssinosis were newly diagnosed by medical appeal tribunals in 1980: 13 of these were from the coal-mining industry, a percentage of 10% of cases heard from the industry.

Industrial Injuries Advisory Council

The Council, an independent body which advises the Secretary of State for Social Services on matters related to the industrial injuries scheme, remains under the chairmanship of Professor C R Lowe. It has sixteen members consisting of an equal number of representatives of employers and employed

earners together with other members, mainly physicians experienced in occupational medicine.

Work continued on two major references, previously made by the Secretary of State to the Council, that had arisen from recommendations in 1978 of the Royal Commission on Civil Liability and Compensation for Personal Injury. One has involved a review of the schedule of prescribed diseases; the other has been concerned with studying the case for enabling individual claimants to obtain benefit if they could prove the occupational causation of a disease or injury not covered by the existing provisions of the scheme. The Council's Industrial Diseases Sub-Committee finished its consideration of whether occupational asthma should be prescribed as an industrial disease, and the Council reported in 1980 in favour of this prescription in relation to workers who have been exposed to any of seven specified sensitizing agents (Department of Health and Social Security, 1981). The Secretary of State accepted the recommendation and it is proposed that regulations should be introduced to implement it by the end of 1981.

Investigations into the possibility of prescribing vibration-induced white finger continued. Evidence was collected, in preparation for the Council's further review of the occupational deafness scheme, on the effects of the extension of the scheme that took place in 1979. The Council also produced its response to the Department's discussion document on Industrial Injuries Compensation (see page 32).

Attendance allowance

This is a non-contributory, non-means tested, non-taxed allowance paid to a disabled person who satisfies the criteria set out in this Report for 1973 (pages 29 and 30). The role and composition of the Attendance Allowance Board was described in this Report for 1979 (page 41). The Chairman remains Dr D L Davies.

The Board meets regularly to decide matters of policy. Usually three members sit weekly to adjudicate upon individual cases referred to them and to monitor standards. As a result of the large number of claims the Board appoints delegated medical practitioners (DMPs) to adjudicate on its behalf. Delegates may be full-time medical officers of the Department or experienced doctors employed part-time on a sessional basis. They are appointed for three years and this is renewable, subject to the Board's approval, every three years to the age of 72.

Initial claims, and reassessment claims where a limited period of attendance allowance has previously been awarded, are decided upon by DMPs based on the ten Regional Offices in England and the Central Offices in Scotland and Wales. Delegates working at North Fylde Central Office deal with reviews which may be requested, in effect, either on the grounds of deterioration or of dissatisfaction with the original decision. Any DMP has, at any time, recourse to the Attendance Allowance Board in the event of difficulty.

Table 2.3 shows that in 1980 the number of claims received increased by 9% over the number for 1979. Of the 147,367 claims, 39,613 were rejected for having failed to satisfy the statutory medical requirements of the Act. The number of claims subject to reassessment following an award of limited duration was 35,257.

The number of review claims received was 21,587. This total was made up of approximately equal proportions of claims for review on grounds of deterioration of the claimant's condition and claims for review where the claimant was dissatisfied with the decision by the Board or a delegated doctor. On review 8,534 claims previously rejected were successful. A further 7,402 awards at the lower rate were increased on review to the higher rate.

The biggest medical group for which awards have been made continues to be the ones concerned with disease of the circulatory system. At the end of 1979 24% of awards were in that respect, followed by diseases of the nervous system and sense organs, (17%). The awards current at that date were as follows:

	Higher rate	Lower rate
Diseases of the circulatory system	31,548	37,680
Diseases of the nervous system and sense organs	24,709	24,254
Mental disorders	17,759	27,574
Diseases of the musculo-skeletal system	14,009	19,923
Congenital anomalies	7,060	14,725
Symptomatic and ill-defined conditions	15,222	20,212
Others	12,941	18,209
	123,248	162,577

Mobility allowance

The allowance is intended as a contribution towards the additional expenses which severely disabled people incur in getting about. It is not affected by, nor does it affect, other Social Security benefits. The allowance is available to severely disabled people between the ages of 5 and 65 and, where an award has been made, payment may continue up to age 75.

The system of adjudication and the part played by medical authorities were described in this Report for 1977 (pages 27 and 28) and the medical conditions to be satisfied in that for 1979. All the medical questions are decided by independent adjudicating authorities following medical examination. What "virtually unable to walk" means is a question of law to be determined by those authorities, but the legislation sets out the kind of factors affecting outdoor mobility which are to be taken into account in assessing a claimant's walking ability. These include the distance a claimant can walk, and the speed, length of time and manner in which he can make progress without severe discomfort. Eligibility for the allowance is not related to specific diagnostic conditions and there is no specific condition which of itself automatically qualifies a claimant for the allowance; the test is always one of walking ability.

From its inception in January 1976 the mobility allowance scheme was introduced gradually on an age-group basis, and the phasing programme was completed in the last quarter of 1979 when the last age group (ie the 61 to 64 year olds) was brought in. The response to the introduction of this group was so large that average clearance times lengthened quite considerably in the early part of 1980. By the end of the year however they had been brought down to a much more acceptable level.

Up to the end of 1980 a total of 258,255 claims had been received from people in age groups eligible to claim (this figure excludes renewal claims from people whose initial awards was for a short period only) and 181,510 (70%) had proved successful. Awards current at the end of 1980 totalled about 158,000 (16,000 for

children aged 5-14 and 142,000 for adults). In addition 26,401 awards had been made for Special Mobility Allowance, ie in respect of people who qualified under special provisions applicable only to beneficiaries under the former Vehicle Service.

Because of the increased claims activity during the latter months of 1979 and throughout the next year, the number of appeals against disallowance increased markedly during 1980; and 9,069 appeals to medical boards were received. Medical boards dealt with 7,895 during the year and decided 2,706 (34%) in favour of claimants. There is a further right of appeal to the medical appeal tribunal from a medical board decision, and during the year 2,605 appeals were received. Medical appeal tribunals dealt with 1,906 appeals and decided 519 (27%) in favour of claimants.

Total awards current at the end of 1980 were in respect of the following broad medical groups:

Diseases of the circulatory system	16,008
Diseases of the nervous system and sense organs	71,436
Neoplasms	2,520
Endocrine, nutritional and metabolic diseases	989
Diseases of blood and blood forming organs	378
Diseases of the respiratory system	9,757
Diseases of the musculo-skeletal system	40,498
Congenital anomalies	10,673
Amputations	3,851
Diseases of the digestive system, of the genito-urinary system and skin and cellular tissue	2,157
Total	158,267

Vaccine damage payments scheme

There has been no further legislation since this Report for 1979 was published.

Only 130 further claims were received during 1980. The total received since applications were first invited in September 1978 had amounted to 2,683 by the end of the year, and 604 awards had been made. Of that figure 266 awards were made by the independent vaccine damage tribunals, each composed of a legally qualified chairman and two consultants who consider requests for review of a medical disallowance; their decisions are binding on the Secretary of State. Altogether 1,344 requests for review had been received by the end of 1980 but 66 claimants subsequently withdrew the request before the Tribunal hearing.

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3

ENVIRONMENTAL HEALTH

The DHSS assisted where necessary by five expert advisory committees provides scientific and medical guidance and advice to the relevant Government Departments on the effects on health of food additives and contaminants, environmental chemicals and consumer products.

Advice given to the Department by the expert Committee on Toxicity on food additives and contaminants is described in this chapter. The Committee is also preparing guidelines for Toxicity Testing. The expert Committee on Carcinogenicity reviewed during 1980 8 chemicals of interest in industry, in the household and in cosmetics. The guidelines on the testing of chemicals for carcinogenicity were developed and it is hoped to include recent methods of assessing the results of tests, after consultation with industry, academic and independent bodies.

The expert Committee on Mutagenicity completed their guidelines for the testing of chemicals for mutagenicity in 1980 and these were published in June 1981 (Department of Health and Social Security, 1981). In brief, the Committee recommend a four-test system for chemicals to which human exposure is widespread and difficult to avoid. These tests comprise, i) a bacterial test for gene mutation, ii) a test in mammalian cells for chromosome damage, iii) a test in mammalian cells or in the fruit fly (Drosophila) for gene mutation and iv) a test in an intact animal, ie a test for the detection of chromosome damage or dominant lethal mutation in rodents. It is envisaged that future activities of the Committee will include specific consideration of the mutagenic potential of substances to which human populations are currently exposed or to which they may be exposed in the future.

During 1980 the Committee on the Medical Aspects of the Contamination of Air and Soil gave advice on cadmium (discussed in a later section) and on the monitoring of air pollution. Among other subjects it began a consideration of the oxides of nitrogen (prior to discussions within Europe) and of claims of benefit from air ionization.

The Joint Committee on the Medical Aspects of Water Quality continues to scrutinize findings of research on chemicals in drinking water, as these become available. In 1980 particular attention was given to lead, nitrate, sodium and asbestos. Detailed advice was given on the reduction of intake of lead from water, following the report of the Lawther Working Party (see page 43). Advice was given on the safe use of pyrethroid insecticides in the disinfestation of water mains and on the choice of chemicals for use in river flow studies and the calibration of water meters. The World Health Organization is to issue Guidelines on Drinking Water Quality to replace the existing European and International Standards and during the year the Joint Committee started to review sections of the Guidelines as they were sent to member states for comment. The Committee's advice on sodium, and the softening of water in the home, is given on page 46.

Industrial chemicals

Regulatory systems for the notification of the toxic properties of new industrial chemicals continue to progress nationally and internationally. Work has

continued in the EEC on the nine annexes to the 6th Amendment to the Directive on the Classification, Packaging and Labelling of Dangerous Substances which was adopted by Council in September 1979 and which prescribes the toxicity testing required for new chemicals (Council of the European Communities, 1979b). Much of the work on the Annexes dealing with dangerous substances (paints, solvents, etc), labelling symbols and test methods to be used for providing data on the physical, chemical and biological properties of substances has now been completed. On the other hand, there was increasing activity on the Annexes dealing with the classification of dangerous substances, on the standard phrases to be used on labels to indicate risks or to give safety advice and the basic and additional data sets required for substances. The Directive is due to be implemented in September 1981.

In the United Kingdom, the implementation of the Directive and its amendments falls jointly to the Health and Safety Executive (worker safety), the Department of the Environment (environmental safety) and the Department of Trade who are particularly concerned with labelling requirements. In this respect, the draft regulations and approved codes of practice for the Notification of New Substances is being published as a Consultative Document in 1981. (Health and Safety Commission, 1981).

The provisions of the parallel EEC Directive on the Marketing and Use of Certain Dangerous Substances and Preparations, adopted in 1976 (Council of the European Communities, 1976b) are being extended to further individual substances. During 1980 restrictions were proposed on the marketing and use of asbestos and of benzene in toys. (Council of the European Communities, 1980a and 1980c). Additional formal contact with the Health and Safety Executive was maintained through representation on its Advisory Committee on Toxic Substances and its Advisory Committee on Major Hazards and advice on toxicology was given during the year to BSI committees on Fire Fighting Media (especially regarding carbon dioxide and halons) and on Toxic Hazards in Building Fires.

Pesticides

The Department has maintained an active interest in health aspects of the use of pesticides and there was close collaboration with the other health and the agricultural departments of the UK and with the Health and Safety Executive, on the Government's Advisory Committee on Pesticides. There was similar collaboration with the Ministry of Agriculture, Fisheries and Food (MAFF) in several other relevant governmental committees, committees of the European Economic Community, Commission of the European Community, World Health Organization and the United Nations Food and Agriculture Organization, as well as through day-to-day consultations at formal and informal levels. Also in collaboration with MAFF, work continues on the production of updated guidance for medical practitioners on pesticide poisoning. A booklet is expected to be published late in 1981. The Department made substantial inputs to the Select Committee of Experts on Pesticides of the Public Health Committee of the Council of Europe in relation to the 5th edition of the booklet *Pesticides.* (Council of Europe, 1981).

Cadmium

The possible health effects of contamination of the environment by the toxic metal, cadmium, were highlighted in 1979. In the course of a geological survey of

metal concentrations in stream sediments, an area enriched with cadmium and other metal ions was identified at Shipham, Somerset, on the site of old lead/zinc mining activities. Subsequent checks confirmed a heavy but uneven soil contamination with cadmium, lead and zinc and showed that certain vegetables grown on this soil contained substantial quantities of metals.

In 1979 a comprehensive survey was initiated to assess the degree of contamination of soil, air dust, drinking water and crops and also to assess dietary intake and effects on the health of villagers. The study was co-ordinated by the Department of the Environment with advice from Sedgemoor District Council, Somerset County Council County Analyst's Department, Ministry of Agriculture, Fisheries and Food and the Department of Health and Social Security.

In December 1980, when most of the survey had been completed, a report was issued to villagers (Department of the Environment, 1980). Soil was found to be highly contaminated with cadmium (average concentrations in individual gardens being 2-520 parts per million compared with a UK average of less than 2 parts per million) and also contaminated with lead (88-8920 parts per million compared with a UK average of 200-300 parts per million). However, average concentrations of lead and cadmium in household dust in Shipham are generally only slightly higher than normal, indicating that harmful contamination of food by dust was unlikely.

The main difficulty is food. Many vegetables contain cadmium and lead in excess of what would usually be expected. In particular, amounts of cadmium are considerably elevated in leafy vegetables such as cabbage, kale, spinach, spring green, lettuce and also in rhubarb and celery. Lead was also found to be elevated in some vegetables, notably in leek and kale. Although cadmium levels in peas, beans, courgettes, marrows and tomatoes were not much greater than normal it was concluded that most crops produced in private gardens from the contaminated part of the village contain raised concentrations of cadmium and/or lead.

Two types of dietary study have been carried out. Seventy four families took part in studies in which food intake was estimated from diaries kept during four week periods in May and September 1979. This showed that average intakes of lead slightly exceeded the national average estimate and that intakes of cadmium were about double that of the national average estimate. Duplicate diet studies based on the analysis of duplicates of a single week's diet, provided by 65 individuals during September 1979, confirmed the elevation in the dietary intake of cadmium, but did not confirm any increase in the intake of lead. This is confirmation that the diary studies tend to produce overestimates of intakes. It was estimated that a small number of individuals exceeded the cadmium intake currently considered tolerable by the joint international committee of the United Nations Food and Agriculture Organization and the World Health Organization.

More than half the residents (564) decided to have health checks. Tests carried out included measurement of cadmium and lead in blood and urine and a wide range of tests of kidney function. Although a few results outside the normal range have been found, which is to be expected when any large group of subjects are investigated, it can be concluded that there is no evidence of any current general health problem related to heavy metals in Shipham. However, in assessing results from this type of study it is important to note that the effects of cadmium, if any, are likely to take some time to become evident, probably 20 to

30 years and that the health checks included only 33 of the 76 villagers who had been resident in the village for more than 30 years. In order to investigate the possibility of possible long-term effects of cadmium intake, residents in the nearby but uncontaminated village of North Petherton are undertaking the same health checks as those of Shipham and these results will become available in 1981.

On the basis of these results it appears that a small number of individuals eating large quantities of garden produce have ingested cadmium in excess of the provisional tolerable value. Although it cannot be said with any certainty that this would produce adverse effects on health, on the grounds of prudence residents are advised not to grow or eat locally-grown crops of those types which are generally consumed in substantial quantities and which contain unusually large amounts of cadmium, eg cabbage, spinach, lettuce, kale, rhubarb and celery. Liming of the soil may reduce the cadmium uptake by crops and consideration should be given to the grassing over of redundant plots. Attention is also drawn to the fact that smoking cigarettes can increase cadmium intake. Epidemiological studies are still in progress to compare the mortality and morbidity of Shipham residents with residents of neighbouring areas who have not been exposed to environmental cadmium. The results from these studies will become available in 1981.

Lead

Policy

The report of the Working Party set up under the chairmanship of Professor P J Lawther to assess the overall effect of environmental lead on health was published by HMSO in March under the title *Lead and Health* (Department of Health and Social Security, 1980). The principal conclusions and recommendations were described in last year's report (pages 45 and 46). The recommendations, together with their practical and economic implications have been discussed by the Government Departments concerned. A statement of government policy on environmental lead was made on May 11 1981 (Hansard, 1981).

Regulations

The Lead in Food Regulations, made under the Food and Drugs Act 1955, were revised in 1979 and became operative on 12 April 1980 (Statutory Instruments, 1979). Their effect is to lower the general limit for lead in food from 2.0 mg per kg to 1.0 mg per kg and they make a number of changes to the list of specified foods and the limits for lead which apply to them.

Monitoring of blood lead and environmental lead

During the year preparations were made for the 2nd phase of the programme of blood lead surveys required by the European Community Directive on Biological Screening of the Population for Lead (Council of the European Communities, 1977). These surveys are being carried out in the early months of 1981. The object of the second phase of the programme is largely to confirm the accuracy of the results of the first but it is also to follow up areas where a pattern of blood lead concentrations outside the reference levels laid down in the Directive was found in the first part and where action to reduce exposure to lead has therefore been taken, so as to check on the effectiveness of that action. Wherever it is practicable, and within the terms of the Directive, the surveys have been planned in order to take account of recommendations in the Lawther Report.

Monitoring of the environment for lead has continued. The Warren Spring Laboratory has published the results of a programme carried out in conjunction with the first EC blood lead survey and designed to determine the amounts of environmental lead near works and roads (Turner et al, 1980). Lead in air, street dust and house dust was measured. The Ministry of Agriculture, Fisheries and Food continues to monitor the amounts of metals in foods offered for sale.
During the year, discussions were held with several local authorities which have leadworks within their boundaries. In some of these the works were remote from residential areas. In two areas action was indicated: at Sandwell two sources of lead were identified and blood lead surveys agreed, and the London Borough of Merton embarked on a programme of environmental monitoring to evaluate the need for a blood level survey.

Alkyl lead
In late 1979 a considerable mortality was noticed among wildfowl and other birds on the Mersey estuary. The cause has not been identified with certainty, but a feature of the disease was an accumulation in the birds' flesh of lead, much of it in organic form. The circumstances did not indicate a hazard to the health of the general population; the local authorities ensured, however, that wildfowlers were advised not to eat fowl from the areas since a high rate of consumption of the polluted birds over a period might result in an undesirable uptake of lead. The problem seems to have been much less in 1980, but the water authority is still investigating the 1979 incident and is continuing to monitor lead levels.

Food additives and contaminants
Advice to the Department and to the Ministry of Agriculture, Fisheries and Food (MAFF) on the possible health effects of food additives and contaminants is given by the Committee on Toxicity of Chemicals in Food, Consumer Products and the Environment (COT).
Over the last year the Committee has completed its review of enzyme preparations and a report has been submitted to the Food Additives and Contaminants Committee (FACC) of MAFF. The COT also completed its consideration of the novel protein material (derived from a fungus grown in culture) mentioned in last year's report (page 51) and a supplementary report has been sent to the Interdepartmental Committee on Novel Foods. Work has continued on the review of alternative sweeteners in food. The epidemiological data on saccharin have now been received and the Committee's Report will include an evaluation of saccharin, cyclamic acid and their salts.
The Committee has also considered the safety-in-use of monotertiary butylhydroquinone (TBHQ) an antioxidant, '*Pimaricin*', an antifungal agent used to prevent mould spoilage on certain cheeses and continental sausages; and monoethanolamine, for use as a fruit and vegetable paring agent. The use of chlorine as a treatment agent for cake flours was re-evaluated following the receipt of data requested previously. Following the endorsement of propylene glycol at the end of 1979 the Committee reconsidered and endorsed the use of propylene glycol aginate. The Committee considered the Working Party on Heavy Metals Report on copper and zinc and made recommendations for future monitoring of the national diet and for the determination of copper and zinc intakes of people consuming atypical diets.
The Committee's earlier evaluations of modified starches and bulking aids, referred to in the 1979 report (page 50), were published in 1980 (Ministry of Agriculture, Fisheries and Food, 1980a and 1980b). More recently, the

Committee's report on additives in infant milk foods, also referred to in the 1979 report (page 50), has been published in the Food Standards Committee's report on infant formulae (Ministry of Agriculture, Fisheries and Food, 1981).
The Department has continued active participation in the Council of Europe Committee of Experts on Flavouring Substances which has begun work on a fourth edition of its publication on flavourings used in food. Work for this edition includes re-consideration of all the artificial flavours previously listed as acceptable or temporarily acceptable as well as the new topics of food, smoking and smoke-flavours as well as reaction or process flavours.

Food contact materials

The Materials and Articles in Contact with Food Regulation (Statutory Instruments, 1978) were amended with effect from 1 January 1981 by the making of the Materials and Articles in Contact with Food (Amendment) Regulations (Statutory Instruments, 1980). The new regulations (i) stipulate that 1mg/kg is the maximum level of residual vinyl chloride monomer which may be present in food contact plastics fabricated from vinyl chloride polymers or copolymers, (ii) prescribe a method of analysis for determining the level of vinyl chloride monomer in food contact vinyl chloride polymers or copolymers and (iii) specify a symbol which may be used to accompany materials and articles intended to come into contact with food.
In the EEC, discussions are progressing on the proposed Directive relating to materials and articles made of regenerated cellulose film intended to come into contact with foodstuffs. The present draft lists the substances (and maximum concentrations) which would be permitted in the manufacture of food contact regenerated cellulose film; any colouring matter could, however, be used provided there was no detectable residue migration into or onto food.
The Council of Europe Committee of Experts on Materials coming into contact with food is working on a second edition of the booklet *Substances used in plastics material coming into contact with food.* (Council of Europe, 1978). When this is completed it is possible that this committee will disband rather than duplicate the work of EEC Committees.

Cosmetics

In the EEC, a Second Amendment to the Cosmetics Directive has been under discussion. (Council of the European Communities, 1976a and 1979a). The proposed amendments would include (i) a list of antimicrobial preservatives which may be used in cosmetics, (ii) revisions to Annex II (concerning prohibited substances) and Annexes II and IV (concerning the substances and colours allowed) of the Directive, and (iii) a procedure for future revisions to the Annexes. The amendment is expected to be adopted shortly and the UK regulation will then be amended to comply with the provisions.
The Council of Europe Committee of Experts on Cosmetics has been revising the booklet *Cosmetic Products and their Ingredients.* (Council of Europe, 1978). The new edition to be published soon will include a list of acceptable sunscreen agents, amendments to the toxicological guidelines and additions to the list of acceptable preservatives.
Following reports of the potential carcinogenicity of 5-methoxypsoralen, which is used in small amounts in certain sun tan products, the Department's expert committees have been reviewing the available data; but they are awaiting the results of ongoing studies before forming a final opinion.

Sodium in drinking water and water softening in the home

Drinking water normally provides only a very small proportion of the total dietary intake of sodium, which is about 4 to 8 g a day in adults. About 90% of large town supplies in the United Kingdom contain on average less than 50 milligrams per litre (mg/l) of sodium. The concentration in river-derived supplies increases during droughts however and wells in a few areas have high values (up to 1000 mg/l has been recorded) as a result of sea water intrusion or sodium salts in the rock. Water begins to have a noticeable taste when the sodium concentration rises to about 200 mg/l and this limits the use of salty ground waters.

Domestic water softeners act by exchanging sodium for calcium and magnesium in the water and can provide over 300 mg/l although usually much less. Lesser amounts can be added by some of the processes used for partial softening of the public supply.

There are three reasons for some concern with the sodium content of drinking water. Firstly, some medical scientists believe, on the basis of animal studies and international comparisons, that a high dietary intake of salt has a role in the development of high blood pressure. Secondly, drinking water can be a relatively important source of sodium in infants and the ability of the kidney to excrete sodium is not fully developed in the first weeks of life; an excessive sodium intake in artificially fed infants, combined with water loss due for instance to diarrhoea can lead to brain damage or even death. This risk is greatly reduced with the use in this country of low sodium milk powders but in addition some restriction on the sodium content of the water used for reconstituting the milk is desirable. Thirdly, the treatment by diuretics or salt restriction of patients with heart failure or high blood pressure would be limited by water with a high sodium content. However, in 1979 following receipt of expert advice it was concluded that water with up to 150 or 200 mg/l of sodium is acceptable for these patients in this country.

The recent EEC Directive on the Quality of Water for Human Consumption (Council of the European Communities, 1980b) provides that in general sodium concentrations will be restricted to 175 mg/l from 1984, reducing to 150 mg/l from 1987. The case for a further reduction to 120 mg/l at a later date is to be studied by the Commission.

The DHSS/DoE Joint Committee on the Medical Aspects of Water Quality has welcomed these steps, because of the needs of infants and some patients. The figures specified in the Directive do not fully apply to sodium added by softening. The Joint Committee has therefore recommended that where a domestic water softener is installed there should continue to be a tap coming directly off the mains to provide water for drinking. There are additional reasons for this recommendation. Naturally soft waters have been statistically associated with high rates of heart disease and it seems better not to consume deliberately softened water unnecessarily, even though the reasons for the association are unknown and are still under study. Softening of water may also increase the tendency of the water to dissolve metal, for example lead, from the plumbing systems. Finally, there is a risk of microbiological contamination in a softener and the purity of drinking water is best assured when it comes direct from the mains. Soft water, of course, has many conveniences for the householder and it is fortunate that it is normally a simple matter to continue to provide the separate mains supply in the kitchen which is so strongly recommended. The organizations concerned are now discussing how best to secure that the retention of such a separate supply becomes the standard practice.

Soil contamination: sewage sludge and redevelopment of land

Sewage slude, the material remaining after sewage treatment, amounts to only 1% of the total volume of sewage arriving at treatment works in the UK but the cost of disposing of the sludge accounts for nearly 50% of the total cost of treatment. In order to keep transport costs to a minimum, sludge is normally disposed of as near to the point of production as possible and almost one third of UK sludge is disposed of at sea. Something less than one quarter of the total is disposed of in land-fill sites or used in land reclamation. The remainder is put to use as a fertilizer. There are sound environmental as well as economic arguments for making the maximum use of it in this way.

The best practice in the use and disposal of sewage sludge, and the control and monitoring of any potential hazards to man or to the environment, are considered by the DoE Standing Committee on the Disposal of Sewage Sludge, on which DHSS is represented. The continued programme of monitoring at sea, for example, has allowed this committee to conclude that the controlled disposal of sewage sludges in UK coastal waters is acceptable. Concern has been greatest with the heavy metals, which may be discharged into the sewage system from both domestic and industrial sources. Over the past three years trade effluent controls have achieved a significant reduction in metal content of sludges disposed of both to sea and land.

The metals which limit from a health point of view the amount of sludge which can be used on the land are commonly cadmium or lead. It is important to know how much of these enter different crops under different conditions of use of sewage sludge, so that the exposure of those eating these crops can be assessed and strictly limited. Research programmes in this country emphasize the study of uptake in natural field conditions. Results are now emerging from a variety of laboratory studies and crop trials which have been in progress over several years and which will help to define the best way of using sludge. Some of the British field work was reported at a recent conference of the EEC Concerted Action Group on the Treatment and Use of Sewage Sludge, on the completion of its first three-year term of office. This Group exists to help co-ordinate research on this topic throughout the Community, and guidelines and practices of member states were compared and discussed at the conference.

The redevelopment of contaminated land sometimes also involves the uptake of higher than usual amounts of heavy metals by crops with potential risks to health as well as effects on crop yields. In addition, however, if remedial action is not taken, there is the possibility of direct exposure, for instance of children playing in gardens developed on such land, not only to metals but to a range of contaminants, depending on the previous use of the land. Contaminated soil may sometimes have to be replaced or covered. DHSS is represented on the Interdepartmental Committee for the Redevelopment of Contaminated Land, which is based at DoE. The Committee co-ordinates guidance on methods for dealing with contaminated land intended for redevelopment and advises on research related to this work. The Committee has recently drawn up tentative guidelines concerning the investigation and development of a variety of types of contaminated land.

Non-ionizing radiations

Microwave ovens

The use of microwave ovens both in the home and in catering premises is on the increase. Allegations in the United States of injury from microwaves, with

efforts to win compensation, have led to questions in the press on the safety of microwave ovens.

Microwaves are short electromagnetic waves situated between the infra-red and radio wave bands which can penetrate tissues and heat them. Such non-ionizing radiation contains far less energy then ionizing radiation, but the exposure of man to large amounts of non-ionizing radiation can cause increases in body temperature, heat stress, cataract formation and other ill effects. There is however no well documented evidence of ill effects from the low levels of non-ionizing radiation to which users of microwave ovens could be exposed.

The National Radiation Protection Board has been carrying out investigations for some years and has recently reviewed the evidence. The Board concludes that users of microwave ovens are not at risk providing the appliances are not damaged and that leakage of radiation is thus avoided.

Sunbeds

The increasing, often unsupervized, use of sunbeds in commercial suntan parlours has focused attention on the potential hazards to health of such equipment. As with natural sunlight, excessive exposure can burn the skin and cause photokeratitis. There is a recognized increase in the risk of skin cancer with substantial long continued exposure to sunlight. It is therefore clear that sun tanning appliances should be used with care. The commercial operation of these appliances is covered by the Health and Safety at Work Act (1974), Section 6 of which requires manufacturers, suppliers and importers to ensure that, as far as is reasonably practical, articles for use at work (which includes sunbeds) are so constructed as to be without risks to health when properly used and to take such steps as are necessary to secure that information is available to the user so that he can avoid such risks.

Since hazards could arise with the use of sunbeds, the Health and Safety Executive is consulting interested parties and will be issuing guidance on the safe use of these appliances.

Citizen's band radio

The Government has announced that Citizen's Band Radio will be introduced during 1981, operating on the 27MHz bands and 934 MHz bands. This will allow members of the public to undertake two-way radio transmission of speech using portable sets. When a facility in the region of the 900MHz band was proposed in a discussion document published recently (Home Office, 1980), claims that exposure to strong radio frequencies in this region could cause cataracts and brain damage were reported in the press.

Advice has been given to the DHSS by the National Radiation Protection Board that there is no scientific evidence that exposure to microwaves or radio frequencies can cause brain tumours or other cancers. Very high power levels of microwaves have been shown experimentally to cause cataracts in animals but the exposure must be such as to raise the temperature of the eye by several degrees Celsius above normal. There is unlikely to be any direct danger to health from hand held transmitters used for "Citizen's band radio" communication in any part of the radio frequency spectrum, when the effective radiated power is less than 3 watts and the transmitters and their aerials are kept more than 1 or 2 cm from the side of the head. When a transmitter has an effective radiated power of 25 watts the aerials should be more than 10 cm from the head.

Good laboratory practice

The 6th Amendment to the European Communities' (EC) Directive on the Classification, Packaging and Labelling of Dangerous Substances (Council of the European Communities, 1979b) requires that all testing is carried out in accordance with current good laboratory practice. Discussions on the development of such a code of practice have been conducted within the EC and also under the aegis of the Organization for Economic Co-operation and Development (OECD). In 1980 OECD completed a document on the principles of good laboratory practice, identifying the key issues and the divisions of responsibility among those involved in laboratory studies for regulatory purposes. During the year, OECD activity in this area was involved in the drafting of a document on the methods of implementation of good laboratory practice which includes the examination of different approaches such as accreditation, study audits and laboratory inspection. At the same time the EEC has been discussing the OECD proposals with a view to adopting them for the purposes of the 6th Amendment of the above Directive. In both situations the objective is to achieve mutual acceptance of data derived from toxicity tests for assessment by member states, on the basis of agreed test methods and adherence to the principles of good laboratory practice.

In the United Kingdom the Department has been involved in discussions on the provision of an inspectorate to monitor compliance of toxicological laboratories with the principles of good laboratory practice. The immediate stimulus for a UK inspectorate is the forthcoming implementation of the 6th Amendment of the Directive and the related responsibilities of the Department of Health and Social Security on behalf of the Health and Safety Executive and the Department of the Environment.

Training of toxicologists

In advising Government on toxicological matters, the Department appreciates the need to increase the level of experience in toxicological work in the United Kingdom. The Department, having a central co-ordinating role in this field organized a meeting in 1979 to review the needs and the training of toxicologists and to obtain the views of industry, academic institutions and professional organizations. As a result a Working Party met in 1980 to examine what education and training needs this demand creates, how training is best delivered in the short and long term and what measures can be suggested to attract people into this subject. At their first meeting, the Working Party decided that an attempt should be made to assess the numbers and backgrounds of individuals involved in toxicological work. Consideration was also given to available training facilities and the establishment of a career structure for toxicologists. These matters are being further considered in 1981.

In this context, it must be mentioned that the Department has recently established a toxicological laboratory at St Bartholomew's Hospital (Director: Dr F A Fairweather). Apart from its activities to conduct toxicological studies for Government Departments, the laboratory has an important function in the training of toxicologists.

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4

COMMUNICABLE DISEASES

Cholera

Four imported cases of cholera were notified in England in 1980, the first since 1977. In late April a girl aged 3 returned from India suffering from diarrhoea and *Vibrio cholerae* biotype eltor was isolated from her faeces. She had travelled with her parents and her mother, who had been ill before the journey, was found to be a convalescent excretor. In August an Indonesian woman aged 24 years arrived from Jakarta feeling unwell and was later admitted to hospital. *V. cholerae* biotype eltor was isolated from her faeces. Her husband was a symptomless excretor; their daughter who travelled with them had negative stools. Later in the same month an English woman aged 37 years returned from India with her 7 year old daughter. The mother had had diarrhoea shortly before her return and 2 days after their arrival the daughter became ill; *V. cholerae* biotype eltor was isolated from her stools but only non-cholera vibrios from the mother.

Hepatitis

The number of notifications of infective jaundice in England fell steadily between 1969 and 1979 from 21,560 to 3,157. The total rose to 5,009 in 1980. It is unlikely that the true incidence of hepatitis B has changed over this period so that the annual figures probably reflect changes in the incidence of hepatitis A.

One major outbreak occurred in 1980, affecting a number of people attending a dinner in the City of London. Of 142 guests, 53 fell ill with jaundice between 19 and 37 days later. The diagnosis of hepatitis A was confirmed in 24 of these patients. Food histories taken from those affected were not helpful but a waiter, who, in common with those guests affected, had only consumed raspberry parfait also developed hepatitis. There was no evidence to suggest that any food had been contaminated by a foodhandler excreting the virus and an investigation of the raspberry parfait and its ingredients was undertaken.

The frozen raspberries used had been purchased from a supermarket owned by a large food retailing company. They were part of a substantial tonnage of frozen fruit purchased by that company in 1978 and distributed widely throughout the United Kingdom.

At about the same time two small family outbreaks of hepatitis A were investigated. In one incident the affected individuals had certainly consumed frozen raspberries purchased from the same supermarket company; in the other incident such purchase and consumption was likely but could not be proven.

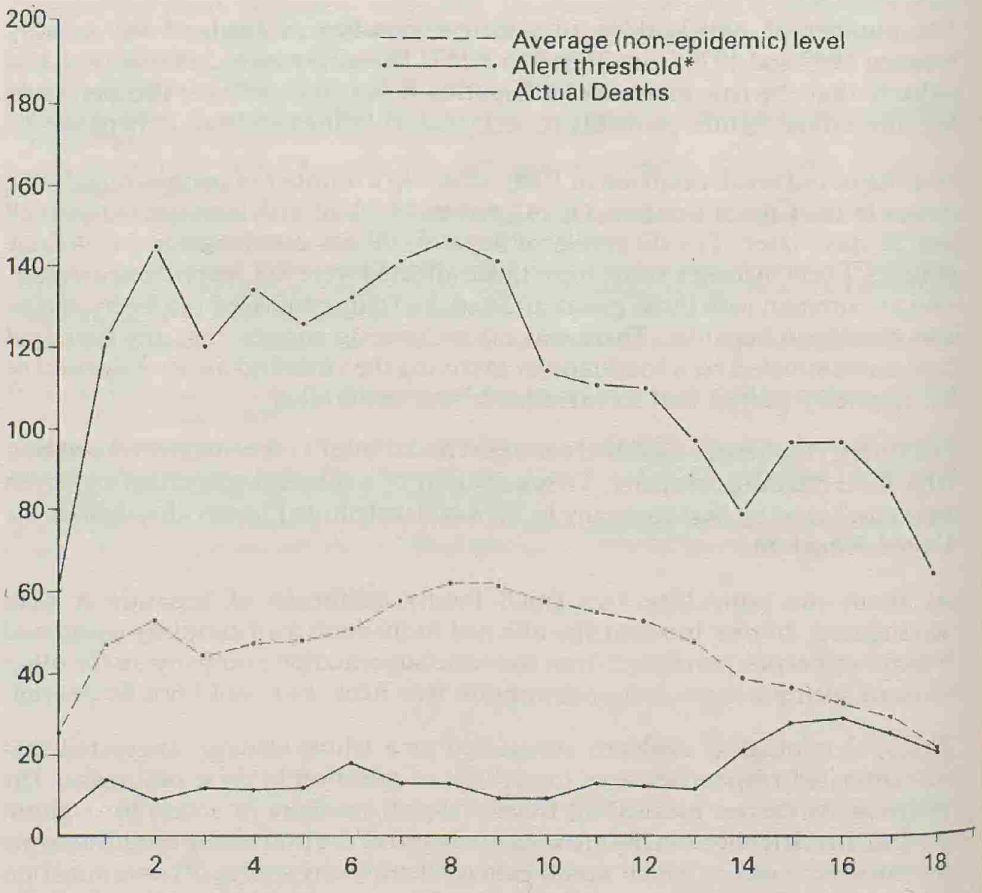
The epidemiological evidence considered as a whole strongly suggested that contaminated raspberries were the vehicle of infection in these outbreaks. The company concerned recalled all frozen raspberries from its stores throughout the UK. Investigations in the growing areas and of the processing establishments provided no evidence which would help to identify any source of contamination of the raspberries. They are picked by hand by casual migrant workers in fields which have no lavatory facilities and it is possible that contamination occurred as a result of the poor hygiene at this stage. Contamination at a later stage, during the handling, packaging and freezing of the raspberries, cannot however

be excluded. Attempts to demonstrate the infectivity of the withdrawn raspberry stocks by feeding a puree to marmosets have not so far been successful.

Influenza

Deaths attributed to influenza and influenzal pneumonia were low throughout the winter, being even lower than the average for years in which there had been no epidemic (see figure 4.1). The number of deaths reported during the first three months of 1980 (156) was lower than for the same period in any of the last 50 years. The relative freedom from influenza was reflected in other indices used to monitor the prevalence of the disease in the community but laboratory reports of influenza A isolations indicated increased activity from late March onwards resulting from sporadic outbreaks in hospital geriatric units and old people's homes in various parts of the country. The number of weekly deaths from influenza reached their highest total of 29 during the week ended 18 April but this was still below the level normally found at this time of the year. As a clinically recognized cause of death influenza again mainly affected those over 75 years of age.

Figure 4.1
Influenza Deaths 1980



*The alert threshold is at 1.65 standard deviations above the mean number of deaths in the corresponding week of previous non-epidemic years.

Most isolations of the virus were of influenza A and, although a few strains of A (H1N1) were isolated, the majority were H3N2 similar to A/Texas/1/77 or intermediate between this and two new variants, A/Bangkok/1/79 and A/Bangkok/2/79. Some strains of influenza B were isolated, the majority being similar to B/Singapore/263/79.

Some evidence of influenza activity appeared in November and early December, with outbreaks in schools and service establishments, caused by influenza A(H1N1) and confined to persons under 25 years of age. Towards the end of December isolations of A(H3N2) strains became more frequent; data from general practice also indicated increased prevalence. Other indices, however, remained at low levels.

Legionnaires' disease

178 confirmed cases and 21 probable cases of Legionnaires' disease occurred in 1980. This compares with 127 cases in 1979 and 77 in 1978. This trend probably reflects the increasing availability of the diagnostic reagents and the greater interest of clinicians rather than a real change in the incidence of the disease. The age and sex distribution of cases (see figure 4.2) shows a preponderance of males, with a male/female ratio of 2.4:1; the mean age for males was 50 years and for females 57 years.

The infection was probably acquired abroad in 78 cases; 25 of these were involved in an outbreak associated with an hotel in Benidorm, Spain. 24 were thought to have contracted the infection in hospital in this country and a clustering of nosocomial cases was observed in four hospitals. 11 cases were identified in an outbreak at the District General Hospital in Kingston-upon-Thames, Surrey; 8 were hospital in-patients, 2 were members of staff and one was a visitor. Epidemiological and environmental studies implicated the plumbing system as the principal source of infection and chlorination of the cold water supply and raising the hot water temperature appeared to be effective in terminating the outbreak.

Many of the patients had pre-existing illness, commonly chronic respiratory disease or neoplasia. There were 25 deaths, including 10 among those who acquired the infection in hospital, but it is not clear how many were directly attributable to legionella infection. The case-fatality rate for those without serious underlying disease was below 10%. As in previous years both indigenous and travel-associated cases showed a distinct seasonal pattern with peak incidence during the summer and autumn.

Leprosy

Twenty eight cases of leprosy were notified during 1980, four more than in 1979. All of these patients had contracted the disease overseas.

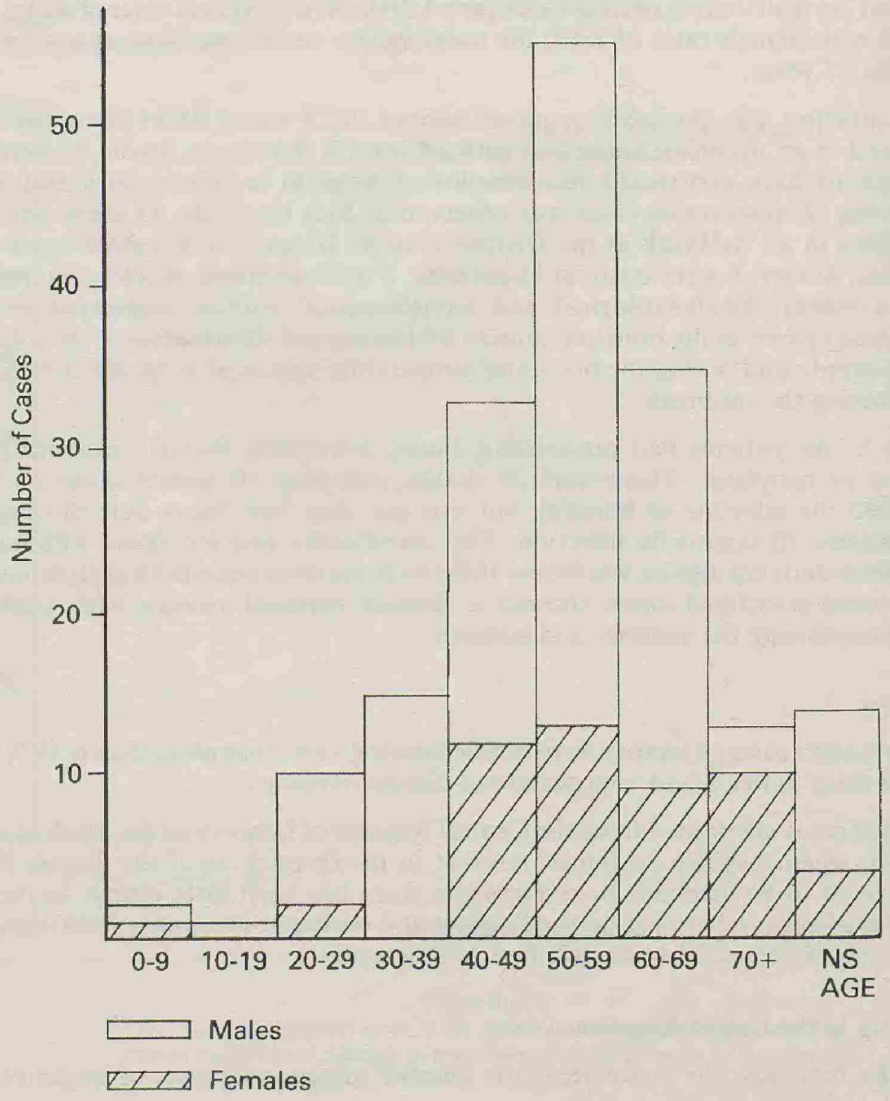
Notified cases are deleted from the Central Register of Leprosy on the death of a patient, when they are no longer resident in the country, or if the disease is considered to be arrested. In recent years there has been little change in the number of cases remaining on the Register and on the 31 December 1980 there were 361; of these 279 were classified as quiescent.

Malaria in the United Kingdom

For the first time for many years the number of reported cases of imported

malaria fell in 1980 when the figure was 1,670 compared with 2,053 the previous year. This reduction probably results from a decrease in travel, associated with the recession, rather than from better malaria control in the world outside, although one hopes that increasing effort by health authorities and by the airlines to bring home to people the need for antimalarials is having some effect. The bulk of cases continue to be due to *Plasmodium vivax* and to have been acquired in the Indian subcontinent. 401 of the infections were due to *Plasmodium falciparum,* the majority acquired in Africa. There were nine deaths and two of these were remarkable in that patients had *Plasmodium vivax* malaria which had been acquired in India. Whether malaria was the main cause of death is not clear. As in other recent years the fatal *falciparum* cases came from Africa with the majority from Kenya. In some cases prophylactics had been taken, though with what regularity is uncertain.

Figure 4.2
Legionnaires' Disease:
Age and Sex Distribution 1980



The situation regarding malaria prophylaxis becomes increasingly difficult, especially as in limited areas of the Kenyan coast and in parts of Tanzania there have now been cases of chloroquine resistance, while chloroquine-resistant *Plasmodium falciparum* has continued to spread as far west as Assam from Thailand and Vietnam, and within South America. The main prophylactics in areas of chloroquine resistance are now preparations containing pyrimethamine and dapsone ('*Maloprim*') and pyrimethamine alone ('*Daraprim*'). A particularly alarming recent feature is the very high prevalence of pyrimethamine-resistance on the borderland between Thailand and Kampuchea. Similar cases have been detected in Papua, New Guinea.

Attempts have been made to get an agreed view on the best approach to prophylaxis for individuals from the United Kingdom going abroad. That current awareness of the problem is increasing is witnessed by the growing number of enquiries received at the Malaria Reference Centre and other bodies concerned with giving advice.

Ornithosis

Laboratory reports of human cases of psittacosis (ornithosis) have more than doubled by comparison with 1979. Small clusters of cases occurred in several areas. Epidemiological investigation of one cluster occurring in the spring of 1980 in East Anglia revealed a continuing source outbreak in workers in the duck rearing and processing industry. In a group of 202 workers 19 had presumptive ornithosis and all but two cases occurred between November 1979 and May 1980. Another outbreak in a party of veterinary surgeons attending a week's training course in poultry inspection occurred in November 1980. Fifteen were ill, mainly with fever, rigors, malaise and non-productive cough, but only one was hospitalized.

Smallpox

On 8 May 1980 the 155 Member States of the World Health Organization, represented by their delegates to the Twenty-Third Health Assembly, unanimously accepted the main conclusions of the Global Commission for the Certification of Smallpox Eradication which were:

1. Smallpox eradication has been achieved throughout the world.
2. There is no evidence that smallpox will return as an endemic disease.

In this country a meeting of experts, including a representative from the World Health Organization, agreed that, however unlikely might be the possibility of a case of true smallpox occurring in the future, there might be occasions when it would be strongly suspected initially. A single unit to provide accommodation for the reception of patients suspected of suffering from smallpox should therefore be maintained for at least two years and would serve England and Wales. Patients would however not be moved from the place where they were found until preliminary confirmation of the diagnosis had been obtained by electron microscopy.

It has been agreed that the Catherine de Barnes Hospital at Solihull in the West Midlands Region should undertake this role.

Tuberculosis

Mortality

Deaths in England assigned to all forms of tuberculosis in 1980 were 834

compared with 853 in 1979. Deaths from respiratory tuberculosis were 435 compared with 451 for the previous year.

Morbidity

In 1980 notifications of all forms of tuberculosis in England totalled 8,752, 103 less than the 1979 figure. Notifications of respiratory tuberculosis were 6,368. Notification rates per 100,000 population were as follows: all forms 18.8; respiratory 13.7.

BCG Vaccination

A report on a trial of BCG vaccination in the South of India called into question the effectiveness of BCG vaccine in that country. The World Health Organization sponsored two meetings to study the issues raised by this trial. While admitting that the lack of protection from BCG in the study population was disturbing, both groups urged the continued use of BCG vaccine, particularly in mass immunization programmes aimed at infants and children. They warned that the results from this trial should not be regarded as applying automatically to other parts of the world. Other, favourable, results were equally valid. In this connection it is important to note the recent publication by the Research Committee of the British Thoracic Association on the effectiveness of BCG vaccination in Great Britain in 1978 (British Thoracic Association, 1980). This Committee concluded that the BCG vaccination of older schoolchildren in Britain continues to offer more than 70% protection against tuberculosis for at least ten years after vaccination. This information was considered by the Joint Committee on Vaccination and Immunization which recommended the continuation of the present policy of offering routine vaccination to schoolchildren.

Outbreaks

An unusual outbreak of tuberculosis occurred in Nottingham. Fifteen cases of tuberculosis — of which thirteen were tuberculosis of the tooth socket and submandibular glands and two were primary pulmonary tuberculosis — were identified following treatment at dental clinics. A dentist was found to have infectious pulmonary tuberculosis and it is probable that the organism entered the raw tooth socket at the time of dental extraction, either by direct inoculation or by infected aerosol. Of the thirteen tooth socket cases, nine were discovered by clinical referral, eight of these being children while the other four, all children, were found by screening. The investigation of this outbreak involved the Heaf testing of over 1400 children.

Typhoid fever

In 1980 the total number of corrected notifications of typhoid fever in England was 208; 179 were of persons presumed to have contracted their infection abroad. The corresponding figures for 1979 were 219 and 189. Over two-thirds of the cases contracted abroad had recently visited or resided in the Indian sub-continent. More than half of the patients who were infected in the United Kingdom were from immigrant households and a source of infection was traced in many of these.

Vaccination and immunization

Vaccination Acceptance Rates in England for children born in 1977 and vaccinated by the end of 1979 were as follows:—

Diphtheria	80%
Whooping Cough	35%
Tetanus	80%
Poliomyelitis	80%
Measles	51%

Acceptance rates for previous years are shown in Table 4.1. It can be seen that the rates for 1979 all show a slight improvement compared with those of the previous year.

Table 4.1 Number of children under 16 completing primary course of vaccination (England) 1968-1978

Year	Diphtheria	Whooping Cough	Tetanus	Poliomyelitis	Measles
1968	672,415(79)	596,644(78)	716,261(79)	691,167(77)	688,124
1969*	490,870(83)	433,364(81)	530,160(83)	523,302(80)	379,402
1970	645,183(80)	587,122(79)	685,644(81)	660,146(79)	601,513(34)
1971	678,820(80)	608,483(78)	713,111(80)	674,390(80)	519,785(47)
1972	657,399(81)	600,863(79)	689,733(81)	662,903(80)	497,074(52)
1973	613,725(81)	556,535(79)	646,993(81)	616,174(80)	459,038(54)
1974	528,767(80)	439,385(77)	557,473(80)	535,484(79)	353,864(53)
1975	476,669(75)	247,339(61)	496,217(75)	480,646(75)	306,367(47)
1976	480,338(75)	236,980(39)	501,949(75)	489,499(75)	316,771(47)
1977	494,333(78)	191,899(41)	516,521(78)	515,575(78)	304,885(50)
1978	511,392(78)	200,260(31)	529,807(79)	520,046(78)	301,917(48)

Figures in parentheses represent acceptance rates, ie children vaccinated by end of stated year as a percentage of total born two years previous.
*Figures for 1969 were affected by the changes in Schedules for Vaccination and Immunization Procedures.

During 1980 the Joint Committee on Vaccination and Immunization met four times. The major topics discussed were the recent whooping cough epidemic and various reports on adverse reactions to whooping cough vaccine which were completed during the year. These have been assembled in a Report on Whooping Cough published by HMSO (Department of Health and Social Security, 1981). Other topics discussed included vaccination against smallpox and influenza, and a re-issue in loose-leaf form of the Memorandum — *Immunization Against Infectious Disease.*

Whooping Cough Epidemic

As a result of the adverse publicity given to whooping cough vaccination in 1974 the acceptance rate for the vaccine fell from a level of 79% in 1973 to 31% in 1978. An epidemic of whooping cough began in the last quarter of 1977 and persisted until mid-1979. It was followed by an inter-epidemic level of notifications several times higher than the level which existed prior to 1974.

Some 102,500 cases of whooping cough were notified in the United Kingdom during the period of the epidemic. Fortunately the fatality rate was lower than that experienced in previous epidemics with 36 children being notified as having died from whooping cough. Nevertheless many of the children affected by whooping cough suffered a prolonged debilitating illness which was distressing for both the children and their families. Some children required admission to hospital for the treatment of complications such as convulsions and pneumonia, and many young infants had to be admitted to intensive care units for intubation

and resuscitation. The long term damage to the respiratory system of previously healthy children has still to be assessed. 1980 remained a quiescent period after the considerable epidemic of 1977-79.

National Childhood Encephalopathy Study

On the recommendation of their Sub-Committee on Vaccination Complications, the Joint Committee on Vaccination and Immunization advised the setting up of the National Childhood Encephalopathy Study which commenced its work in July 1976. This was a nationwide survey of children admitted to hospital between the ages of 2 months and 3 years suffering from severe neurological illness and encephalopathies. Since this was a case control study children admitted to hospital were matched with controls of similar age. Enrolment into the Study ceased in June 1979 and the one year follow-up period in first time cases was completed in June 1980. The findings were considered and accepted by the JCVI and these were published in 1981 (Department of Health and Social Security, 1981).

The JCVI also considered reports submitted to the Committee on Safety of Medicines (CSM) on data relating to pertussis vaccine. The first of these reports was from a Panel under the chairmanship of Professor Dudgeon, Dean of the Institute of Child Health which examined the case histories of 50 children who had been reported to the CSM as being suspected of having suffered serious reactions following immunization with vaccines containing pertussis antigen.

The second was a Panel chaired by Dr T M Meade director of the MRC Epidemiological Research Unit, Northwick Park Hospital which examined data on adverse reactions supplied by the Association of Parents of Vaccine Damaged Children and the CSM; these comprised 229 cases reported between 1970 — 1974 alleged to have suffered adverse reaction following triple vaccine.

The Joint Committee on Vaccination and Immunization, after careful consideration of these reports (Department of Health and Social Security 1981), have reaffirmed their advice that the benefits of vaccination against whooping cough outweigh the risks and that, with due attention to contra-indications, whooping cough vaccine should continue to be recommended as part of the basic course of immunization in childhood.

Vaccination against smallpox

Following the ratification by the World Health Assembly in May 1980 of the report of the Global Commission for the Certification of Smallpox Eradication declaring the world free of smallpox the Joint Committee issued recommendations on those groups which should now be vaccinated against smallpox. These are as follows:

a. Investigators and staff working on or associated with smallpox virus.

b. Staff who have agreed to man any hospital which will be designated to deal with patients strongly suspected of having smallpox.

Vaccination should also be offered to the families of these categories and to those engaged in the manufacture of vaccine or who perform vaccination. This information was promulgated in a Chief Medical Officer letter of 26 August 1980 (Department of Health and Social Security, 1980a).

Vaccination against influenza

It was noted that the strains of influenza virus likely to be prevalent during the

winter of 1979/80 were A/Bangkok/1/79 (H3N2), A/Brazil/11/78 (H1N1) and B/Singapore/222/79. These strains, or closely related strains, were incorporated into vaccines made available for the winter and this information was circulated to the medical profession by the Chief Medical Officer on 10 September 1980 (Department of Health and Social Security 1980b).

BCG Vaccination

During 1978, 638,872 school children and students were tuberculin tested, 568,321 were found to be negative and of these 563,922 were vaccinated with BCG.

Food poisoning

Tables 4.2 and 4.3 are based on returns for 1979 made by English local authorities. They are derived from cases of food poisoning and suspected food poisoning notified by medical practitioners and from other cases ascertained during the investigation of food poisoning incidents. Cases associated with general outbreaks with a source outside England are, for the first time, shown separately. Table 4.4 gives cases ascertained during the investigation of incidents of non-food poisoning salmonellosis. The corresponding figures for 1978 are given in parentheses.

Table 4.2 shows that in 1979 there were 3,114 more cases of food poisoning originating from sources in England than were reported in 1978. This is an increase of 28%. This was largely due to an increase in the number and size of general outbreaks. The number increased by 28%, while the number of cases reported in such outbreaks rose by 62%. These general outbreaks nevertheless still accounted for less than half the total number of cases of food poisoning. The number of household outbreaks fell by 22%, but the number of cases associated with such outbreaks only fell by 11%. Sporadic cases increased by 20%.

Table 4.2 Food poisoning in England, 1979: excluding general outbreak cases with source outside England (1978 figures in parentheses)

Causative agent	General outbreaks		Household outbreaks		Known sporadic cases	Total No. of cases (Cols 2+4+5)
	No. of separate outbreaks	No. of known cases	No. of separate outbreaks	No. of known cases		
	1	2	3	4	5	6
Salmonella	28	575	186	467	984	2,026
typhimurium	(30)	(554)	(234)	(562)	(903)	(2,019)
Other	133	3,159	406	1,047	2,420	6,626
salmonellae	(92)	(1,835)	(552)	(1,258)	(2,338)	(5,431)
Clostridium	37	407	25	105	60	572
welchii	(35)	(442)	(35)	(106)	(49)	(597)
Staphylococcus	11	241	9	29	38	308
aureus	(6)	(148)	(10)	(26)	(20)	(194)
Other	28	398	96	211	1,339	1,948
causes	(30)	(247)	(104)	(191)	(752)	(1,190)
Cause	93	1,417	133	381	1,051	2,849
unknown	(65)	(605)	(161)	(364)	(815)	(1,784)
Totals	330	6,197	855	2,240	5,892	14,329
	(258)	(3,831)	(1,096)	(2,507)	(4,877)	(11,215)

Salmonellae continued to be the commonest causative organisms. *Salmonella hadar* food poisoning had become increasingly common over the last few years (Rowe *et al,* 1980) and is now second only to *Salmonella typhimurium. Salmonella hadar* is widespread in poultry and the consumption of poultry is the largest single cause of food poisoning outbreaks. Multiple-antibiotic resistant strains of *Salmonella typhimurium* are being increasingly reported (Threlfall *et al,* 1980). Fortunately antibiotics are rarely necessary in the treatment of salmonellosis.

Table 4.3 Food poisoning in England, 1979: general outbreak cases with source outside England (1978 figures in parentheses)

	Source			
	Outside UK		Wales/Scotland/NI	
	No. of separate outbreaks	No. of known cases	No. of separate outbreaks	No. of known cases
Totals	107 (71)	243 (111)	7 (Nil)	25 (Nil)

Table 4.4 Salmonellosis not associated with food poisoning in England, 1979 (1978 figures in parentheses)

	General outbreaks		Household outbreaks			
Causative agent	No. of separate outbreaks	No. of known cases	No. of separate outbreaks	No. of known cases	Known sporadic cases	Total No. of cases (cols 2+4+5)
	1	2	3	4	5	6
Salmonella *typhimurium*	6 (8)	22 (39)	66 (35)	151 (69)	178 (219)	351 (327)
Other salmonellae	18 (13)	98 (29)	131 (137)	262 (318)	404 (523)	764 (870)
Totals	24 (21)	120 (68)	197 (172)	413 (387)	582 (742)	1,115 (1,197)

In cases of non-food poisoning salmonellosis (Table 4.4), *Salmonella typhimurium* is still the most common cause, reflecting its ubiquity.

The total number of corrected notifications of food poisoning in England received by the Office of Population Censuses and Surveys in 1980 was 9,633 compared with 10,437 in 1979. Complete figures for cases ascertained by local authorities in 1980 are not yet available, but the total number is likely to be less than that for 1979.

Scombrotoxic food poisoning

In this report for 1979 (page 63) reference was made to a number of cases of scombrotoxic food poisoning, mainly associated with consumption of smoked

mackerel. In 1980, following discussions with the Department, the White Fish Authority and the Fishmongers' Company issued advice to trade interests on the hazards associated with mackerel and on the correct handling procedures required to ensure its safety for human consumption. During the year a number of cases have been reported associated with the consumption of canned fish, particularly tuna, which is of the scombroid family, and sardines, which are not scombroid fish.

Waterborne gastro-enteritis

In July the Medical Officer for Environmental Health, Leeds District Council, reported a large outbreak of what was apparently virus gastro-enteritis in the North West part of his District. Investigations showed that there had been sewage contamination of a well supplying the Bramham area associated with failure of automatic chlorinating equipment. The monitoring system used by the water authority had apparently not been able to achieve early recognition of the hazard. More stringent precautions have now been introduced.

Pre-cooked Chilled Food

The chilling of cooked food and its reheating before consumption is nowadays common practice in catering establishments. If cooling, storing and reheating is not performed correctly a serious hazard to health can ensue. Inadequate temperature control during these procedures has been an important factor in many outbreaks of food poisoning. The practice of chilling and reheating food, however, is desirable for reasons of economy and convenience. A Departmental Working Party was therefore set up to see how it could be done safely. The Working Party obtained the views not only of food hygienists, microbiologists and epidemiologists but also of the manufacturers of refrigerating and cooking equipment and of caterers in this country and abroad who are already using the system. The Working Party has now produced a booklet *Guidelines on Pre-cooked Chilled Foods* (Department of Health and Social Security 1980c) giving advice, which, if followed, should enable pre-cooked chilled food systems to operate safely.

References

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5

SEXUALLY TRANSMITTED DISEASES

The reported incidence of many sexually transmissible diseases remained high throughout the year. The total number of new cases seen at the clinics continued to rise. Details are shown in Tables 5.1, 5.2, 5.3 and 5.4.

An increasing proportion of the patients in large urban clinics are homosexual men. In addition to infections with syphilis, gonorrhoea, genital warts and herpes, enteric pathogens, such as *Entamoeba histolytica* and *Giardia lamblia,* are being found with increasing frequency. Many homosexual men now attend clinics at regular intervals for a check-up to exclude infection.

Non-specific genital infection

Non-specific genital infection remains the commonest condition diagnosed. There was an 8.9 per cent increase in the condition during the year, bringing the total number of cases to 108,080. It is now generally accepted that between 40 and 50 per cent of these cases are related to *Chlamydia trachomatis,* an agent which has been shown to produce pelvic inflammatory disease in women, often resulting in sterility, the risk of ectopic pregnancy and recurrent pelvic pain. The cause of the remaining 50 or 60 per cent of cases of non-specific genital infection remains unknown but research is beginning to reveal some additional causes of the condition.

Reported infections with *Herpesvirus hominis* increased by 5.6 per cent, reaching a total of 9,281 cases. This is undoubtedly a gross underestimate of the true incidence as many cases never reach the clinics. Publicity about the condition has resulted in considerable anxiety among those suffering from the disease, especially as its relationship to cancer, and possible dangers to neonates have been widely discussed in the press and on television. A systemic treatment for this important sexually transmitted infection is urgently needed.

Candidiasis also increased by 5.6% to a total of 41,695 cases, of which 44,067 were in women and 8,628 in men. Trichomoniasis, of which there were 20,205 cases, was also diagnosed much more frequently in women with 18,466 cases as opposed to 1,739 cases in men.

Genital warts form a very time-consuming part of the work in the clinics and treatment is unsatisfactory as relapses are common. 26,144 cases were diagnosed, 9,384 in women and 16,760 in men.

Gonorrhoea

There was a slight overall increase in gonorrhoea of 0.8% with a total of 55,784 cases identified and treated. There has been a marked increase in the number of cases infected with penicillin resistant beta-lactamase producing strains of gonococci from 31 in 1978 to 211 in 1980. Although the numbers are still small in England, the situation requires careful study because in other areas of the world these strains are widespread. For example, in Hong Kong 10 per cent of all strains are beta-lactamase producers and for Singapore the figure is 30 per cent.

Syphilis

There was a decrease of 4.1 per cent in the diagnosis of cases of early infectious syphilis and late syphilis decreased by 4.9 per cent. Cases of congenital syphilis have become very rare and only 122 cases were reported.

Staffing of clinics

The number of hospital medical staff working in genito-urinary medicine in England and Wales at 30 September 1980 totalled 205 (190.6 whole time equivalents (wte) compared with 217 (198.3 wte) in September 1979. The figures for 1980 included 108 (104.1 wte) consultants, 29 (26.2 wte) senior registrars and 43 (41.1 wte) registrars compared with 107 (101.6 wte) consultants, 33 (30.5 wte) senior registrars and 41 (38.7 wte) registrars in September 1979. At 30 September 1980 in addition to the above there were 21 (5.6 wte) hospital practitioners and 155 (35.5 wte) part-time medical officers (clinical assistants).

Contact Tracing

The long awaited *Handbook on Contact Tracing in Sexually Transmitted Diseases,* published by the Health Education Council (Health Education Council, 1980) became available during the year. It represents an expert account of all aspects of contact tracing as practised in the United Kingdom.

The DHSS is now establishing a general training programme for contact tracers throughout the country and details of training schemes are being elaborated. A suitable training programme for all new entrants into this branch of the work should help to establish and maintain the status of contact tracers in the Health Services.

Education

The postgraduate courses for doctors in Liverpool and London continue to flourish and the postbasic courses for nurses of the Royal College of Nursing have attracted a high standard of applicant.

Doctors continue to benefit from the financial support from the DHSS to enable them to visit centres overseas to study special aspects of the subject and to learn new techniques. Several international meetings took place during the year. They were well attended by physicians from all over the world and British doctors contributed significantly to their success.

Reference

Health Education Council, 1980. *Handbook on contact tracing in sexually transmitted diseases,* London, The Health Education Council.

Table 5.1 Cases of syphilis, gonorrhoea and chancroid reported in England for the year ending 30 June 1980, with the revised figures for year ending 30 June 1979 in parentheses (for the incidence rate per 100,000 population see Table 5.3).

	Total		Male		Female	
Syphilis						
Early	2,534	(2,641)	2,156	(2,283)	378	(358)
Primary & Secondary only	1,551	(1,630)	1,343	(1,439)	208	(191)
Late	1,399	(1,471)	959	(1,003)	440	(468)
Congenital	122	(120)	54	(39)	68	(81)
Gonorrhoea						
All forms	55,784	(55,366)	35,146	(34,924)	20,638	(20,442)
Post-pubertal gonorrhoea						
All ages	55,747	(55,323)	35,136	(34,912)	20,611	(20,411)
Under 16 years	395	(412)	78	(97)	317	(315)
16-19 years	10,781	(10,416)	4,524	(4,265)	6,257	(6,151)
20-24 years	18,904	(18,371)	11,334	(11,043)	7,570	(7,328)
25-34 years	18,212	(18,617)	13,180	(13,377)	5,032	(5,240)
35-44 years	5,533	(5,667)	4,417	(4,568)	1,116	(1,099)
45 years & over	1,922	(1,840)	1,603	(1,562)	319	(278)
Chancroid	49	(49)	43	(45)	6	(4)

Table 5.2 Other sexually transmitted diseases reported in year ending 30 June 1980 together with the revised figures for year ending 30 June 1979 in parentheses (for incidence per 10,000 population see Table 5.4.)

	Total		Male		Female	
Lymphogranuloma venereum	23	(31)	15	(24)	8	(7)
Granuloma inguinale	25	(19)	16	(14)	9	(5)
Non-specific genital infection (NSGI)	108,080	(99,235)	83,709	(78,786)	24,371	(20,449)
NSGI with arthritis	500	(415)	475	(398)	25	(17)
Trichomoniasis	20,205	(19,346)	1,739	(1,553)	18,466	(17,793)
Candidiasis	41,695	(39,388)	8,628	(7,994)	33,067	(31,394)
Scabies	2,180	(2,062)	1,739	(1,677)	441	(385)
Pediculosis pubis	7,775	(7,167)	5,443	(4,898)	2,332	(2,269)
Genital herpes	9,281	(8,601)	5,747	(5,346)	3,534	(3,255)
Genital warts	26,144	(24,405)	16,760	(15,668)	9,384	(8,737)
Genital molluscum	1,021	(1,013)	644	(681)	377	(332)
Other treponemal diseases	984	(1,102)	606	(747)	378	(355)
Other conditions requiring treatment in a centre	54,142	(48,107)	32,100	(29,236)	22,042	(18,871)
Other conditions not requiring treatment in a centre	103,596	(100,043)	64,974	(62,157)	38,622	(37,886)
Other conditions referred elsewhere	2,293	(2,131)	1,311	(1,297)	982	(834)

Table 5.3 The venereal diseases — new cases per 100,000 population by age seen at hospital clinics in England 1976-1980

	1976			1977			1978			1979			1980		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Early Syphilis															
All ages	8.86	1.50	5.08	9.67	1.71	5.59	10.27	1.91	5.98	10.77	1.77	6.16	9.54	1.59	5.46
Primary & secondary only	6.40	0.87	3.56	6.58	1.04	3.74	6.69	1.04	3.79	6.38	0.08	3.52	5.94	0.87	3.34
Under 16 years	0.07	0.09	0.08	0.04*	0.04*	0.04	0.20	0.10	0.15	0.05	0.04	0.05	—	0.08	0.04
16-19 years	7.52	3.30	5.46	5.72	4.56	5.15	6.8	4.52	5.69	4.99	2.90	3.97	3.95	3.52	3.74
20-24 years	19.35	3.46	11.58	17.76	5.02	11.56	19.10	4.76	12.10	16.83	3.44	10.29	15.00	3.44	9.34
25 years and over	7.40	0.68	3.85	8.01	0.66	4.13	7.77	0.66	4.02	7.79	0.60	3.99	7.38	0.62	3.82
Late Syphilis															
All ages	3.87	1.76	2.79	3.67	1.70	2.66	4.38	1.89	3.10	4.44	1.97	3.17	4.24	1.85	3.02
Congenital Syphilis															
All ages	0.28	0.33	0.30	0.25	0.37	0.31	0.23	0.45	0.34	0.17	0.34	0.26	0.24	0.28	0.26
Gonorrhoea (post pubertal)															
All ages	163.91	89.60	125.79	164.70	92.23	127.54	161.38	89.94	124.73	154.67	85.84	119.36	155.40	86.64	120.14
Under 16 years	1.87	8.57	5.13	1.98	8.52	5.16	2.56	7.76	5.09	1.75	5.99	3.82	1.43	6.13	3.72
16-19 years	331.52	513.05	420.19	329.41	510.53	417.73	304.17	473.06	386.66	287.65	434.41	359.37	297.63	431.52	363.00
20-24 years	728.41	475.72	604.92	736.92	490.17	616.71	696.65	471.19	586.58	659.05	458.49	561.14	666.70	464.42	567.69
25 years and over	147.97	42.73	92.40	145.38	43.36	91.52	144.92	43.52	91.39	140.63	42.67	88.92	137.83	41.62	87.10
Chancroid															
All ages	*0.03	0.15	0.17	0.17	*0.01	0.09	0.19	0.02	0.10	0.20	0.02	0.11	0.19	0.03	0.11

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

Table 5.4 Other sexually transmitted diseases and other conditions — new cases per 100,000 population at all ages seen at hospital clinics in England 1976-1980

	1976			1977			1978			1979			1980		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Lymphogranuloma venereum	0.14	0.01*	0.07	0.12	0.04*	0.08	0.12	0.00	0.06	0.11	0.03	0.07	0.07	0.03	0.05
Granuloma inguinale	0.05	0.02*	0.03	0.04	0.02	0.03	0.05	0.01	0.03	0.06	0.02	0.04	0.07	0.04	0.05
Non-specific genital infection	310.35	73.60	188.91	329.01	84.84	203.79	341.37	82.07	208.35	349.04	86.00	214.10	370.23	102.44	232.93
Non-specific genital infection with arthritis	2.07	0.01	1.06	2.43	0.18	1.28	2.06	0.15	1.08	1.76	0.07	0.09	2.10	0.10	1.07
Trichomoniasis	6.81	76.23	42.42	7.55	76.93	43.13	7.62	77.04	43.24	6.88	74.83	41.74	7.69	77.62	43.54
Candidosis	27.68	125.84	78.02	30.09	126.26	79.40	37.67	129.62	83.38	35.42	132.03	84.98	38.16	138.99	89.86
Scabies	9.41	2.19	5.17	7.82	1.96	4.81	7.85	1.98	4.84	7.43	1.62	4.45	7.69	1.85	4.70
Pubic lice (pediculosis pubis)	16.07	6.58	11.21	18.12	7.39	12.62	19.44	7.88	13.51	21.70	9.54	15.46	24.07	9.80	16.76
Herpes simplex	19.10	9.83	14.35	20.80	11.10	15.82	22.63	12.28	17.32	23.68	13.69	18.56	25.42	14.85	20.00
Warts (condylomata acuminata)	60.31	30.71	45.13	64.82	32.54	48.26	67.11	34.75	50.51	69.41	36.75	52.65	74.13	39.44	56.34
Molluscum contagiosum	2.53	1.08	1.78	2.67	1.25	1.94	2.78	1.22	1.98	3.02	1.40	2.19	2.85	1.58	2.20
Other treponemal diseases	2.94	1.60	2.25	3.27	1.75	2.49	3.15	1.61	2.36	3.31	1.49	2.38	2.68	1.59	2.12
Other conditions requiring treatment in a centre	112.32	55.75	83.30	114.48	59.09	86.08	125.81	66.67	95.47	129.52	79.37	103.79	141.97	92.65	116.68
Other conditions not requiring treatment in a centre	237.48	136.00	185.43	252.54	146.72	198.27	270.62	152.23	209.89	275.37	159.34	215.85	287.37	162.34	223.27
Other conditions referred elsewhere	2.40	1.33	1.85	5.06	3.13	4.07	5.19	3.32	4.23	5.75	3.51	4.60	5.80	4.13	4.94

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

6

PRIMARY HEALTH CARE

The development of the concept of a team approach to primary care which has evolved over the past decade, together with advances in the disciplines of medicine and nursing in particular, has meant that an increasing number of people can receive medical and nursing care in the community. Multidisciplinary teams are able to provide co-ordinated and comprehensive care in a community setting. In many places this approach has been outstandingly successful but in some, perhaps not surprisingly, there have been problems; while in others this method of providing health care has not been fully developed. A Joint Working Group was set up by the Standing Medical Advisory Committee and Standing Nursing and Midwifery Advisory Committee with terms of reference 'to examine problems associated with the establishment and operation of primary care teams and to recommend solutions'. The group under the chairmanship of Dr Wilfrid Harding completed its work during 1980 and its report was published in May 1981 (Central Health Service Council, 1981). Also continuing work during 1980 was the sub-group of the London Health Planning Consortium, mentioned in last year's report (page 72), set up under the chairmanship of Professor Donald Acheson to look at primary health care in London; this sub-group finished its work early in 1981 and its report which was, in many aspects, complementary to the other was also published in 1981 (London Health Planning Consortium, 1981). Both are expected to provide further stimulus for discussion about and development of primary care services, particularly in deprived areas.

The two subjects featured in this year's report are *The Work of the Regional Medical Service* and *Prescribing.*

The Regional Medical Service

Each of the 4 countries of the United Kingdom has its own Regional Medical Service (RMS) and since each differs from the others in various ways, the following paragraphs refer specifically to the English RMS.

The RMS may be defined as the regionally based staff of the Headquarters Medical Division responsible for general practice policy. The functions of the RMS and its HQ component cover much common ground with a constant dialogue between the two.

The RMS is divided into 6 Divisions, each having its own headquarters known as a Divisional Medical Office. With one exception the divisional areas are conterminous with two or more of the 1974 NHS regions.

Staffing and Reference Work

Each of the 6 Divisions is headed by a Senior Medical Officer who is designated as the Divisional Medical Officer (DMO). His full-time medical staff consists of the Regional Medical Officers (RMOs) and he also has a full-time lay support staff. In addition there are the part-time medical referees (PTRs) who are active or retired general practitioners or retired members of the RMS, and the nurses who carry out duties at the various medical examination centres in the larger towns and cities. The part-time doctors and nurses are employed on a sessional basis, and, together with the vast majority of the lay staff, spend their time

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

exclusively in the conduct of the referee service, ie the provision of an independent medical opinion to the Social Security side of the Department on the capacity for work of claimants to certain benefits. Full-time RMOs spend an average of about two-thirds of their time in this work, as Table 6.1 shows, though by no means all of this is taken up with examination of claimants. A significant proportion of their referee work involves the scrutiny of doctors' reports about claimants, and deciding what action should be taken. On the basis of these reports, an average of 42.5% of Social Security claimants can be deemed incapable of work without the need to examine them. A small proportion of an RMO's time is taken up with paying domiciliary visits to those claimants who are deemed to require examination but who are unfit to attend a medical examination centre.

Table 6.1 Regional medical service referee work as a percentage of RMO working time, England 1980

Medical examination of claimants/disabled persons	44.07%
Scrutiny of doctor's reports	17.70%
Domiciliary visits	2.79%
	64.56%

The number of references received has steadily grown over the years and in 1980 the RMS received just over half a million references. Of these over 40,000 were from the Department of Employment, (Table 6.2), and most of these form part of a person's application to be registered disabled. A fairly comprehensive assessment of the person's functional ability is required in these cases, together with a view on what types of work he might be able to do and what types of work should be avoided, and consideration is also given to a recommendation or otherwise for employment rehabilitation. Although these references only amount to about 8% of the total reference load, in terms of workload they require on average 50% more time for their examination and report than a sickness benefit reference. Furthermore the disabled persons are likely to attend for examination, whereas 14.5% of sickness benefit and other claimants do not attend. Hence references from the Department of Employment constitute a very significant proportion of the referee work of the RMS.

Within the compass of this brief description of RMS work it is not possible to go into detail on the remaining references, but they include, as Table 6.2 shows, reference of claimants on sickness and invalidity benefit, injury benefit,

Table 6.2 Regional medical service, references received, England 1980

Source	Type of reference	*Number*
DHSS	Sickness & invalidity benefit	451,615
	Injury benefit	21,641
	Maternity benefit	216
	Supplementary benefit	2,299
Doctors		6,093
Department of Employment (Employment Service Agency)		42,751
EEC		65
		524,680

supplementary benefit, cases referred under reciprocal EEC arrangements and, more importantly, cases referred by doctors themselves.

On the outcome of the examination of claimants by the medical staff of the RMS, it is perhaps appropriate to look at the sickness and invalidity benefit references, which form by far the largest number of references to the RMS. Table 6.3 shows the opinions formed on claimants examined in 1980, expressed as percentages of total references and as percentages of those examined. In the latter group it is perhaps worth noting that one-third of claimants are thought to be not incapable of some sort of work.

Table 6.3 Sickness & invalidity benefit references, outcome of RMS examinations, England 1980

Opinion	of total references	of those examined
Not incapable of work	7.8%	20.1%
Incapable of work	25.9%	66.0%
Incapable of work at present occupation but capable of suitable alternative work	5.15%	13.25%

The referee work of the RMS is kept within bounds by a quota system under which the Social Security references may not rise in number above an agreed maximum. No such control exists on Department of Employment references, and neither does it exist on the liaison work of the RMS.

Liaison Work

Each RMO is responsible for an area served by several hundred general practitioners, each of whom he attempts to visit once in every two years to discuss matters of mutual interest, which can amount to almost any subject connected with general practice. The important aspect of these visits is that the RMO and the GPs get to know one another. Problems of general practice and Departmental policy can be discussed and the RMO quickly builds up a picture of general practice in his region which he crystallizes into a summary report which is sent to Headquarters for distribution to interested policy divisions. Headquarters Divisions show great interest in these reports and they are circulated widely within the Department. The RMO also liaises with FPC Administrators, and others concerned with NHS administration, and many attend as observers at meetings of Local Medical Committees. In short, the RMS provides perhaps the best information organization that the Department possesses, not only relating to general practice, but also relating to the impact of all other components of the NHS and the Personal Social Services on general practice and the community in general.

There are also what might be called "preventive" liaison visits which have a specific purpose, often concerned with the possible contravention of one of the many rules and regulations under which GPs are obliged to work. The term "preventive" is used since the RMO does not get involved in nor initiate any formal proceedings against a doctor. Examples of these visits include matters concerning doctors' obligations under the Misuse of Drugs Act, the Social Security Acts and the NHS Act. It follows that the RMO must make himself very familiar with these regulations, and he must conduct this side of his work with considerable tact so that the doctor appreciates that his advice is informal and

amicable. It is very important that he does not endanger the valuable professional relationships he has formed in connection with the rest of his work.

In addition to the above each RMS Division normally has specialist RMOs who deal with such matters as practice premises and postgraduate education. The "practice premises" RMO advises doctors and FPCs on the medical suitability of surgery premises in relation to the very complex arrangements now in force for various grants and loans. The "educational" RMO has the task of familiarizing himself with the postgraduate network in his divisional area, so that he can give maximum help on educational matters, including the new Vocational Training Regulations, to the practitioners in that area and also the clinical tutors, postgraduate deans, regional advisers etc., when required.

Prescribing visits

These are undertaken by all RMOs and are concerned with a number of aspects of prescribing. The role of the RMS in this field is described in the following section.

Table 6.4 shows the number and types of visits made to practitioners during 1980.

Table 6.4 Types of RMO visits, England 1980

Routine	3,680
Prescribing	579
Misuse of Drugs Act	137
Practice premises & organization	903
Others	799
Total	6,098

Prescribing

On 12 May 1980 the Committee of Public Accounts of the House of Commons examined Departmental Officers on the cost control of pharmaceutical prescribing in the NHS and its report was published in November (House of Commons, 1980). A small decrease in the total number of prescriptions dispensed in 1979 compared with an annual increase of 3% over the preceding five years was noted. This change was beginning before the increase in prescription charges from 20p to 45p in July 1979. It is possible that, in part, it could be attributed to the greater drive in the direction of health education and the increasing awareness of the medical profession of the limitations of drug therapy expressed in a Joint Statement of the then Secretary of State and the Chairman of the BMA Council in 1978. The Committee was reminded that a general practitioner is obliged by his terms of service to prescribe whatever drug he considers necessary for the patient's treatment once he has determined that drug therapy is required in the particular case. The Permanent Secretary told the Committee that he could find no valid reasons for judging that the total cost of NHS prescribing is excessive in relation to need, very largely because there are so very many needs which, because of resource restraint and other reasons, cannot be met within the NHS. For example the rising number of elderly patients, the increased use of drug treatment in keeping people at work, keeping people out of hospital and maintaining patients awaiting a hospital bed are all factors which can influence a doctor's prescribing.

The Department has some influence on pharmaceutical costs through the Pharmaceutical Price Regulation Scheme which exercises some control over what prices and profits are reasonable for the industry and this in turn is reflected in the price the NHS pays for drugs.

The Department continues to monitor the cost of pharmaceutical prescribing by general practitioners which in 1979, in England & Wales totalled £796 million. As already noted the Regional Medical Service (RMS) as part of its liaison role with general practitioners is concerned with a number of aspects of prescribing. Of the 6,000 visits paid to general practitioners' surgeries by members of the RMS in 1980, 579 were specific prescribing visits using data supplied to the Department by the Prescription Pricing Authority. Within the limitations of the availability of Regional Medical Officers' time and the capacity of the Prescription Pricing Authority to produce sufficient data, the Regional Medical Service has concentrated its effort on three groups of general practitioners. The first consists of high cost prescribers, 70% of whom are seen, after a study of the next available prescribing statistics, to be responsive to informal approaches by the RMO to discuss analyses of their prescribing. The second group consists of the new younger general practitioners, usually vocational trainees, many of whom find audit more readily acceptable than some of their more senior colleagues. The third group is an increasing number of established practitioners with average prescribing costs who are interested in their prescribing habits. The evolution of the Department's policy of providing general practitioners with as much feedback as possible about their own prescribing began with an announcement in the November 1978 edition of *Health Trends* offering the return of priced prescriptions to interested doctors. Two hundred doctors initially responded. Following this, with the co-operation of the Prescription Pricing Authority the facility for production of self audit analyses has been steadily developed within the limitations imposed by first, the primary function of the Prescription Pricing Authority, which is to reimburse the pharmacists, and secondly the inevitably slow manual preparation of analyses. Distribution of this information has thus been limited to a quota system for each monitored month based on a cycle of monitoring of prescribing in each of the 90 FPC areas.

Distribution of the self audit prescribing analyses has been through the Regional Medical Service and the majority of doctors who have been offered the help of experienced RMOs in interpreting this information have been very ready to accept it. During the monitoring cycle of the period September 1979 to August 1980 553 doctors received self audit analyses. It is too early to determine what effect this information has had on the prescribing habits of this group of doctors, but in the preceding year despite the fact that many of these practices had prescribing costs at or below the area average, 50% of them showed a reduction after receipt of an analysis.

Additionally Regional Medical Officers are increasingly becoming involved in talking to groups of general medical practitioners and particularly vocational trainees, on the subject of prescribing patterns.

The other major strand of Departmental prescribing policy is to help doctors to appraise their own prescribing habits by encouraging the distribution of independent information about drug developments and therapeutics. The medical profession, as represented by the BMA and the Royal College of General Practitioners, have shown themselves to be in support of the strategy that places in the hands of doctors as much information as possible about prescribing.

1980 saw the continuing development of Regional Drug Information Services providing up-to-date information and advice on the prescription of drugs entirely free from commercial bias. Such information is distributed by multidisciplinary groups in the Regions which include, pharmacists, clinical pharmacologists, hospital consultants, general practitioners and specialists in particular areas of medicine.

Further evidence of the willingness of the medical profession to concern itself with the current trends in prescribing was the setting up of an Informal Working Group on Effective Prescribing which held its first meeting in December 1980. It consists of representatives of the General Medical Services Committee, the Royal College of General Practitioners, the Joint Consultants Committee, the BMA and the Department. It is proposed to hold meetings at about two monthly intervals to discuss, away from the negotiating arena, ways of promoting effective prescribing.

The Department has continued to distribute information in the form of the well-accepted cost comparison charts and has provided continuing support for the production of *Prescribers' Journal.* Commencing in September 1980 arrangements were made for the free distribution of the *Drug and Therapeutics Bulletin* and the *Adverse Drug Reaction Bulletin* to all doctors working in the NHS.

During the past three years the Joint Formulary Committee of the BMA and Pharmaceutical Society has worked on the production of a revised version of the *British National Formulary* (BNF) and this was published on 9 February 1981 and distributed to all doctors working in the National Health Service. The revised format offers for the first time comprehensive guidance for prescribers on drugs within the same therapeutic sub-groups and gives relative indications of prices. Unlike previous editions, which included only a limited selection of drugs which had the confidence of the Committee, the scope of the present edition has been widened to include information on most of the products available to prescribers in the United Kingdom. Because of the rate of change of developments in the field of therapeutics it is no longer acceptable to publish at long intervals and it is anticipated that in future two editions of the BNF will be published each year.

Research on Prescribing

Following publication of a report on Prescription Pricing Authorities (Tricker, 1978) the then Secretary of State authorized a study to be carried out by the DHSS and the Prescription Pricing Authority (PPA) for England and Wales to find out if it was possible to devise satisfactory cost effective methods of extracting data from prescription forms. A feasibility study was set up in 1978 to conduct comparative trials of different methods of data capture, to look for data input devices which would handle a volume of work of the kind which processes over three hundred million prescriptions a year throughout England and Wales and to enable continuing use to be made of the expertise of the PPA staff. Data capture trials started in September 1979 to run until July 1980. During the first part of 1980 this experimental computer project showed that computerized working was feasible and that data capture could be done in a cost effective way. In May 1980 the Secretary of State approved the necessary expenditure for the development and implementation of computerized working in one Division of the Prescription Pricing Authority and it is hoped that this will be operational by August 1982. Additionally during 1980 the Unit for Research in Drug Usage of

Heriot-Watt University in co-operation with the PPA and the Department began a study into the effect of the prescribing habits of doctors in four FPC areas who had expressed an interest in receiving computerized data on their prescribing. During 1979 all the general practitioners in the Newcastle, Sunderland, Cambridge and Suffolk Family Practitioner Areas were offered two analyses at 6 monthly intervals based on their prescribing in 1980. An average of 70% of all these general practitioners responded positively. The first part of the study was due for completion by the end of March 1981. The study will continue to assess long term effects of providing this information and look at ways of improving the presentation of it.

The Department is also supporting other research projects, one of which is based on the Department of General Practice at St Mary's Hospital, Paddington, where in two London FPC areas the effects of offering prescribing analyses to interested general practitioners every six months for two years, combined with a chance to discuss the receipt of information with other general practitioner recipients, is being studied. Preliminary reports of the progress of the study suggest that there are trends towards a reduction in the volume of prescribing of hypnotics, sedatives and tranquillizers, an increase in approved name prescribing and a significant drop in costs.

The Department is also supporting a research project in the Mersey Region to determine whether the prescribing of drugs by general practitioners can be influenced by Drug Information Services. In its first annual report the Mersey Region Drug Information Service demonstrates quite clearly that locally produced information in the form of Drug Information Letters is accepted by most general practitioners as a useful authoritative document which is widely read and retained. The effect of the four drug information letters analysed so far has been to produce more rational and economic prescribing in the community of the drugs discussed.

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7

MATERNAL AND CHILD HEALTH

Birthrate

During 1980 the birthrate was 13.3. This compares with the rate of 13.0 in 1979, and 12.1 in 1978. The actual numbers of live births in 1980 was 656,200 compared with 638,000 in 1979 and 596,000 in 1978. These figures represent a marked slowing of the upward trend in the birthrate which began in late 1977. During 1980 birth registrations were 2.9% higher than in 1979.

This modest increase in the number of births must be viewed against the continued rise in the number of women of childbearing age, as women born during the peak years (for numbers of births) in the middle 60s begin their childbearing. If the rate of increase in the birthrate of 1979 had been maintained during 1980, the number of births would have been approximately 25,000 (4%) greater. Undoubtedly multiple factors have been responsible for the lower than expected increase in birthrate but among these, more understanding and better knowledge and use of contraception, deferment of the first pregnancy and an overall reduction in family size have all contributed. The fact that the rapid rise in birthrate during 1978/79 was not sustained also strengthens the view that adverse publicity about the safety of oral contraceptives was largely responsible for the sharp but temporary increase referred to in last year's report (Department of Health and Social Security, 1980a) page 77.

Some indication of the proportion of conceptions ending in abortion can be obtained by comparing the number of registered births with the number of terminations among resident women notified to the Chief Medical Officer. Figures for the years 1969 (the first full year in which the Act was in force) to 1980 are shown in Table 7.1. The third column shows that the ratio of abortions to births rose steeply in the years 1969-72. Despite fluctuations in the birthrate and variations in the number of women of child-bearing age the ratio varied slightly between 1974-1979, but showed a steeper rise between 1979 and 1980.

Table 7.1 Births and abortions among residents of England and Wales, 1969-1980

Year	Total live & still births England & Wales (thousands)	Abortions to residents of England & Wales (thousands)	Ratio of abortions to births
1969	808	50	1: 16.2
1970	795	76	1: 10.5
1971	793	95	1: 8.3
1972	734	109	1: 6.7
1973	684	111	1: 6.2
1974	647	109	1: 5.9
1975	610	106	1: 5.8
1976	590	102	1: 5.8
1977	574	103	1: 5.6
1978	601	112	1: 5.4
1979	643	119	1: 5.4
1980	661	130	1: 5.1

Use of maternity beds

There were on average 18,400 maternity beds during 1980. This is 400 fewer than in 1979; of the available beds 15,400 (84.2%) were in consultant units, while 2,900 (15.8%) were in general practitioner maternity units. Average length of stay including both ante- and post-natal admissions was 5.9 days in consultant units and 4.4 days in GP units. The average bed occupancy in consultant units was 73.3% compared with 74.1% in 1979, and 44.8% in GP units compared with 43.7% in 1979. Overall occupancy was 67.5%.

The case birth ratio (index of the number of admissions to the number of maternities) increased in 1980 at 1.34 admissions per maternity patient compared with 1.33 in 1979. This index reflects the importance now attached to ante-natal admissions in the prevention and management of conditions that may adversely affect the outcome of pregnancy.

In last year's report (Department of Health and Social Security, 1980a) reference was made to the likely effect of the increase in birthrate on bed occupancy. It was then apparent that some hospitals would have difficulty in coping with the anticipated number of births. During 1980 reports were received of a few hospitals which had had to restrict bookings to women resident in their own Health Districts, but in general the available maternity bed stock has been sufficient to provide a bed for all mothers who wish to be confined in hospital. To meet the anticipated increase in the number of births in the middle and late 80s Health Authorities have prepared outline plans to increase the number of available beds.

Maternal deaths

Preparation of the ninth triennial Report on Confidential Enquiries into Maternal Deaths in England and Wales continued during the year, and it is expected that this report covering the period 1976-1978 will be published during 1982. It has been suggested that the impact of the confidential enquiry reports would be greater if the interval between the events reported on and publication could be reduced. It is hoped that the 1976-78 Report will include about 98% of all the known true obstetric deaths, and to achieve this coverage of deaths up to a year after confinement or pregnancy, an interval is inevitable to allow the individual records of these cases to be collected from all concerned with them. There is then the detailed and time-consuming analysis of all the cases before the Report is ready for publication. While every effort is made to expedite publication a general review of the aims, objectives and mechanism of the report, concluded that there would be no advantage gained by altering the format of the report simply to speed publication. Despite the reduced number of maternal deaths, the report fulfils a valuable role and it is felt that to alter its format might only result in a less valuable commentary.

The causes of maternal death are not directly comparable between 1979 and 1980 (see Table 7.2) and the earlier years 1975-1978 (see Table 7.3). This is because of a change made in 1979 to the 9th revision of the International Classification of Disease (ICD) coding. As far as possible the deaths in 1979 have been grouped to correspond with the causes of death in the earlier years to make a reasonable comparison.

Table 7.4 shows the maternal mortality for England for the 5 years 1976-1980. The death rate per 1000 live and stillbirths has fallen marginally during the last 5 years. The death rate during 1980 for deaths from abortion has fallen but Table

7.2 shows that there were an unusually large number of ectopic pregnancies where a fatal outcome occurred.

Table 7.2 Causes of death ascribed to pregnancy and childbirth, England 1979 and 1980. (Based on death registration data received by the Registrar General).

ICD NO (9th revision)	Cause of death	1979	1980
633	Ectopic pregnancy	3	10
631-632 & 634-637	Abortion (all types)	5	3
640	*Haemorrhage in early pregnancy	—	—
641	Ante-partum haemorrhage, placental abruption and placenta praevia	6	3
642	Hypertension complicating pregnancy, childbirth and the puerperium including pre-eclampsia and eclampsia	12	10
643-648	Other complications mainly relating to pregnancy	8	11
666	Post-partum haemorrhage	2	3
651-654, 658-659 Rem 660-669	Other complications of pregnancy, labour and delivery	12	11
670	Major puerperal infection	1	3
673	Obstetrical pulmonary embolism	6	9
Rem 671-674	Other complications of the puerperium	12	5
	Total	67	68
	Total, excluding abortion	62	65

*Haemorrhage before completion of 22 weeks gestation

Table 7.3 Causes of death ascribed to pregnancy and childbirth, England 1977 and 1978. (Based on death registration data received by the Registrar General).

ICD NO (8th revision)	Cause of death	1977	1978
631	Ectopic pregnancy	9	6
632	Haemorrhage of pregnancy	2	—
Rem 630-634	Other complications of pregnancy	8	5
635-639	Hypertensive disease of pregnancy	17	21
640-645	Abortion of all types	6	5
651	Delivery complicated by placenta praevia or ante-partum haemorrhage	2	3
652-653	Post-partum haemorrhage	4	1
Rem 650-662	Other deaths from delivery	12	11
671-673	Puerperal phlebitis, thrombosis and pulmonary embolism	8	10
Rem 670-678	Other complications of puerperium	4	3
	Total	72	65
	Total, excluding abortion	66	60

Table 7.4 Maternal mortality, England 1976-1980.

	Total live and still births	Maternal mortality from childbearing ICD Nos 640-676		Maternal mortality from all types of abortion excluding ectopic pregnancy ICD Nos 630-639		
		Deaths	Deaths per 1000 live & stillbirths	Deaths	Deaths per 1000 live & stillbirths	Rate per million women aged 15-44
1976	555,722	68	0.12	6	0.01	1
1977	542,040	66	0.12	6	0.01	1
1978	567,380	60	0.11	5	0.01	1
1979	606,127	62	0.10	5	0.01	1
*1980	622,894	65	0.10	3	0.005	0.3

*Provisional figures

Maternity outcome

Table 1.10 in Chapter 1 provides information on perinatal mortality and stillbirths and their respective rates during the period 1960-1980. Analyses of perinatal statistics by the National Perinatal Epidemiology Unit have shown that during this period the perinatal mortality rate has fallen more rapidly than at any time in the last 30 years. Although the perinatal mortality rate in this country (14.5) remains at a higher level than in Scandinavia (eg — Sweden 10.1) and some other European countries, lethal congenital malformations and infants of very low birth weight contribute disproportionately to the total of perinatal deaths in England. Table 7.5 illustrates how little fluctuation there has been in the proportion of infants of low birth weight during the past 15 years. This table also shows the percentage of premature, live and stillborn infants for the same years, which has also remained virtually unchanged. National data are not available but there is some evidence (Mutch *et al,* 1981) that if the effects of congenital malformations and very low birthweight are excluded, avoidable perinatal deaths are not as frequent as the overall perinatal mortality rate would suggest.

Home confinements

The number of home confinements in England and Wales — 8,131 — continued to decline slowly. In 1979 there were 8,869 and in 1978, 9,586. A number of groups continue to press for an expansion of home confinement services. In evidence to the Social Services Committee enquiry into Perinatal and Neonatal Mortality, the Department reaffirmed previous advice to Health Authorities that women should be encouraged to be confined in fully equipped hospital maternity departments (Department of Health and Social Security, 1980b). Authorities are expected to maintain a domiciliary confinements service that is as safe as circumstances permit for those mothers who, despite the medical and safety arguments, wish to be confined at home.

The Standing Medical and Standing Nursing and Midwifery Advisory Committees discussed the practical difficulties of providing a domiciliary service that faced some Health Authorities. They concluded that as local circumstances varied widely, no single solution was possible, and that each Health Authority should convene local discussions between the relevant professional groups — midwives, general practitioners and obstetricians — to determine how

Table 7.5 Premature births, low birth weight babies (2,500 grams or less), England & Wales 1964-1969, England only, 1970-1980

	Live Born			Live and stillborn		
Year	Number of low weight	Number of all weights	Low weight as a percentage of all weight	Numbers of Low weight	Number of all weights	Low weight as a percentage of all weight
	000's	000's	%	000's	000's	%
1964	55.9	875.8	6.4	64.1	890.2	7.2
1965	54.7	860.7	6.4	62.5	874.4	7.2
1966	55.2	848.4	6.5	62.9	861.5	7.3
1967	53.8	827.8	6.5	61.2	840.1	7.3
1968	54.2	814.6	6.7	61.0	826.4	7.4
1969	53.4	795.8	6.7	59.6	806.3	7.4
1970	50.8	739.7	6.9	56.6	749.1	7.6
1971	47.2	739.2	6.4	52.6	748.4	7.0
1972	45.4	686.9	6.6	50.3	695.0	7.2
1973	41.3	638.2	6.5	45.8	645.4	7.1
1974	38.9	602.5	6.5	42.9	609.0	7.0
1975	36.4	570.0	6.4	40.1	575.9	7.0
1976	35.4	551.5	6.4	38.7	556.8	7.0
1977	35.0	537.5	6.5	38.2	542.5	7.0
1978	37.1	563.7	6.6	40.2	568.4	7.1
1979	40.7	602.0	6.5	43.9	606.7	7.2
1980	42.5	619.4	6.9	45.5	623.9	7.3

domiciliary confinements should be organized in the light of local factors. In reaching this conclusion they were aware of the particular problems of emergency transport that had occurred in some parts of the country where obstetric flying squads are not available, or are called out very rarely indeed. In some places the absence of resident staff during a flying squad call effectively withdrew immediate obstetric cover from the hospital maternity unit. For this reason the Standing Medical Advisory Committee advised the Department that Health Authorities could not be expected to organize flying squads where these could only function by putting at risk the care available to obstetric in-patients. In such circumstances Authorities would need to consider what alternative emergency transport facilities should be provided.

Family planning

Attendances at family planning clinics continued to decline in 1980, when total attendances were 3,269,450 a decrease of 1.1% from 1979 when 3.3 million attendances were recorded.

This was the third successive year in which attendances at clinics fell, although the number of clinic sessions decreased from 206,000 in 1979 to 202,000 in 1980.

The number of women attending General Practitioners for family planning advice since 1975 when the general practitioner family planning service was introduced is shown in Table 7.6. It will be seen that in common with clinics there was a drop in attendances between 1977-79, but a small increase in total attendances between 1979 and 1980. Since 1976 there has been little variation in the percentage of general practitioners offering contraceptive services, although the actual number of practitioners providing services has increased each year.

Table 7.6 Family planning services provided by general practitioners, England 1975-1980

Year	GP principals providing contraceptive services	As a percentage of all GP principals	Patients attending for IUDs (thousands)	Others patients (thousands)	Total seen (thousands)
1975	18,809	91%	14	1,144	1,158
1976	19,515	94%	54	1,845	1,899
1977	19,869	94%	68	1,970	2,038
1978	20,140	94%	98	1,861	1,959
1979	20,512	95%	110	1,812	1,922
1980	21,018	95%	107	1,917	2,024

Changes in the method of family planning

The decline in popularity of oral contraceptives among women attending clinics continued during 1980.

In 1977 over 966 thousand women were taking oral contraceptives at their first clinic attendance. In 1980 the use of oral contraceptives by clinic attenders was 800 thousand, or 54% of clinic attenders. While figures are not available of the use of oral contraceptives by women obtaining family planning advice from general practitioners there is some evidence from prescriptions dispensed that the number of women obtaining oral contraceptives from general practitioners began to increase during the year, thus reversing the downward trend which began in 1977. In contrast the use of intra-uterine devices increased

markedly among women attending both clinics and general practitioners during 1978 and 1979, but the increase in popularity of the IUD was not sustained in 1980 among either category. The decline in IUD usage may also have been partly due to adverse reports which drew attention to the increased risk of pelvic infections that are associated with this mode of contraception. During the year there were several such reports, and debate continues about the significance of changes suggestive of the presence of actinomyces that are observed in the cervical smears taken from some women who have an inert IUD *in situ.* It was this latter observation which led the manufacturers of the Dalkon Shield IUD — an inert device whose sale in the UK had ceased in 1974 — to write to all doctors in November 1980, advising that any remaining Dalkon Shields should be removed. This followed considerable adverse publicity in the media alleging a high complication rate with this device which had led the Department to make a number of enquiries to find out how many Dalkon Shields were still in use, and whether the complications noted in the USA had also occurred in this country. The replies from professional bodies suggested that few women were in fact using the device, and that those who were, were doing so with the agreement of their doctors. There was little evidence that Dalkon Shields had caused complications in the UK on the scale noted in publications in the United States.

The manufacturers letter recommending removal of any remaining Dalkon Shields was endorsed by the relevant professional bodies and supported by the Department.

Table 7.7 Method of birth control adopted at time of woman's first visit to clinic, England 1978-1980

Method	1978 (thousands)	1979 (thousands)	*1980 (thousands)
Oral contraception	873.7	802.2	799.8
IUD	298.7	317.2	307.9
Cap/diaphragm	115.2	117.4	122.0
Sheath	130.4	141.0	147.4
Chemical methods	13.9	12.4	10.1
Rhythm method	0.2	0.2	0.2
Sterilization (female)	1.4	1.8	1.2
Vasectomy	16.6	15.6	15.7
Other	7.3	9.1	8.3
None	64.7	72.7	80.1
Total	1522.2	1489.6	1487.8

*Provisional figures

Vasectomy and sterilization

Tables 7.8, 7.9 and 7.10 show the available statistics on sterilizations performed in the years 1968-1979. Table 7.11 shows the number of vasectomies performed for patients attending family planning clinics. Unfortunately comprehensive figures are not available as data are not collected on the number of operations performed on outpatients and day cases in the NHS, or of the considerable number of vasectomies and sterilizations now performed in the private sector. There is however no doubt that increasing numbers of couples are choosing these methods of permanent family limitation in preference to readily reversible

alternatives. The doubts about oral contraceptives and IUDs already mentioned no doubt contribute to the increasing popularity of these methods.

Table 7.8 Estimated numbers of sterilizations associated with delivery, England & Wales 1968-1979 (Source HIPE)

Year	Estimated number of sterilizations associated with delivery	Percentage of total deliveries
1968	10,930	1.7
1971	26,650	3.9
1972	22,600	3.5
1973	21,860	3.5
1974	19,200	3.4
1975	17,480	3.2
1976	16,380	2.9
1977	14,110	2.6
1978	13,940	2.4

Table 7.9 Sterilization associated with legal abortion, England & Wales 1968-1978 (Source OPCS Abortion statistics)

Year	In NHS hospitals	In other approved places	Total	Total as a % of all abortions
1968	—	—	5,128	23.0
1969	—	—	11,126	22.3
1970	13,732	214	13,946	18.4
1971	14,193	269	14,462	15.3
1972	13,512	379	13,891	12.8
1973	11,434	484	11,918	10.8
1974	10,250	483	10,733	10.8
1975	8,515	657	9,172	8.6
1976	8,145	764	8,909	8.7
1977	7,889	983	8,872	8.6
1978	7,971	1,174	9,145	8.2

Table 7.10 Estimated numbers of hospital discharges where the principal operation was sterilization, England and Wales 1971-1978 (Source HIPE)

Year	*Estimated number of operations*			Rate per 1,000 women aged 15-44
	Division & ligation of oviducts†	Endoscopic sterilization	Total	
1971	32,910	1,780	34,690	372.1
1972	27,830	7,870	35,700	381.2
1973	28,020	10,660	38,690	410.3
1974	20,840	13,020	33,850	357.5
1975	14,980	8,190	23,170	243.5
1976	16,410	15,100	31,510	328.3
1977	10,530	19,930	30,460	314.1
1978	11,850	27,970	39,830	405.4

†Note: Prior to 1975 figures include a number of other operations on the oviduct

Table 7.11 Estimated number of vasectomies performed for persons attending family planning clinics, England & Wales 1974-80

	Total
*1974	11,368
1975	17,604
1976	17,528
1977	17,182
1978	18,097
1979	16,336
1980	14,432

*9 month period only

Advice on contraception for children aged under 16

The 1974 Memorandum of Guidance on Family Planning (Department of Health and Social Security, 1974) contained a section on family planning services for the young which had been the subject of criticism. On 6 May 1980 the Minister of State (Health) announced to the House of Commons the general principles on which this section was to be revised in order that it should be more supportive of family life, and the responsibilities and rights of parents.

The revised memorandum was issued to Health Authorities in December 1980 in a Health Notice HN(80) 46 (Department of Health and Social Security, 1980c). The new guidance emphasizes that in any case where a doctor or other professional worker was approached by a person under the age of 16 for advice in these matters, the doctor, or other professional, would always seek to persuade the child to involve the parent or other person *in loco parentis* at the earliest stage of consultation, and would proceed from the assumption that it would be most unusual to provide advice about contraception without parental consent. At the same time, the guidance recognized the importance of confidentiality between doctor and patient and accepted that there would be exceptional circumstances, for example where the parents were unconcerned, entirely unresponsive or grossly disturbed, where it might be inappropriate to involve parents. The guidance recognized that in the exceptional cases where parents were not involved, the decision whether or not to prescribe contraceptives must be for the clinical judgement of the doctor.

Abortion

During 1980 the total number of abortions notified in England and Wales was 164,000, an increase of 10.6% on the 1979 total of 147,000. The number of abortions on resident and non-resident women both rose. The former by 9.4% to 130,000 and the latter by 15.6% to 33,000. The increase in the number of abortions to non-resident women reverses the downward trend that occurred during 1978 and 1979.

The number of operations performed for resident women within the NHS was 60,000 an increase of 9.8% over 1979. Abortions in the private sector among resident women also increased by 9.1% from 64,000 in 1979 to 70,000. The number of abortions performed on resident single women showed a continuation of the upward trend noted in 1978 and 1979. The increase was greatest, 15.6%, among single women aged over 20 whereas there was an increase of 12.8% among younger single women aged 16-19.

Arrangements for notification of abortion

During 1980 a number of changes were made to the abortion notification system. These included the Abortion (Amendment) Regulations (Statutory Instruments, 1980) which introduced a new Abortion Notification form. Changes were also agreed in the presentation of statistics based on abortion notifications and published by OPCS. Thirdly it was decided that in future all personal particulars supplied through abortion notification, including the notification forms themselves should be destroyed three years after the date of the operation. This arrangement will allow for the notification form to be retained for the same period of time as an operating practitioner is required to retain the Certificate of Opinion given under Section 1(1) of the Abortion Act.

The Abortion (Amendment) Regulations 1980

The Abortion Notification form had remained virtually unchanged since it was introduced in 1968. There have been a number of changes in the intervening period and the Abortion (Amendment) Regulations laid before Parliament on 19 November provided for the introduction of a new notification form that had been designed to provide better information about aspects of abortion that have attracted public and professional concern. The form was designed with four principles in mind:—

(a) To monitor recent changes in abortion practice such as day care and agency arrangements between NHS authorities and the private sector.

(b) To provide more accurate information about the period of gestation which on the old notification form was derived from the date of the last menstrual period. This method of calculating gestation was known to have been inaccurate in a significant proportion of cases.

(c) To collect more detailed information about the medical condition affecting the patient and/or the suspected handicapping condition affecting the fetus.

(d) To reduce the number of items of data on the notification form by elimination of redundant questions and items that have never been used for systematic statistical analysis.

The Regulations introducing the new form came into effect on 1 March 1981. Following the introduction of the new notification form changes in the arrangements for publication of statistics for abortions performed in England and Wales will be introduced. Currently OPCS prepare monthly, quarterly and annual tabulations based on the number of notifications received. The monthly tabulations are found to fluctuate widely depending on the number of working days in the period covered. When the new form has been introduced quarterly and annual tabulations will be prepared by OPCS on the basis of events during a given period rather than the number of notifications received. The quarterly tabulations will be simpler to interpret but wider in the range of parameters covered than the present quarterly Abortion Monitor.

The role of the nurse or midwife in the termination of pregnancy by medical induction methods.

During 1979 the Department was asked for clarification of the legal position of a nurse or midwife who assisted a doctor in a termination of pregnancy carried out by medical induction methods in which the involvement of the nurse or midwife

included the administration and regulation of abortifacient drugs. It had been suggested that although a nurse or midwife was acting on the instructions of a doctor and performing duties that were generally undertaken by nurses and others in accordance with accepted professional practice the administration or regulation of abortifacients by persons other than registered medical practitioners was unlawful.

The Department took legal advice on this complex issue and on 21 February 1980 a circular letter (Department of Health and Social Security, 1980d) was sent to Regional and Area Medical and Nursing Officers which set out the circumstances in which the Department understood that nurses and midwives might lawfully participate in the termination of pregnancy by medical induction.

Subsequently the Royal College of Nursing sought an injunction in the High Court that the Department's circular letter was unlawful.

The case was heard in the High Court of Justice, Queen's Bench Division on 24 July 1980 when the Royal College of Nursing was refused the injunction sought. Instead the Department was granted a declaration that the advice contained in the circular letter did not involve the performance of unlawful acts by nurses who assisted with terminations carried out by medical induction methods. The Royal College of Nursing appealed against this decision and on 7 November the Court of Appeal reversed the High Court judgement granting the Royal College of Nursing an injunction that the Department's advice was unlawful but gave leave for the Department to appeal to the House of Lords. The Department immediately suspended the advice given to Health Authorities in the circular letter.

On 8 and 9 December the House of Lords heard the appeal and ruled in favour of the Department directing that the order of the High Court should be restored. On 12 December 1980 the Department reinstituted the advice given in the circular letter confirming the circumstances in which it was lawful for nurses and midwives to assist in terminations performed by medical induction methods.

The private sector

At the beginning of 1980 there were 61 nursing homes approved under the Abortion Act. During the year one application for approval was confirmed and the approval of one nursing home was withdrawn. At the end of 1980 one application for approval was under consideration.

In January 1980 there were 35 Pregnancy Advice Bureaux on the register. During the year a further five bureaux were registered, and registration of one bureau was withdrawn. The name of a second bureau was removed from the register following its closure and transfer to other premises. At the end of the year there were a total of 38 bureaux on the register with three applications for registration outstanding.

Agency arrangements between Health Authorities and the private sector

In December 1979 Warwickshire Area Health Authority concluded an agency arrangement with a private sector nursing home which enabled women who had been registered with the Warwickshire Family Practitioner Committee for a period of 12 weeks or more to be referred by their general practitioner to one of the local Pregnancy Advice Bureaux run by the British Pregnancy Advisory Service. Where patients seen under this agency arrangement were found to fulfil

the criteria laid down by the Abortion Act the British Pregnancy Advisory Service then arranged for admission and treatment for termination of pregnancy in one of its nursing homes.

During the year a number of other Health Authorities developed similar agency arrangements, for example the Birmingham Area Health Authority have introduced an agency scheme whereby patients seeking termination of pregnancy are first assessed by the authority's own doctors to see if the criteria of the Abortion Act are met. If so patients are referred for operation to one of a number of approved nursing homes in and around Birmingham.

Such arrangements are considered to be consistent with the Government's general policy of encouraging Health Authorities to make use of services available at private hospitals and clinics for the provision of various forms of treatment for NHS patients.

Legislation relating to abortion

The Abortion (Amendment) Bill, which had been introduced by Mr John Corrie MP in July 1979 began its Report stage debate on 8 February 1980. It was further debated on 15 and 29 February and on 14 March when further debate was adjourned until 4 July. On 25 March Mr Corrie withdrew the Bill when it became apparent that it had run out of Parliamentary time.

On 22 April 1980 Mr David Alton MP tabled a motion in the House of Commons to introduce a further Abortion (Amendment) Bill under the 10 minute rule. This sought to impose an upper time limit for abortion of 24 weeks gestation by amendment to the Abortion Act. The Bill was debated but did not receive a second reading.

Perinatal and neonatal mortality

An enquiry into perinatal and neonatal mortality was begun in November 1978 by the House of Commons Social Services and Employment Sub-Committee of the Expenditure Committee. This enquiry was mounted because of public concern about perinatal mortality and because recorded mortality rates in England and Wales were falling less quickly than in some other developed countries. Between December 1978 and February 1979 evidence was taken from the DHSS and various official bodies. Owing to the general election in 1979 the enquiry was suspended before it had completed its task, but was resumed following the establishment of the new Social Services Committee in November 1979.

Evidence was taken from many individual organizations and professional bodies and in February 1980 The Secretary of State for Social Services and DHSS Officials gave oral evidence to the Committee. The Committee finished taking evidence in March 1980 and published its report on 16 July 1980 (House of Commons, 1980).

The report covers the whole field of antenatal, intra-partum and postnatal care, including related aspects such as research, health education and social benefits. Considerable attention is given to medical staffing. The Report includes 152 recommendations which the Committee placed in 3 categories:—

a) 98 recommendations which the Committee suggested could be implemented immediately at little or no cost.

b) 40 recommendations which they recognized as having significant cost implications.

c) 14 to which no cost or timing were attached.

The Committee urged that the very highest priority should be given to recommendations in categories (a) and (b) and that for those in category (c) a special allocation of funds should be channelled to health authorities as a matter of urgency.

The Government's reply was published as a Command Paper (Department of Health and Social Security, 1980b) on 3 December 1980 and it was followed by a debate in the House of Commons on 5 December 1980.

The Government welcomed the Report which re-emphasized many aspects of the maternity and neonatal services which have given cause for concern in recent years. Many of its recommendations are based on current practice and endeavour but in spite of steady improvement in perinatal mortality over the years there is still plenty of room for more improvement in services which are themselves rapidly developing. Nevertheless the Government was concerned lest the report should arouse unrealistic expectations of the number of deaths and serious handicaps which are avoidable in the present state of medical knowledge.

Sustained effort is essential to provide the best possible professional care for mother and child, and at the same time to ensure that arrangements for clinical care are sensitive to the needs of parents throughout the crucial period of pregnancy, birth and the neonatal period. With this objective in mind the Government wholeheartedly endorsed measures directed at humanizing maternity care. Improvements in the management of antenatal clinics, to reduce inconvenience to pregnant women and to make them aware of the relevance and importance of regular attendance, are key features in the campaign to improve services for at-risk groups. Similarly the Government supported the health educational aspects of the Report and recognized the importance of preparation for parenthood before and during pregnancy.

The Government's reply stressed that the great majority of the recommendations in the report fell to health authorities, and professional and other bodies but that of the more than 40 recommendations that applied to central Government, over two-thirds were accepted or under consideration. A Health Circular drawing the attention of health authorities to those recommendations in the report that concerned them and to the Government's reply was issued in December 1980 (Department of Health and Social Security, 1980e).

Community child health

The Childrens Committee. The Committee published the reports of two working groups in the form of discussion documents (Childrens Committee, 1980a and 1980b); one on *The Needs of the Under-Fives in the Family* and the other on *Out-of-Hours Social and Health Care.* A national workshop on the latter was planned to take place in the spring of 1981, and preparatory work took place. The Committee published a report on its Conference on Perinatal Mortality, held in December 1979, in July 1980 (Childrens Committee, 1980c). Formal advice was submitted to the Secretary of State, identifying certain points for consideration by the Government.

Congenital Hypothyroidism

The Joint Standing Sub-Committee on Screening in Medical Care submitted to the Standing Medical Advisory Committee a report setting out evidence in support of screening for congenital hypothyroidism. The Standing Advisory Committee warmly welcomed the report, and Ministers agreed to the need for screening to be introduced by health authorities at the earliest opportunity. A Health Notice issued in 1981 to health authorities (Department of Health and Social Security, 1981) recommended that development of this screening service, as resources permit, should be a desirable part of an authority's priority strategy for prevention. Following discussions with the Department, the Medical Research Council are to establish a co-ordinating committee.

Steering Group on Health Services Information (HSI), Working Group D

This working group was set up in 1980 to examine information in the broad field of Community Health Services, which includes services for children. The principal aim of the group, carrying forward the general philosophy of the HSI Steering Group, is to base information systems on the needs of local managers in the National Health Service. The group began its work by studying existing information systems, preliminary to formulating recommendations on how these could be made more relevant to the needs of local managers.

Preparation for parenthood

During the International Year of the Child (1979) the Department organized a study conference together with the Department of Education and Science and the National Children's Bureau on preparation for parenthood. The proceedings of the conference were published in January 1980 (Pugh, 1980). Following on from this, the Department arranged to provide funding for 3 years to form a Preparation for Parenthood Clearing House at the National Children's Bureau. The project provides a clearing house for the dissemination and interchange of ideas and information on schemes and services being carried out in schools, in antenatal preparation and in support for families with young children.

Liaison with Other Government Departments

a. *Home Office, Mother and Baby Units in Prisons*

Representatives of the Home Office Prison Department have held discussions with representatives from Children's Division in DHSS about the operational policies of these units. The Department has provided advice on the health and welfare of infants and young children who accompany their mothers while in custody.

b. *Interdepartmental Consultative Group on Provision for the Under-Fives.*

This group, which was reported on last year (page 86), continued to meet during 1980, including another joint meeting with the Local Authority Associations, the National Association of Health Authorities, and relevant bodies under the auspices of the Voluntary Organizations Liaison Committee for the Under-Fives (VOLCUF) and the National Council of Voluntary Child Care Organizations (NCVCCO). The Group, established in 1973, includes representatives of DHSS, DES, DOE, Department of Employment, Home Office, Scottish Office and Welsh Office. A theme of the Group's discussions has

been the use of scarce resources for the optimum benefit of children and encouragement of good low cost schemes, with emphasis on the voluntary sector. During the year, Sir George Young, Parliamentary Under Secretary of State, DHSS and Baroness Young, Minister of State, DES have made joint visits to under-fives projects in Haringey and Hounslow. Work in preparation for a one-day national seminar on Provision for the Under-Fives commenced in 1980. The seminar will take place in the Autumn of 1981, and will be sponsored by DHSS and DES.

Prevention in the child health services

A Departmental paper *Prevention in the Child Health Services* (Department of Health and Social Security, 1980f) was made available in March 1980 following consultations with health authorities and interested professional organizations. The paper outlined the main objectives and content of child health services in the light of Government decisions on the Court Report (Department of Health and Social Security, Department of Education and Science and Welsh Office, 1976) and suggested a basic programme of child health surveillance. It stressed the need to reach all children and emphasized that the primary objective of health surveillance, namely to assist parents in carrying out their responsibilities for the promotion of their children's physical and mental health, could not be achieved unless those concerned saw their task as involving partnership with parents. The paper also drew attention to the need for close working relationships between those working in the health and local authority services for children.

Special needs in education

In August 1980 the Department of Education and Science published a White Paper entitled *Special Needs in Education* (Department of Education and Science and Welsh Office, 1980). This was the Government's response to the Warnock Committee's Report *Children with Special Educational Needs* (Department of Education and Science, Scottish Office and Welsh Office, 1978).

The Warnock Committee was set up "to review educational provision in England, Scotland and Wales for children and young people handicapped by disabilities of body or mind, taking account of the medical aspects of their needs, together with arrangements to prepare them for entry into employment; to consider the most effective use of resources for these purposes; and to make recommendations".

The White Paper stated that present legislation relating to educational provision for handicapped children relied too heavily on the identification of specific disabilities of mind or body. In its proposed revision of the law the Government was seeking to provide the flexibility needed for educational advance; to safeguard the interests of children and young persons with more serious difficulties, and to take full account of the legitimate wishes of their parents. The Government agreed with the Warnock Committee that the present form of categorization not only assumed that handicapped children had only a single disability, but also focused on the type of provisions available in the field of special education rather than the special needs of individual children.

The White Paper pointed out that no system of classification could readily describe simultaneously the medical, psychological, educational and social aspects of a particular child's needs. Where a child has difficulties in the

education environment, assessment of a complexity of needs should be carried out by a multi-disciplinary team, in which child health services have a crucial role to play.

Accidents in childhood

The prevention of childhood accidents is included as part of the general subject of "Prevention of Accidents" which appears in Chapter 14, page 137.

Community health doctors

Discussions between the Health Departments and the profession continued in the joint working group set up to consider a career structure and training for community health doctors. Proposals on training, prepared by the professional side of the working group, were discussed at a meeting arranged by the Department on behalf of the group in February 1980, at which the major professional bodies concerned with paediatric training were represented. The joint working group held its last meeting in July 1980, when it was agreed that the profession's representatives would take forward the whole question of postgraduate training for community health doctors with appropriate professional bodies, and explore the means by which a national professional body could be established to develop and supervise training programmes and give guidance to regional postgraduate committees. The working group agreed that there would continue to be a need for two grades of doctors working in the community health services. They will be known as senior clinical medical officers and clinical medical officers.

These would be career grades in which training would take place, and admission to each would normally be through some form of advisory appointments committee. Any need for modifications to the terms and conditions of service for this group of doctors, including the question of establishing a training grade, would be referred to the Joint Negotiating Body for doctors in community medicine and the community health services.

Child care

The report of the working party costing the unimplemented provisions of the Children Act 1975 was produced in November 1980 and showed that although the total additional expenditure for implementation would be in the order of £12 million a year a number of important provisions, including the freeing of children for adoption and the approval of adoption societies could be introduced at little or no cost.

The Children Act 1975 includes provision for the present system of local authority registration of adoption societies to be replaced by a system of approval by the Secretary of State. A Departmental working party sat during 1980 to consider the criteria and procedures for approval and Ministers accepted the working party's recommendations.

Child abuse

In August 1980 a Health Notice and Local Authority Social Services letter (Department of Health and Social Security 1980g), were issued consolidating and extending earlier guidance on register systems for recording cases of child abuse. It recommended that the procedures should be extended to include

children subjected to severe emotional abuse and outlined more precise criteria for registration in order to secure greater uniformity throughout the country. In February 1980 the Leicestershire County Council and Leicestershire Area Health Authority published the findings of the Independent Inquiry into the death of Carly Taylor (Leicestershire County Council and Leicestershire AHA, 1980) and the report of the inquiry set up by the Secretary of State under statutory powers to investigate the case of Paul Steven Brown was published in December (Department of Health and Social Security, 1980h).

In response to requests from field authorities the Department is undertaking a study of all the published reports of child abuse inquiries, both statutory and non-statutory with the aim of identifying common features and highlighting the lessons to be learned from them. The study is particularly concerned with identifying lessons for professional practice and procedures across the whole range of agencies dealing with child abuse.

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8

DENTAL HEALTH

General dental services

The numbers of permanent teeth filled or extracted in 1980 were a little higher than for 1979 but lower than in 1978. Compared with last year the number of teeth conserved by endodontic treatment rose by 13.2% and the provision of crowns by 17.5%. 30,160 bridges were provided in 1980, considerably more than the 22,810 in 1979. A 5% decrease was noted for the requirement for general anaesthesia in 1980. In comparison with the previous year, treatment involving deciduous teeth was less by 6.7% for fillings and by nearly 3% for extractions.

During the year dental officers in the reference service of the Department examined 26,031 patients in connection with the provision of treatment under the general dental services other than when orthodontic treatment was involved. The dental officers agreed with treatment plans completely, or with slight modification, for 64.7% of the proposed courses. Where the patients' treatment had been completed the dental officers found the treatment entirely satisfactory and the patients dentally fit in 64.2% of cases but 31.9% required minor additional work. In the dental officer's opinion in 2.8% of the patients seen the majority of the completed treatment was unsatisfactory or a considerable amount of additional treatment was needed.

Dental officers of the orthodontic section of the reference service examined 1,219 patients during 1980. Of the 873 patients examined regarding proposed treatment the dental officers disagreed, to a major degree, in 56% of cases. 297 patients were seen after completion of treatment and 53% of these were considered not to have had their treatment satisfactorily completed. These figures are, however, probably less disturbing than they appear since the particular patients examined may be unrepresentative in the context of all orthodontic treatment provided in the general dental services. Many patients are referred for clinical examination by the Dental Estimates Board because study models and X-ray evidence are not considered sufficient for a satisfactory orthodontic assessment to be made.

As noted in this report for 1979 (page 89) Health Authorities were asked to consider the need for additional emergency services at week-ends and Bank Holidays. By the end of August 1980 emergency service schemes had been set up in 23 centres in which 1843 patients were seen in 260 sessions. In October an item was introduced in the scale of fees to be paid for the provision of general dental services to cover attendance by a dentist at a surgery in an emergency outside normal working hours.

The working group studying the feasibility of an experimental capitation payment model for child dental care (see this report for 1978, page 84) agreed a final report, which is being considered by the British Dental Association, the Department of Health and Social Security, the Scottish Home and Health Department, the Welsh Office and the Dental Strategy Review Group.

Hospital dental services

The number of dentists in hospitals service posts in England and Wales,

excluding hospital practitioners and paragraph 107 appointments, was 1,241 at 30 September 1980, an increase of 14 since the previous year. The number of dentists in the specialty of dental surgery decreased from 889 to 863, whereas the number in the specialty of restorative dentistry increased from 119 to 153; part of the change being due to reclassification. The numbers of staff in the specialty of orthodontics increased from 219 to 225. The number of women dentists in the hospital service increased from 120 to 220 between 1975 and 1979, but in 1980 showed a small decline to 216.

Community dental service

In a school population in England of 8.6 million, 5.2 million school-children received a dental inspection during 1979, of whom 567,000 were re-inspected. In addition, 90,000 children under five years of age were inspected. There were 2,770 surgeries available, of which 295 were in mobile clinics. 1.2 million school-children received treatment. The statistics in the last four years have shown that although more children have been examined, less treatment has been required. There is increasing evidence of a fall in the incidence of dental caries in children. According to one Authority, Lambeth, the major trends over the past five years have been as follows:—

a. Fewer children are found at dental inspection to require treatment.
b. Fewer fillings are needed.
c. Fewer teeth need extraction.
d. Fewer general anaesthetics are required.
e. More pre-school children receive care.
f. More socially deprived children are cared for.
g. More children become 'regular' attenders.
h. More schools are inspected.
i. Fewer children receive no care.
j. The adult mentally handicapped receive care.

Adult dental health survey

The first volume reporting the second national Adult Dental Health Survey carried out in 1978 (Office of Population Censuses and Surveys 1980) showed that the dental health of adults had improved considerably since the first survey in 1968. There had been a reduction of those edentulous from 37% to 29%. The large differences in the level of total tooth loss between the Regions had diminished, but there were still considerable variations in respect of social class. 11% of professional classes were edentulous compared with 47% in unskilled social class V. However the greatest improvement was in the lowest social class groups, and this is shown in Groups IV and V where among 35-44 year olds in 1978 and 14% had lost all their teeth, compared with 34% in 1968. There had also been an improved attitude to dental health, and the results pointed to a dental environment where restorative treatment and good oral hygiene were more highly valued than before.

Dental education

The Nuffield Foundation Committee of Inquiry into Dental Education reported at the end of the year (The Nuffield Foundation, 1980). The Committee took

into account the report of the Royal Commission on the National Health Service (1979), visited all the dental schools in the United Kingdom and nine more in Europe, and received evidence from over a hundred organizations and eighty individuals. A broad view was taken of dentistry, and thirty-five principal recommendations were made. The first three related to the length of training, proposing that for the first year after graduation dentists be required to work under approved supervision before being admitted to the Dentists Register; that the introduction of this compulsory pre-registration year be used by dental schools to reduce the repetitious element at present necessary in clinical teaching; and that after registration a two-year period of vocational training be carried out under approved supervision before a dentist is permitted to become a principal in general dental practice. It was proposed that ultimately dentists giving general anaesthesia should be limited to a list of those with the requisite post-graduate education and training. The Committee also recommended that steps should be taken to revitalize the Community Dental Service by defining clearly the extent of its responsibilities, raising its status, expanding its remit and maintaining a constant evaluation of its functions and efficiency. The report is being considered by the Dental Strategy Review Group, a body which has been set up to review the development of dental health policy as noted in last year's report (page 6).

British Dental Association

The Association celebrated in July the centenary of their incorporation in 1880 under the initial presidency of Mr (later Sir) John Tomes. The occasion was marked by a Presidential Meeting in the Royal Festival Hall at which His Royal Highness the Duke of Edinburgh was invested as President of Honour 1980-81. At the Presidential Luncheon the Toast to the Association was proposed by the Rt. Hon. Patrick Jenkin, Secretary of State for Social Services. During the remainder of the day, and the following day, there were clinical and historical displays, lectures, and scientific sessions. An exhibition of typical dental surgeries of different periods from the Victorian era to the present day was on display at the Science Museum for four months.

Medicines Act

During the year, twenty-six dental medicinal products were processed by the Licensing Authority. Sixteen of these were of a nature that required assessment by the Committee on Dental and Surgical Materials, and two by the Committee on Safety of Medicines. The Committee on Dental and Surgical Materials also considered further evidence submitted by two companies in written representations, one of which was successful. For the first time a written representation concerning a dental medicinal product was made to the Medicines Commission, and this succeeded. Following consideration of several proprietary products in connection with endodontic treatment and dry sockets the Committee on Dental and Surgical Materials advised the Licensing Authority to undertake an accelerated review of these two groups of materials. A small Working Party was established by the Committee to give general guidance in the form of Notes to the companies concerned on the likely requirements needed for the full assessment of such products.

Dental materials

The British Standard Methods of Biological Assessment of Dental Materials

(British Standards Institution 1980), published in October, recommended certain test methods to enable manufacturers and others to assess dental products for biological safety. Tests for biological risks to the dental team which could be considered to be essentially of an environmental nature were not included. It is intended to include appropriate screening tests for mutagenicity and carcinogenicity in a future revision of the Standard.

The Department recognizes that there is a need for new or revised test methods concerning the physical and mechanical properties of some dental materials for inclusion in appropriate British Standard Specifications, and is funding research in this field. It is hoped that the tests produced will be incorporated in new or revised British Standards, and that they will align where possible with those in International Standards.

Preventive treatment

Evidence is accumulating which suggests that there has been an improvement in dental health over the last few years and particularly noticeable has been a reduction in the incidence of dental caries in young children. The change in pace seems to have been coincident with the use of fluoridated tooth-paste, but it is difficult to estimate the extent to which this has been more effective than other factors. The areas with a fluoridated water-supply have continued to show a very much lower incidence of dental disease than those deprived of the benefits of fluoridation, where many children have suffered unnecessarily, and often with results affecting their health and happiness for the rest of their lives. The lower socio-economic groups in non-fluoridated areas suffer the most, since they are less likely to have the benefit of fluoridated tooth-paste or regular dental care.

Criticism of the general dental service for not providing preventive dentistry does less than justice to both the dental profession and the integrated National Health Service. The community service and the hospital service may provide any form of preventive dental treatment required, and in these specialized services appropriate treatment can be given to patients most seriously in need of protection. For these patients dental treatment often needs to be co-ordinated with treatment for other conditions. While individual cases requiring exceptional care can readily be clinically recognized, it would be difficult to define the categories of patients who should be eligible if specifically preventive items such as fissure sealants and topical fluoride application were to be introduced into the general dental services. Although the limited time contract basis of the general dental services requires that there should be some condition presented requiring treatment to justify treatment being given, nevertheless many in the profession have found it possible within these terms to provide effective preventive treatment.

Conservation of teeth prevents their loss, and consequently results in less likelihood of deterioration of the periodontal state or necessity for dentures. Regular scaling and treatment of early periodontal conditions prevents more serious periodontal disease. Orthodontic treatment prevents conditions which could arise from traumatic occlusion, over-crowding of the dentition, or other functional disability. Items in the scale of fees concerned with oral hygiene advice and the treatment of periodontal disease have been extended and made more readily available in recent years, and form a rapidly increasing proportion of the total treatment provided. Advice is included in both examination and periodontal treatment items, and there is seldom an oral state so perfect that no advice could be justified. Careful oral hygiene instruction to all patients, but

particularly children and parents, results in the elimination of incipient disease and prevents its recurrence, by instilling the habit of self-care. Both patients and dentists are rewarded by further disease either being prevented, or else decreased in extent and speed of onset so that examination and any treatment needed are easier, less traumatic, and less time-consuming.

In 1980 about 850 dental hygienists were estimated to be taking part in the general dental services, over twice as many as five years ago. Their particular expertise in oral hygiene and prophylaxis is a valuable asset to dental manpower.

Research into immunization against dental decay has achieved successful results at the tooth surface in animals. Developments indicated that application of the technique to humans might soon be possible, which could radically change both prevention and manpower requirement.

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9

MENTAL HEALTH

The Secretary of State speaking at the MIND conference in October 1980 said "We have long since left behind us the old days when the mentally ill were out of sight and out of mind and in many cases condemned to a perpetual isolated institutionalized existence. Today there is growing public interest from Parliament, from the Press, from the pressure groups and from the consumer movement. This is something wholly to be applauded since interest and concern must precede understanding".

The Mental Health field is far from static. The understanding of mental disorder is growing, so are the services which are developing to help people with these problems and the role of the specialist within these services.

Providing a mental health service means more than treating the mentally disordered. It embraces the promotion of mental health and the prevention of mental disorder and consequently other services such as housing, employment and education all have a role to play.

The pattern of services for the treatment of mental disorder is changing with a greater emphasis on out-patient and day patient care, and self-help groups. There is a need for psychiatric services to be developed more closely with primary health care, social services and voluntary organizations which care for a great many persons with both minor and major psychological problems.

Finally, if services are to develop in this way there is a need for skilled planning, co-ordination and liaison, which are essential to the provision of services in a period of change.

Services for the mentally ill

Hospital services

A number of publications of significant importance to mental health services were published in 1980. In January the Report of the Working Group on *Organizational and Management Problems of Mental Illness Hospitals (the Nodder Report)* was published and commended to health authorities under a Health Notice (Department of Health and Social Security, 1980a). The working Group had been set up in 1977 to review problems in relation to developing community mental health and social services, and health services in general, following a number of enquiries in psychiatric and mental handicap hospitals which had indicated defects in professional and mangement practices. The Working Group comprised professional workers in the field of mental illness in the NHS and the social services with some members from the Department and representatives from COHSE and MIND. Since there were considered to be common problems affecting psychiatric hospitals and mental handicap hospitals an observer from the National Development Group was also a member. The report's recommendations covered the different aspects of management of large mental illness hospitals with a separate chapter about some implications for hospitals for the mentally handicapped. Most of its recommendations sought to generalize from current practice and there was detailed consideration of management at different levels, the monitoring of services and the role of professional workers,

both in their individual and joint practice. A major recommendation was that each health district should have a Psychiatric Services' Management Team (PSMT), to manage all the district psychiatric services or, where there were few or none, its first task would be to plan their introduction and development. The report recommended that this team should have a budget allocated to it for the provision of district psychiatric services.

The report identified specific bodies for the implementation of its recommendations. Among these it was suggested that DHSS should produce further guidance on minimum standards and qualitative standards of care and that RHAs should set guidelines in a form of targets for the development of district services for mental illness. Account should be taken of the increasing numbers of elderly mentally ill patients, and each Area Health Authority (AHA) should plan its services on Regional guidelines by means of a Joint Care Planning Team (JCPT) with representatives from social services departments. A PSMT should be set up in each district. The report recommended that the District Management Team (DMT) should decide each year the requirements of the mental illness service and provide each PSMT with its own budget. Social services departments of local authorities should take part in drawing up plans for mental illness services for the area in the setting of the JCPT. Tasks were also specified for the PSMT and the hospital management team.

The covering Health Notice drew the Working Group's report to the attention of health authorities asking them to make copies available to managers and staff of mental illness hospitals and mental handicap hospitals, to send copies to the Directors of Social Services and to invite discussion of relevant parts of it with them.

In July the Health Circular on Structure and Management of the Health Service (Department of Health and Social Security, 1980b) was published. This provides guidance to the RHAs and the District Authorities on the Implementation of the Restructuring Proposals for the NHS which were discussed in *Patients First* (Department of Health and Social Security and Welsh Office, 1979). In general the recommendations of the Nodder Report were well received and consideration is now being given to how those recommendations can be fitted in to the advice in the circular on Structure and Management of the New Service (Department of Health and Social Security, 1980b). The Circular calls for services to be arranged into units of management below district level and indicates that a psychiatric unit of management within a district might include a mental illness hospital, a psychiatric department in a general hospital and the range of psychiatric community services in that district. The association of these different parts of the service into a functional whole with its own management structure as described in the circular would produce an arrangement on the lines of the PSMT recommended in the Nodder Report. The circular also recommends the establishment of unit budgets which is in line with the recommendation in the Nodder Report. It is too early to say how broadly the Nodder recommendations as a whole can be related to those of the circular but in the meantime the Department is considering the wider implications for the psychiatric services of restructuring.

In May a consultation paper on the future Pattern of Hospital Provision in England (Department of Health and Social Security, 1980c) was issued and this was followed by conferences in Birmingham and London. This paper reflects the Government's concern about the continuing development of large hospitals, opens for wider consideration the argument on the advantages and

disadvantages of big district general hospitals and proposes that as a general rule no more than about 600 beds should be provided as a main hospital. This has implications for the development of psychiatric services. Since 1962 the policy has been that psychiatric departments should be developed in general hospitals at a level of provision that would enable each department, supplemented by local long-stay wards for elderly psychiatric patients, and other complementary health and social services facilities for day care to provide a comprehensive psychiatric service to the catchment area it serves. It was envisaged that as such provision developed the services provided by the existing psychiatric hospitals would diminish and ultimately they would close. The hospital consultation paper now recognizes that some districts have a well sited mental illness hospital which has acceptable physical standards and provides an effective psychiatric service, and that this will provide the district's psychiatric needs for many years in the foreseeable future. Further, the prospect of smaller district general hospitals in some other districts has suggested alternative patterns of providing local psychiatric services. For instance a DGH psychiatric unit may be smaller than was previously considered to be an optimal size and other psychiatric beds may be provided elsewhere in the district either as a second small unit in another DGH or in another hospital. Indeed it may be that a psychiatric department with fewer beds than the current guidelines suggest, together with good community facilities, can meet local psychiatric needs. There is now a good deal of evidence that it is possible to provide a comprehensive service with fewer than 0.5 beds/1,000 but this does largely depend upon the availability of active community services and adequate provision for the elderly with mental disorder. A further possibility is to base the district psychiatric service on an existing small local hospital ensuring that close links with the DGH are established. The planning options for developing district psychiatric services are now wider with prospects for the establishment of varying patterns of provision in different parts of the country.

Day care

It has for some time been a goal of government policy that the main services needed by mentally ill people should be available locally in each district. Of all the services described in the 1975 White Paper *Better Services for the Mentally Ill* (Department of Health and Social Security, 1975) day care is perhaps the least developed.

In November 1979, the Parliamentary Under Secretary of State (HPSS) drew attention to one possible reason for this when replying to a Parliamentary Question. He suggested that disappointing progress in day care may be due to lack of clarity about such provision for the mentally ill. He proposed that the Department should review current policies and consider how best to get ideas and policies across to those at local level providing and planning services for the mentally ill.

The Department issued a discussion paper on Day Care for the Mentally Ill in March 1980 (Department of Health and Social Security, 1980d) inviting comments on the main issues set out in the paper. At the same time help from professional persons with experience in this field was enlisted in reviewing policy and considering the responses to the discussion paper; they took part in a number of visits to day centres and day hospitals for the mentally ill. A meeting on "What Direction for Day Services" was organized by MIND and held in London on 21 and 22 May 1980. This meeting was addressed by the

Parliamentary Under Secretary of State (HPSS) and the DHSS discussion paper circulated. The discussion paper was favourably received and the response is being currently reviewed along with the information obtained from the visits.

It is proposed that the ideas, innovations and comments learnt from this review should be made available to individuals and planning authorities.

Behaviour modification, report of a Joint Working Party

The Working Party, chaired by Professor O L Zangwill was set up by the Royal Colleges of Psychiatry and Nursing and the British Psychological Society. It was established on the initiative of Sir Keith Joseph following a recommendation of the report of a professional investigation into Medical and Nursing Practices on certain wards in Napsbury Hospital near St Albans.

Their report was published in 1980 (Royal College of Psychiatrists, Royal College of Nursing and British Psychological Society, 1980). In a foreword the Secretary of State for Social Services, Mr Patrick Jenkin, expressed the hope that the Report would be studied by all those involved in behaviour modification programmes.

In the introduction to the Report the Working Party discussed the definition of the term "behaviour modification" and made the distinction between its application to individual patients and its application in the treatment of groups of mentally handicapped or chronic psychotic patients. It was with the latter that the Working Party was principally concerned.

In considering the ethical problems involved in the practice of behaviour modification the Working Party identified and discussed six areas of concern:

(a) Information and access — to all concerned with the practice

(b) Consent to treatment

(c) Conduct

(d) Responsibility

(e) Review bodies

(f) Training

The Working Party made a number of recommendations on guidelines for the practice of behaviour modification:

(a) Full information should be available on aims, methods and form of behaviour modification. Relatives should be kept fully informed, especially when the patient is unable to give consent.

(b) Consent should be obtained from patient, relatives or third party advocate where appropriate; written consent for certain procedures associated with behaviour modification might be considered, to ensure full understanding and agreement.

(c) Basic rights and privileges of patients must be preserved.

(d) Restrictions on patients as part of the programme should be explained to relatives and patients. Where restrictions are used as part of treatment they should be strictly temporary and subject to consent, monitoring and supervision.

(e) The use of aversion treatment in behaviour modification poses an ethical dilemma. The mild forms of "negative reinforcement" used sparingly, may be acceptable and anything more than this should only be used as a last resort

when other techniques have failed and should be subject to full interdisciplinary discussion and consent in writing.

(f) The practice of behaviour modification is made possible largely by acceptance of the multi-disciplinary therapeutic team. The Working Party drew the attention of the Department of Health and Social Security to the considerable debate regarding issues of responsibility in the implementation of behaviour modification programmes.

(g) The Working Party originally recommended that DHSS be advised to establish Behaviour Modification Review Committees at RHA level. This proposal was withdrawn because it was unacceptable to two of the three parent bodies — nonetheless, the Working Party recommended that review arrangements for programmes should continue to be debated.

(h) The Working Party recommended training, workshops and courses of instruction for those practising behaviour modification therapy. The multidisciplinary character of behaviour modification should be taken account of in training.

(i) Research and evaluation of programmes should be encouraged and fostered.

Forensic psychiatry

Applications for the admission of patients to Special Hospitals fell slightly although the actual number admitted remained constant. The number of patients transferred to NHS hospitals and those discharged home or to a hostel remained about the same. It is regrettable that over 200 patients in Special Hospitals recommended for transfer were still awaiting places in NHS hospitals at the end of the year.

Park Lane Special Hospital at Maghull, near Liverpool, became operational during the year under review with accommodation for 100 patients in single rooms with 'ensuite' facilities. A number of patients were admitted directly and 12 patients were transferred from Broadmoor.

The Rampton Management Review Team, set up in July 1979 by the Secretary of State, under the chairmanship of Sir John Boynton, published its Report in November 1980 (Department of Health and Social Security, 1980e). The Team's terms of reference were to review the organization, management and functioning of Rampton Hospital, and to recommend changes.

The Report praised the dedication and hard work of most staff at the hospital and many of the facilities, but was critical of the way the hospital was managed and called for improvements in the treatment and care of the patients.

The most important of its 205 recommendations was that a Rampton Hospital Review Board, consisting of six to seven members, should be appointed by the Secretary of State for a period of three years, with responsibility for ensuring that the proposals in the Report be implemented. Local responsibility for the day-to-day running of Rampton should be vested primarily in a Hospital Management Team consisting of the Medical Director, the Chief Nursing Officer and the Administrator.

The Secretary of State accepted the Review Team's analysis and the main thrust of the proposed reforms.

Progress continued in implementing Circular HSC(1S)61 (Department of Health and Social Security, 1974) on security in NHS hospitals during the year.

The first permanent Regional Secure Unit opened in November, and construction on two others has begun. There remains only one Regional Health Authority which has not made a formal submission to the Department, although consultations have taken place and there is general support for its proposals.

Child and adolescent psychiatry

An Observation and Assessment Working Party was established in 1978. Its terms of reference were:

> To consider observation and assessment services for children and young persons referred to local authority social services departments; to clarify the role of observation and assessment centres; to consider the promotion of non-residential observation and assessment, to consider what improvements in present assessment practice might be helpful or necessary and to make recommendations.

The Working Party consisted of members of different disciplines in the field, and officers of DHSS, Welsh Office and DES, under the chairmanship of Professor Norman Tutt. Oral and written evidence was received. This included contributions from the relevant medical and nursing colleges or organizations, British Psychological Association, British Association of Social Workers, Association of Directors of Social Services, representatives from Social Services Departments and Voluntary Organizations, as well as many others involved in the assessment of children and young people.

The final report was submitted to DHSS in November 1980. Although the report is as yet unpublished, the conclusions reached indicate that the overwhelming need for a transfer of emphasis to non-residential assessment is professionally desirable in the interests of the child, family and society; and likely in the longer term to lead to overall savings.

Youth Treatment Centres

Departmental officers and management representatives of St Charles Youth Treatment Centre (YTC) at Brentwood, reviewed the Centre's methods of working in depth during the year and reported to the Department's Headquarters Youth Treatment Centre Committee.

The vacancy at St Charles YTC for a shared post for a consultant child and adolescent psychiatrist and honorary senior lecturer at the London Hospital was filled following a joint assessment by the N E Thames RHA, London University and DHSS.

Glenthorne YTC, Birmingham opened its fourth and final unit towards the end of the year, increasing the number of places available from 34 to 46. Recruitment of group worker staff continued.

Services for the mentally handicapped

A review of mental handicap services in England, undertaken by a team consisting of DHSS officials and Professor Peter Mittler, with observers from other departments concerned, was completed and their report *Mental Handicap Progress, Problems and Priorities,* was published in December (Department of Health and Social Security, 1980f). The Report describes the progress made by the authorities towards targets set ten years ago in the White Paper *Better Services for the Mentally Handicapped* (Department of Health and Social

Security and Welsh Office, 1971), and considers the need for modification of policy and objectives, noting areas in which further study is needed. The study shows that there is still wide geographic variation in NHS provision with 90% of all mental handicap beds provided by one-third of health districts. Encouragingly, the report shows that despite the relatively slow growth in residential provision outside hospitals, the number of children in mental handicap hospitals has fallen rapidly and that the White Paper target for NHS children's beds is now too high. The Report suggests, on the evidence of Mental Handicap registers, that local circumstances, such as migration in or out of an area, will affect local prevalence, and that planners in each authority will therefore have to assess their own needs. For profoundly handicapped people, and those with additional disabilities or behaviour disorder, further study is needed to determine the nature of the day and residential services most appropriate to their needs.

Progress, Problems and Priorities reaffirms the White Paper policy that services should be based on a pattern of local provision. In a speech to a conference on the day of publication, the Secretary of State, in referring to children, stated that large hospitals do not provide a favourable environment in which a mentally handicapped child can develop fully. To encourage initiatives for local projects to help discharge children from mental handicap hospitals he was offering up to £1 million, spread over four years, to match on a £1 for £1 basis funds raised by voluntary bodies for such projects.

The National Development Group for the Mentally Handicapped was wound up in April 1980 on completion of its final exercise on accreditation. Its publication *Improving the Quality of Services for Mentally Handicapped People, A Checklist of Standards* was published in December (National Development Group for the Mentally Handicapped, 1980). The 'Checklist' is intended to provide direct care staff, service providers and planners with a means of appraising the services they provide. It is a working document outlining the components of the services needed to meet the requirements of all mentally handicapped people, against which field and voluntary bodies can measure their own services and aim to move towards improving them at the local level.

The Government has accepted in principle the model of care recommended in the Report of the Committee on Mental Handicap Nursing and Care (Department of Health and Social Security, Scottish Home and Health Department and Welsh Office, 1979), but considers that the recommended time scale for the change to a service based on small local units is unrealistic and that further work needs to be done to determine the type of provision needed for the most severely handicapped people. On staff training the Committee recommended that residential care staff in the health and social services should receive a common training, but this received little support on consultation, from other than social services bodies, and was rejected in the Government's response to the Report in July. Instead a General Nursing Council/Central Council for Education and Training in Social Work Working Group has been set up to look urgently at ways of introducing common elements into the future training of nurses and social workers.

The Development Team for the Mentally Handicapped — Second Report 1978-1979 was published in 1980 (Department of Health and Social Security, 1980g). This report shows that the number of children in mental handicap hospitals is continuing to fall, that there are still significant numbers of adult residents in mental handicap hospitals who do not have any specific special health needs and

that the number of residents over 65 years of age continues to rise. Only two of the six regions visited during the period of the report had all their consultant posts filled, and shortages of therapists and psychologists persisted.

A Health Notice issued in September (Department of Health and Social Security, 1980h) included Interim Building Design Guidance for Health Service Residential Accommodation for the Mentally Handicapped. In accord with the 1971 White Paper *Better Services for the Mentally Handicapped* (Department of Health and Social Security and Welsh Office, 1971) it gives advice to the authorities to plan and develop new accommodation for the mentally handicapped in units of domestic scale to serve defined districts. With the Secretary of State's advice to authorities to 'think small' when planning new services, this interim guidance details the basic principles and accommodation for the design and development of residential units, of 24 beds or less in new or adapted premises. The guidance allows considerable scope for local experiment and innovation.

Services for drug misusers

Drug misuse presents a growing problem with an increase in notified narcotic addicts, increased seizures of illicit drugs and growing availability of heroin on the black market. The number of addicts known to be receiving narcotic drugs from medical practitioners in treatment of their addiction at December 1980 was 2,849, which was an increase of 7% over the 2,669 known at December 1979. This is only one aspect of the problem; other forms of drug misuse are increasing with multiple drug use, and misuse of a wide range of prescribed drugs particularly dipipanone hydrochloride (Diconal), barbiturates and other psychotropic drugs. The true prevalance of the abuse of non-opiate drugs is not known.

Last year's report (page 98) recorded that a decision had been taken in principle to control certain barbiturates under the Misuse of Drugs Act 1971. However, the original proposals for the control of five specific named substances would have required substantial additional resources. An alternative form proposed by the Advisory Council on the Misuse of Drugs under a generic formula of all 5-5 disubstituted barbituric acids, would have required fewer resources to operate, but would have included phenobarbitone, which, it has been argued, is not abused, but is a recognized and much-used treatment for epilepsy. Discussions are continuing on ways of overcoming the various objections that have been raised.

The increasing problem of drug abuse and its changing nature are presenting problems in the treatment and rehabilitation services. The Treatment and Rehabilitation Working Group of the Advisory Council on the Misuse of Drugs continued its investigation into treatment and rehabilitation facilities for drug users. Members undertook visits to Drug Dependence Units, and evidence was also received from professional and voluntary workers in the field.

In March 1980 a conference was held under the auspices of the Department's Homelessness and Addictions Research Liaison Group on research into careers, treatment and rehabilitation of drug misusers. The conference was attended by researchers, representatives from Government Departments, other statutory bodies and relevant professional organizations, including members of the Advisory Council on the Misuse of Drugs. The conference provided a forum for

discussion of current research issues and a basis for developing a research strategy and defining priorities. In addition there was general recognition of the complexity and differences between problems in London and the provinces and between different localities; and of the complexities of responsibilities and relationships between the various national and local agencies working in the field.

Alcohol abuse

On 7 June 1980 the Secretary of State for Social Services spoke in Cardiff at the opening of the XXVIth Institute on the Prevention and Treatment of Alcoholism. The Secretary of State drew attention to the evidence of increasing alcohol-related harm with the number of people with serious drink problems in the United Kingdom being possibly as high as 740,000, an increase of 40% over 10 years. He spoke of the need for people to be better informed so that problem drinkers can be identified sooner and services for them made more effective. He called for a major drive among employers and trade unions to develop more effective policies to help with detection, early treatment and counselling.

The Report of a National Survey on Drinking Habits commissioned by the Department of Health and Social Security and carried out by the Office of Population, Censuses and Surveys in 1978, was published in October (Office of Population Censuses and Surveys, 1980). 6% of the men and 1% of the women reported weekly alcohol consumptions higher than was considered safe for health (equivalent to either 4 pints of beer, 8 single measures of spirits or 8 glasses of wine for men daily; and 3 pints of beer, 6 single measures of spirits or 6 glasses of wine for women daily). Groups with a high average consumption included young people (18-24 years), single or divorced/separated people (35-54 years), unemployed men and working women with no children. People tended to describe themselves as lighter drinkers than an assessment based on the previous week's consumption suggested. Most heavy drinkers described themselves as only moderate drinkers.

Both the BMA (British Medical Association, 1980) and the Faculty of Community Medicine (Faculty of Community Medicine, 1980) published statements on the use of alcohol which drew attention to the upper safe levels of daily consumption to avoid harm. This reinforced the useful review and guidance given by the Royal College of Psychiatrists in their publication *Alcohol and Alcoholism* (Royal College of Psychiatrists, 1979).

The British Association of Psychopharmacology published a report of their Conference on *The Psychopharmacology of Alcohol* (British Association for Psychopharmacology, 1980) which demonstrated the many medical implications of unwise alcohol consumption. The report of an international symposium on *Addiction: Biochemical Aspects of Dependence and Brain Damage* which was held in Oxford in 1979 was also published in 1980. (Richter, 1980). Both reports draw the attention of the medical profession to important areas of medical concern not previously well recognized.

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10

SERVICES FOR THE PHYSICALLY DISABLED AND THE ELDERLY

The physically handicapped

As noted in this report for 1979 (page 100) the United Kingdom was one of the co-sponsors of the United Nations' motion which declared 1981 the International Year of Disabled People (IYDP) and the report described the Department's arrangements for co-ordinating the public sector response and for funding the secretariat of the Voluntary Organizations Committee which is to stimulate and co-ordinate the voluntary sector response at both a national and local level. A main objective of IYDP will be to stress the theme of promoting the full participation of disabled people in society. Realization of this aim depends on the development of those statutory and voluntary services which are directed towards enabling disabled people to achieve maximum independence and to have their health and social needs met in the community rather than in segrated residential institutions. An example of the way in which the Department's policies for these services are proving to be effective can be seen by an examination of the statistical returns from Units for the younger disabled. In the eight years between 1972 and 1979 the average length of stay in these units has been reduced from 331 days in 1972 to 137 in 1979, reflecting the change in their function from that of long stay accommodation to one of assessment, active rehabilitation and short term holiday relief — a change which has allowed these units to become a more flexible and integrated part of the total pattern of services for disabled people.

Because of the participation of disabled people themselves the voluntary sector is particularly well placed to identify and to respond to changing need. The use of grants under Section 64 of the Health Services and Public Health Act (1964) particularly to encourage new initiatives, provides a means of helping to stimulate the voluntary activity which can so effectively complement the statutory services. Grants under this Act totalling £1,014,203 were made to voluntary bodies operating in the field of physical disablement in 1979-80, an increase of 20% over the preceeding year; five bodies were assisted for the first time and grants were increased for a further twenty two.

In preparation for the International Year, letters were sent to the Medical Royal Colleges and Faculties, and the Council for Postgraduate Medical Education asking them, when drawing up programmes for scientific meetings in 1980, to consider ways in which professional awareness of the prevention and treatment of disability could be heightened. The replies reflected an enthusiastic response.

Services for the hearing impaired

In 1980 the standard range of hearing aids was extended by the introduction of a high powered post-aural aid and a very high powered body-worn aid. The introduction of these aids was preceded by a series of seminars for audiological technicians and scientists conducted by officers of the Department's Scientific and Technical Branch. Nine hearing therapists completed training at the City Literary Institute and there were fourteen therapists in post at the end of 1980. A further ten students, nominated by Regional Health Authorities, commenced training in 1980 thus ensuring the steady development of this rehabilitative service.

At its final meeting on 3 October 1980 the Advisory Committee on Services for Hearing Impaired People received and endorsed the report of its Children's Sub-Committee; this report will be issued in 1981. The Advisory Committee under the chairmanship of Mr John Ballantyne has given valuable service to the Department during the seven years since its formation and the reports it has produced have contributed significantly to the development of services for the hearing impaired of all ages. The Department is grateful to the Committee and its Chairman for the comprehensive programme of work completed, and the generous amount of time devoted to it.

Spinal units

This report for 1979 described the plan to rebuild the National Spinal Injuries Centre at Stoke Mandeville Hospital, Aylesbury with monies raised by voluntary donation (page 100). The Minister of State (Health) launched the appeal in January 1980 and it provided an impressive example of the willingness of the public and private firms, to subscribe in cash or kind to imaginatively presented schemes. The appeal has been directed by Jimmy Savile OBE. Members of the Oxford RHA and the Department who have provided him with administrative and technical support have recognized that the success of the appeal has been largely due to the enthusiasm of Jimmy Savile. Although the financial target was not reached by the end of the year, work on site had already commenced.

The project teams for the specially designed units at the Royal National Orthopaedic Hospital, Stanmore (24 beds) and Odstock Hospital, Salisbury (48 beds) made considerable progress. A temporary unit of 16 beds will be opening at Stanmore in mid-1981 prior to the completion of the main unit. Work started on the site at Odstock in July 1980 and the unit is expected to open in 1983.

The Department's officers were closely involved with the Spinal Injuries Association in the preparation of a booklet (Spinal Injuries Assocation, 1980) on the treatment and care of persons before they reach the special units. The publication of this booklet, the first of a series on *People with Spinal Injuries* was launched by the Secretary of State in June 1980, and it has been widely distributed throughout the NHS.

Although for some time the service has been designated the Spinal Injury Service it has become increasingly apparent that the skills in treatment and management of patients who have suffered lesions of the spinal cord as a result of trauma are equally applicable to a number of people with lesions of the cord resulting from disease. This development has been encouraged by the Department and it is hoped it will receive added impetus from the inclusion of neurophysiological laboratories in the new Units at Odstock and Stanmore.

General aids and equipment for the disabled

The Department continues to support two aids information services, the Disabled Living Foundation's Information Service and "Equipment for the Disabled". 1980 saw the completion of a study of the use of these services by 'Social and Community Planning Research', an independent institution for social research. The results indicated that both information sources were widely used by staff in health and social services but suggested that staff in community health services lacked access to them. A report of the study will be published in 1981.

In November 1980 the Department published a revised version of the booklet, *Aids for the Disabled* (Department of Health and Social Security and Welsh Office, 1980) which described the arrangements for providing information about the aids which are available, and the ways in which aids are provided by statutory authorities. The booklet also touches on the part played by voluntary bodies and other organizations. It has been well received and 28,000 copies were issued in the first four months.

The Aids Assessment Programme has continued its work. The reports on four projects were made available for distribution to health and social services and voluntary bodies; these reports which are among those listed in the Department's Quarterly Bulletins of Publications (Department of Health and Social Security, 1981) are:

Assessment of Self Rise Chairs and Cushions — Summary Report, Norfolk and Norwich Hospital.

Easy Chairs for the Arthritic — Royal National Hospital for Rheumatic Diseases, Bath.

An Assessment of Long Handled Reachers at Middlesbrough General Hospital — Summary Report.

A Comparative Assessment of 3 types of Moulded Body Support — Summary Report, Derbyshire Royal Infirmary.

Further studies are in progress in six centres. They are concerned with: chairs and tables for disabled children at Norfolk and Norwich Hospital; garments and pads for urinary incontinence (adults) at St Pancras Hospital, London NW1; garments and pads for urinary incontinence (children) in Harrow; wheelchair cushions at the Westminster Hospital; office furniture, mainly chairs, suitable for arthritics at the Royal National Hospital for Rheumatic Diseases, Bath; and selected food preparation aids at the London Hospital.

The approach of the International Year of Disabled People seemed the right time to make a further effort to increase professional awareness of the importance of aids to daily living for the disabled and the elderly and to disseminate knowledge about information sources. The Department made available a small static display which could be used in postgraduate medical centres. This project was fully supported by the Council for Postgraduate Medical Education and the exhibits were ready for the spring of the International Year (1981).

The state of development of communication aids for those who are handicapped by severe problems is volatile. It has gained a new impetus with the growth of micro-electronic techniques, and a wide range of approaches to the design of speech substitute aids is being demonstrated by commercial firms and academic departments.

The breadth of development is such that it is unlikely that any guidelines for their use will be established in the near future, but the areas of work of particular importance that have so far been identified are, firstly, studies of prevalence of speech impairment and handicap and secondly, evaluative studies of equipment which is already available. The Department is currently considering how it can best assist in these objectives. It is contributing to the international initiative proposed by the International Commission on Technical Aids, Housing and Transportation to achieve collaboration on research studies, evaluation and information exchange.

Rehabilitation

During 1980 the manpower requirement of the remedial professions was examined in some detail.

A paper reviewing the arrangements for undergraduate and postgraduate training of medical students and doctors in rehabilitation was prepared for the committee of the Council of Europe which is concerned with the disabled.

There is only one chair in Rehabilitation Medicine in England and this was vacant during most of 1980. Only six medical schools give specific teaching in rehabilitation, most others indicated that rehabilitation was included as an integral part of the syllabus for medical and surgical specialties.

A national analysis of occupational therapy manpower was carried out by the Department in collaboration with the College of Occupational Therapists and the Council for the Professions Supplementary to Medicine. The resulting paper (Department of Health and Social Security, 1980) sets out available information about occupational therapists from 1970, and attempts to forecast the likely position during 1980-83. Increased student training is estimated to be sufficient for an annual increase in NHS staffing levels of 4% to 5%. Local differences in the pattern of resources and staff are however bound to continue and to require different solutions. Similar analyses are in preparation in respect of chiropody and physiotherapy.

The Central Management Services of the DHSS also undertook a study in 10 selected Health Districts to provide information about the current deployment of staff in the remedial professions — physiotherapists, occupational therapists and remedial gymnasts and the make up of their workload. It is hoped to use information from the study to determine desirable staffing levels in the three professions. The Report, which is listed in the Department's Quarterly Bulletin of Publications (Department of Health and Social Security, 1981) is available on request.

The Department together with the Health Departments in Scotland and Northern Ireland has provided funds for the establishment of an educational development unit for the Remedial Professions situated at the Kings Fund Centre, London. The Unit was planned in collaboration with the College of Occupational Therapists, the Chartered Society of Physiotherapists and the Society of Remedial Gymnasts with the aim of furthering the development of post registration training.

Care of the elderly

The impact of the elderly on acute hospital services

The importance of the specialty of geriatric medicine to the treatment, rehabilitation and subsequent maintenance in the community of very old people who suffer from an association of medical, surgical and social problems has rightly been emphasized in the professional literature and offical publications. But the impact of an ageing population on the specialties traditionally described as acute and the particular contribution of surgical specialties to the relief of pain, the quality of life and the independence of the elderly, has had less general mention.

In England the general acute sector treats around 75% of hospital in-patients aged 65 and over, and over 60% of those aged 75 plus. In 1977 the former group occupied some 39% of surgical, and 44% of medical beds; corresponding figures

for those aged 75 and over were 19% and 20%. The specialties chiefly involved are general medicine, traumatic and orthopaedic surgery, general surgery, ophthalmology, and urology. Table 10.1 shows for these specialties and radiotherapy, the proportion of discharges and deaths and beds used by the various age groups. The heavy demand made by patients above 65 years is apparent.

Table 10.1 Percentage of beds used and hospital discharges in certain specialities by age groups, England and Wales, 1977.

Age Group	Traumatic & orthopaedic surgery		General medicine		General surgery		Ophthalmology		Radiotherapy		Urology	
	Beds used	Dis-charges	Beds used	Dis-charges	Beds used	Dis-charges	Beds used	Dis-charges	Beds used	Dis-charges	Beds used	Dis-charges
0-4 yrs	2.3%	4.4%	0.3%	0.5%	2.1%	4.0%	3.6%	9.2%	0.3%	0.2%	1.0%	1.6%
5-14 yrs	8.2%	13.5%	0.5%	1.1%	5.2%	10.9%	7.3%	14.4%	1.5%	1.2%	2.7%	4.3%
15-16 yrs	45.4%	57.8%	47.4%	60.9%	50.8%	59.1%	35.1%	35.0%	55.4%	62.5%	40.9%	47.9%
65-75 yrs	16.7%	11.4%	27.5%	22.5%	23.3%	15.5%	25.9%	20.6%	28.2%	24.6%	31.5%	28.6%
75-84 yrs	18.1%	8.9%	18.2%	12.3%	15.0%	8.6%	22.1%	16.7%	12.6%	10.0%	19.6%	14.9%
85 yrs & over	9.4%	4.0%	6.1%	2.8%	3.6%	0.9%	6.0%	4.0%	2.0%	1.5%	4.4%	2.6%

Table 10.2 Estimated discharges and deaths per 10,000 population for two specialities by age groups, England and Wales, 1971-1977.

	Age group	Discharges and deaths per 10,000 population						
		1971	1972	1973	1974	1975	1976	1977
Traumatic &	All ages	83.1	83.5	84.1	85.8	84.7	92.0	95.0
Orthopaedic	0-4 yrs	61.5	60.3	63.2	66.6	65.7	66.6	67.1
Surgery	5-14 yrs	71.9	70.5	73.2	73.7	77.1	78.8	80.7
	15-44 yrs	76.7	75.1	76.6	78.7	76.0	84.4	87.3
	45-64 yrs	80.5	81.7	80.6	81.1	74.7	83.6	85.7
	65-74 yrs	100.8	105.6	100.5	102.3	101.6	114.6	117.4
	75+	193.9	205.7	199.1	102.0	217.4	220.6	230.8
Urology	All ages	14.8	15.1	15.9	16.7	16.6	18.3	20.6
	0-4 yrs	2.9	2.9	4.8	4.2	3.4	3.9	5.4
	5-14 yrs	4.3	4.0	4.7	4.9	4.8	5.0	5.5
	15-44 yrs	8.3	8.3	8.1	8.5	7.6	8.3	9.3
	45-64 yrs	20.6	20.2	21.1	22.1	22.1	23.8	36.5
	65-74 yrs	43.3	45.2	47.2	50.3	48.7	57.2	63.9
	75+	44.6	48.5	48.9	51.6	59.1	60.6	68.4

During the next decade the overall growth in the geriatric sector will be insufficient to provide a comprehensive national service for elderly patients and large numbers will continue to be treated by the general acute medical services. These services will need to assume more widespread responsibility for the care of elderly patients from admission to discharge home. Close collaboration with physicians in geriatric medicine and rotating appointments at junior level between geriatric and general medical departments can help to develop the necessary skills. The contribution physicians in geriatric medicine can make to the early discharge of the older patient in surgical specialties has been

demonstrated in many centres in which close co-operation has developed between them and orthopaedic surgeons. The anticipated rise in the numbers of the very old in the population in the next ten to fifteen years therefore make it important for doctors in all specialties to know how to organize and co-ordinate the many services which sustain the older patient and allow earlier discharge from hospital.

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THE ARTIFICAL LIMB, VEHICLE AND APPLICANCE SERVICE

The artificial limb service

As anticipated in last year's Report the new Sheffield ALAC in the grounds of the Northern General Hospital was opened in September 1980.

Except for two Centres all full time ALACs are now situated in or adjacent to hospital grounds.

The trial of the technique for producing vacuum formed thermoplastic patella tendon bearing sockets developed by Biomechanical Research and Development Unit (BRADU) has continued successfully throughout the year and it is anticipated that production models of the new equipment will become available at three Centres in 1981.

New patients in 1980 numbered 5,599 (156 more than in 1979). 174 of these were non-amputation cases, 137 having congenital limb deficiencies or deformities.

Table 11.1 First attendances at Artificial Limb Centres during 1980

Single arm amputations	216	(208)
Single arm non-amputations	143	(115)
Single leg amputations	4,641	(4,524)
Single leg non-amputations	21	(18)
Double arm amputations	7	(4)
Double arm non-amputations	3	(5)
Double leg amputations*	548	(549)
Double leg non-amputations	4	(5)
Other multiple amputations	13	(9)
Other multiple non-amputations	3	(6)
Total	5,599	(5,443)

(figures for 1979 in parentheses)

*340 previously single leg amputees became double leg amputees during the year.

The ratio of male to female amputees was 2.14 to 1 (2.12 to 1 in 1979); in the congenital deficiency or deformity group and ratio of male to female was 1.25 to 1 (1.1 to 1 in 1979). The overall ratio of arm amputations to leg amputations was 1 to 23 (1 to 24 in 1979).

The number of arm amputees resulting from trauma increased from 133 (1 double) in 1979 to 160 (5 double) in 1980 and the number of leg amputees resulting from trauma decreased from 390 (21 double) in 1979 to 361 (15 double) in 1980. The number of arm amputees due to industrial injury was 66 (68 in 1979).

The resulting ratio of arm amputations due to trauma to leg amputations due to trauma was 1 to 2.26 (1 to 3 in 1979). The corresponding ratio of arm amputations due to disease to leg amputations due to disease was 1 to 77 (1 to 60 in 1979). Two out of every three leg amputations were performed because of peripheral vascular disease, a ratio that is unchanged from the previous two years.

Peripheral vascular disease remained the commonest cause of amputation accounting for 3,411 out of a total 5,425 (62.9%) patients referred to the Service in 1980. Diabetes mellitus (included in Table 11.2 under metabolic disease) was the cause of amputation in 1,080 cases (19.9%). Peripheral vascular disease accounted for 71% and diabetes mellitus accounted for 22% of all leg amputations in patients over the age of 60 years. Between the ages of 40–79 amputation for peripheral vascular disease was three times more common in men than in women, as was noted in previous years. Above the age of 80 years the male to female ratio remained at 1 to 1.

Malignancy accounted for limb ablation in 255 patients (260 in 1979), the ratio of male to female being 1.2 to 1 and the loss of a leg was 5.5 times more frequent from this cause than the loss of an arm.

Road traffic accidents accounted for 261 cases (4.8% of the total for the year); of these 149 had been the driver or passenger of a two wheel vehicle. The ratio of leg loss or arm loss from this cause was 6 to 1. 340 single leg amputees became double amputees during 1980 (313 in 1979). If other levels of amputation are excluded the overall percentage of above knee amputations and below knee amputations are 59% and 41% respectively. This shows only a 2% increase in the ratio of below knee procedures to above knee procedures compared with 1979. It is known that individual 'Centres of excellence' perform below knee amputations in up to 70% of cases requiring amputation as a result of peripheral vascular disease and diabetes mellitus. The now well established advantages of a below knee amputation compared with an above knee amputation are therefore still being denied to a considerable number of patients. This was referred to in last year's Report but despite the efforts of individual ALAC Medical Officers to encourage the lower procedure whenever possible the national response has remained disappointing.

The logistic trial of the simple lightweight permanent artificial limb for above knee amputees was successfully concluded and by the end of the year was available within a two week delivery period at 22 Centres.

A modified above knee modular assembly prosthesis using a preformed adjustable polypropylene socket was introduced at five Centres. In medically suitable cases this could be provided on the day of referral and thus goes a long way to answering criticism about delays in the delivery of prostheses to new amputees. The limb also has the advantage that it may be converted to a permanent definitive modular limb at a later date if required.

The provision of an immediate temporary limb utilizing a thermoplastic socket for below knee amputees continued successfully and is now available at 15 Centres.

As a result of these and other developments the majority of new amputees are being provided with a prosthesis within ten working days or less, of their first attendance at an ALAC.

The limited trial of a rotator device incorporated in the lower limb prosthesis (the function of which was described in the 1979 Report, page 107) has continued successfully throughout the year and 20 units have been prescribed. A larger trial leading to general availability is planned for next year.

The trial of the Swedish myoelectric hand continued throughout the year and a further 29 children were fitted. The trial will be completed early in 1981 when a final report will be produced. It is anticipated that this report will favour the

continuing supply of myoelectric hands. Prototypes of a larger myoelectric hand developed by the U.K. upper limb manufacturer became available at the end of 1980 and was supplied to 7 children who had outgrown the Swedish hand. It is anticipated that production models will be available in 1981.

The British body-powered mechanical hand did not become available in 1980 as envisaged but will be introduced in 1981. In the meantime only an imported artificial hand can be supplied to this prescription.

Table 11.2 Patients seen for the first time in 1980. Reason for amputation.

		Male	Female	Total
Trauma:	Industrial	127	6	133
	Home	20	21	41
	Recreation	6	3	9
	Armed forces	22	2	24
Sub-total		175	32	207
Traffic:	Pedestrian	58	21	79
	Road vehicle users	164	18	182
	Rail	17	9	26
	Other	27	4	31
	Sub-total	266	52	318
Disease:	Vascular insufficiency	2,367	1,044	3,411
	Metabolic	672	418	1,090
	Infection	52	41	93
	Malignancy	138	117	255
	Neurogenic deformity	26	25	51
	Sub-total	3,255	1,645	4,900
	Congenital malformations	76	61	137
	All other non-amputations	28	9	37
	Sub-total	104	70	174
	Totals	3,800	1,799	5,599

The appliance service

Charged under the Royal Warrant with the prescription and supply of orthoses to War Pensioners the Service is responsible for 16,991 pensioners, a decrease of 5% on the number for 1979 (17,818).

The vehicle service

The number of powered vehicles and private car allowances have continued to decrease as more patients take up the offer to change to the Mobility Allowance.

It is now considered that the record of the number of chairs in use in 1978 and 1979 was inflated due to some inaccuracies in the recording of chairs withdrawn from patients. However if the figures for 1980 are compared with those for 1977 they show a 27% increase in wheelchairs on issue and a 17% increase in powered chairs over the three years.

Table 11.3 Analysis of vehicle and chairs in use at 31 December 1980.

(Figures for 1979 in parentheses)		
(a) Powered vehicles and private car allowance		
Motor cars	7,822	(8,622)
Motor propelled three wheelers	10,998	(12,232)
Electrically propelled three wheelers	311	(388)
Private car allowances	2,317	(2,826)
Total	21,448	(24,068)
(b) Non-powered invalid chairs		
Wheelchairs and spinal carriages	290,594	(300,411)
Pedal and hand tricycles	3,026	(4,815)
Total	293,620	(305,226)
(c) Powered invalid chairs		
Indoor electric chairs	7,810	(8,344)
Outdoor electric chairs	7,824	(9,282)
Total	15,634	(17,626)
Grand total	330,702	(346,920)

Table 11.4 Patients using the services, 1980.

(Figures for 1979 in parentheses)		
Artificial Limb Service*	65,759	(64,020)
Vehicle Service**	279,184	(270,765)
Appliance Service	16,991	(17,818)

*Upper limb amputees account for 12,729

**Figures in Table 11.4 refer to patients whereas figures in Table 11.3 refer to numbers of vehicles on issue (one patient may have a motor vehicle or PCA, a powered chair and one or more wheelchairs).

N.B. One patient may well receive care from two or all three services.

Biomechanical research and development unit (BRADU)

The clincial trial of thermoplastic patella tendon bearing sockets made on the new BRADU vacuum forming machine and fitted to a modular limb structure is nearing completion. Acceptance of the socket type has been total and mechanical performance very satisfactory. The delivery of more machines is expected early in 1981 and they will be installed in some of the provincial Artificial Limb and Applicance Centres. Other methods of producing prostheses from thermoplastics continue to be investigated in detail.

The Bouncy Knee device mentioned in the 1979 Report (page 108) has shown sufficient benefit to the amputee on its very limited exposure to encourage a 10 patient trial, which will start in 1981.

The work on shape replication has continued with the logging of limb shapes from volunteer non-amputee subjects.

The trial of the Valgus-Varus Knee Brace, now known as the TVS (Telescopic Valgus/Varus Support), has been completed. The Scientific and Technical Branch of the Department are now independently assessing the brace prior to acceptance for prescription.

Assessment of the usefulness of the Pedobarograph as a means of biofeedback in the balance training of stroke patients and amputees is being carried out in conjunction with Queen Mary's Hospital, Roehampton.

On 1 October BRADU was transferred from the Department of Health and Social Security to University College, London (UCL). It is now an integral part of UCL's Department of Mechanical Engineering and in future will be known as the Bioengineering Centre. The excellent co-operation that previously existed between BRADU and the Limb Fitting Service at Roehampton will continue under the new management although there will be no contribution from the Bioengineering Centre in future Annual Reports.

MEDICAL MANPOWER AND POSTGRADUATE MEDICAL EDUCATION

Contractual matters

The implementation of the changes to the consultant contract announced in PM(79)11 (Department of Health and Social Security, 1979a) progressed smoothly during 1980. Discussions were held with the profession concerning the level at which consultant contracts are to be held in the restructured NHS. Agreement was reached with the profession to a change in the title of the medical assistant and assistant dental surgeon grades to "associate specialist". At the same time it was agreed that there would be the option of a maximum part-time contract in this grade. These changes will be introduced during 1981. Agreements were also reached on charges for residence and mileage payments.

Doctors in general practice

The numbers of doctors entering NHS general practice for the first time as principals rose slightly from 1,222 in 1979 to 1,276 in 1980. At the same time the numbers of doctors in their trainee year in general practice rose by 221 to 1457.

The total number of general practitioners increased by 2.6% and the percentage of women general practitioners rose to 17.3%. Some 32.3% of trainee general practitioners are women. British born male practitioners form 62.2% of unrestricted principals and practitioners from overseas (excluding Ireland) 21.5%. The numbers of those coming from the Irish Republic, Northern Ireland and the Channel Islands and the Isle of Man continue to decline and form only 4.9% of the total.

An indication that a more equitable distribution of doctors is being achieved is the decrease in the numbers of patients living in under-doctored areas from 4.1 million in 1979 to 2.25 million in 1980. (4.3% of the total population).

The tendency for general medical services to be provided by unrestricted principals continues; restricted principals (0.9%) and assistants (1.1%) forming a decreasing proportion of the total. Changes since 1979 are shown in Tables 12.1 and 12.2.

Table 12.1 Number of unrestricted principals in general practice, England & Wales, 1979-80

	1979			1980		
	Male	Female	Total	Male	Female	Total
No of unrestricted principals (U/Ps)	19,275	3,421	22,696	19,540	3,644	23,184
No of U/Ps born in Great Britain	14,318	2,477	16,795	14,424	2,637	17,061
No of U/Ps born in Irish Republic, Northern Ireland, Channel Islands and the Isle of Man	1,013	163	1,176	976	160	1,136
No of U/Ps born elsewhere	3,944	781	4,725	4,140	847	4,987
No entering as U/Ps for first time	904	318	1,222	934	343	1,277
Born in Great Britain	662	220	882	600	243	843
Born in Irish Republic, Northern Ireland, Channel Islands and the Isle of Man	21	11	32	25	7	32
Born elsewhere	221	87	308	309	93	402

Table 12.2 Net changes in the various types of general medical practitioners, England & Wales, 1979-80.

Types of practitioner	Changes in period 1 Oct 1979 — 1 Oct 1980
All practitioners	+650
Unrestricted principals	+488
Restricted principals	–19
Assistants	–39
Trainees	+220

Vocational training for general practice

On 16 February 1980 the National Health Service (Vocational Training) Regulations (Statutory Instruments, 1979a) came into operation. After 15 February 1981 only doctors who are exempt or have certificates of either prescribed or equivalent experience are able to enter general practice as principals. The contents of the Regulations were described in last year's report (page 75), (Department of Health and Social Security, 1980a). The Joint Committee on Postgraduate Training for General Practice, the body prescribed by the Secretary of State to issue such certificates began considering applications and answering enquiries from doctors.

Doctors in hospital practice

The number of doctors employed in the hospital service continued to increase in 1980. On 30 September 1980 the total staff in post (excluding para 94 appointments and doctors appointed to the hospital practitioner grade) in England and Wales was 35,352 compared with 34,450 in 1979. Numbers in the grades of consultant, senior registrar, registrar and SHO are shown in Table 12.3

Table 12.3 Number of doctors of certain grades in hospital practice, England and Wales, 1979 and 1980.

	Consultants			Senior registrars			Registrars			SHOs		
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
1979	12,531	11,198	1,333	2,849	2,348	501	5,782	4,671	1,111	9,296	6,983	2,213
1980	12,778	11,368	1,410	2,968	2,397	571	5,879	4,705	1,174	9,681	7,271	2,410

There has been further growth (4.2%) in the SHO grade, which is not centrally controlled. Discussions are proposed with Health Authorities on the possibility of imposing a freeze on the creation of further SHO posts.

The total consultant numbers increased by 247 of whom 77 were women. The growth was most marked in the following specialties:— General Medicine +34, Geriatric Medicine +18, Paediatrics +25, Traumatic and Orthopaedic Surgery +17, Anaesthetics +26, Radiology +15, Haematology +18, Mental Illness (Adult) +28, Child and Adolescent Psychiatry +25.

The Department gave approval for 325 new consultant posts to be advertised in the year 1981/82. It was necessary to restrict approvals in some specialties because of insufficient numbers in the training grades to satisfy demands for new

Table 12.4 Distinction and award holders, analysis by type of award and specialty and percentage distribution at 31 December 1980 England and Wales.

Table 12.4 Distinction and award holders, analysis by type of award and specialty and percentage distribution at 31 December 1980 England and Wales.

Speciality	Eligible practitioners	Award holders											Non-award holders	
		Total		A+		A		B		C				
	No	%	No	%	No	%	No	%	No	%	No	%	No	%
All specialties	14,032	100.0	4,862	34.6	122	0.9	453	3.2	1,297	9.2	2,990	21.3	9,170	65.4
Accident and emergency	131	0.9	12	9.2	—	—	—	—	1	0.8	11	8.4	119	90.8
Anaesthetics	1,627	11.6	445	27.4	10	0.6	27	1.7	90	5.5	318	19.5	1,182	72.6
Audiological medicine	11	0.1	5	45.5	—	—	—	—	4	36.4	1	9.1	6	54.5
Blood transfusion	29	0.2	9	31.0	1	3.4	1	3.4	2	6.9	5	17.2	20	69.0
Cardiology	114	0.8	64	56.1	4	3.5	12	10.5	24	21.1	24	21.1	50	43.9
Cardio-thoracic surgery	112	0.8	71	63.4	2	1.8	15	13.4	25	22.3	29	25.9	41	36.6
Chemical pathology	173	1.2	73	42.2	1	0.6	5	2.9	22	12.7	45	26.0	100	57.8
Child and adolescent psychiatry	303	2.2	43	14.2	1	0.3	4	1.3	6	2.0	32	10.6	260	85.8
Clinical genetics	18	0.1	4	22.2	1	5.6	—	—	1	5.6	2	11.1	14	77.8
Clinical neurological physiology	47	0.3	13	27.7	—	—	—	—	6	12.8	7	14.9	34	72.3
Clinical pharmacology and therapeutics	39	0.3	11	28.2	1	2.6	1	2.6	3	7.7	6	15.4	28	71.8
Clinical physiology	31	0.2	13	41.9	—	—	1	3.2	5	16.1	7	22.6	18	58.1
Community medicine	640	4.6	132	20.4	—	—	15	2.3	26	4.0	91	14.0	516	79.6
Dermatology	209	1.5	82	39.2	3	1.4	9	4.3	18	8.6	52	24.9	127	60.8
Diseases of the chest	215	1.5	97	45.1	—	—	6	2.8	22	10.2	69	32.1	118	54.9
Ear, nose and throat	371	2.6	128	34.5	2	0.5	13	3.5	32	8.6	81	21.8	243	65.5
Endocrinology	21	0.1	12	57.1	2	9.5	1	4.8	4	19.0	5	23.8	9	42.9
Forensic psychiatry	18	0.1	6	33.3	—	—	—	—	1	5.6	5	27.8	12	66.7
Gastroenterology	43	0.3	21	48.8	—	—	1	2.3	9	20.9	11	25.6	22	51.2
General medicine	1,058	7.5	419	45.3	21	2.0	62	5.9	127	12.0	269	25.4	579	54.7
General pathology	11	0.1	4	36.4	—	—	—	—	1	9.1	3	27.3	7	63.6
General surgery	959	6.8	465	48.5	15	1.6	51	5.3	127	13.2	272	28.4	494	51.5
Genito-urinary medicine	108	0.8	22	20.4	—	—	2	1.9	8	7.4	12	11.1	86	79.6
Geriatric medicine	406	2.9	98	24.1	3	0.7	3	0.7	16	3.9	76	18.7	308	75.9
Haematology	335	2.4	106	31.6	—	—	11	3.3	31	9.3	64	19.1	229	68.4
Histopathology	555	4.0	219	39.5	3	0.5	25	4.5	60	10.8	131	23.6	336	60.5
Immuno-pathology	45	0.3	13	28.9	—	—	1	2.2	7	15.6	5	11.1	32	71.1
Infectious diseases	27	0.2	14	51.9	—	—	2	7.4	3	11.1	9	33.3	13	48.1
Medical microbiology	293	2.1	103	35.2	1	0.3	7	2.4	34	11.6	61	20.8	190	64.8

Medical oncology	25	0.2	5	20.0	—	—	2	8.0	3	12.0	—		20	80.0
Mental handicap	157	1.1	33	21.0	—	—	3	1.9	7	4.5	23	14.6	124	79.0
Mental illness	1,109	7.9	316	28.5	11	1.0	20	1.8	72	6.5	213	19.2	793	71.5
Nephrology	65	0.5	32	49.2	—	—	3	4.6	14	21.5	15	23.1	33	50.8
Neurology	159	1.1	85	53.5	3	1.9	11	6.9	29	18.2	42	26.4	74	46.5
Neuropathology	33	0.2	18	54.5	1	3.0	4	12.1	4	12.1	9	27.3	15	45.5
Neurosurgery	89	0.6	55	61.8	1	1.1	11	12.4	22	24.7	21	23.6	34	38.2
Nuclear medicine	22	0.2	12	54.5	—		1	4.5	3	13.6	8	36.4	10	45.5
Obstetrics and gynaecology	707	5.0	259	36.6	9	1.3	18	2.5	70	9.9	162	22.9	448	63.4
Ophthalmology	403	2.9	141	35.0	3	0.7	10	2.5	39	9.7	89	22.1	262	65.0
Paediatrics	515	3.7	172	33.4	5	1.0	14	2.7	43	8.3	110	21.4	343	66.6
Paediatric neurology	5	0.0	2	40.0	—	—	1	20.0	—	—	1	20.0	3	60.0
Paediatric surgery	40	0.3	20	50.0	1	2.5	2	5.0	7	17.5	10	25.0	20	50.0
Pathology (PHLS only)	50	0.4	22	44.0	1	2.0	1	2.0	6	12.0	14	28.0	28	56.0
Plastic surgery	85	0.6	36	42.4	—	—	3	3.5	16	18.8	17	20.0	49	57.6
Psychotherapy	61	0.4	11	18.0	—	—	1	1.6	2	3.3	8	13.1	50	82.0
Radiology	835	6.0	264	31.6	6	0.7	23	2.8	73	8.7	162	19.4	571	68.4
Radiotherapy	192	1.4	83	43.2	1	0.5	9	4.7	33	17.2	40	20.8	109	56.8
Rheumatology and rehabilitation	219	1.6	65	29.7	—	—	7	3.2	15	6.8	43	19.6	154	70.3
Traumatic and orthopaedic surgery	654	4.7	224	34.3	3	0.5	11	1.7	56	8.6	154	23.5	430	65.7
Urology	148	1.1	69	46.6	1	0.7	9	6.1	20	13.5	39	26.4	79	53.4
All medical specialities	13,530	96.4	4,688	34.6	117	0.9	439	3.2	1,249	9.2	2,883	21.3	8,842	65.4
Dental surgery	299	2.1	115	38.5	4	1.3	9	3.0	32	10.7	70	23.4	184	61.5
Orthodontics	133	0.9	40	30.1	1	0.8	3	2.3	10	7.5	26	19.5	93	69.9
Restorative dentistry	70	0.5	19	27.1	—	—	2	2.9	6	8.6	11	15.7	51	72.9
All dental specialties	502	3.6	174	34.7	5	1.0	14	2.8	48	9.6	107	21.3	328	65.3

posts. These specialties were: Radiology, Anaesthetics, Geriatric Medicine, Mental Handicap, Mental Illness (Adult) and some of the Pathology specialties.

The number of distinction award holders by specialty and percentage distribution is shown in Table 12.4

Selected specialties showing the growth in NHS paid senior registrars are shown in Table 12.5.

Table 12.5 Number of senior registrars in selected specialties. England and Wales, 1979 and 1980.

Specialty	Senior Registrar staff in post	
	1979	1980
Anaesthetics	348	380
Radiology	189	206
Geriatric medicine	81	86
Psychotherapy	14	18
Histopathology	93	104
Mental illness	269	288

A further 131 hospital practitioners were appointed in 1980 bringing the total to 732, and the number of clinical assistants fell from 7,146 to 6,965. The number of women doctors employed in the hospital service continues to increase and at 30 September 1980 it was 7,044 compared with 6,680 in the previous year. The number of doctors born outside the United Kingdom and Irish Republic was 11,404 compared with 11,364 in 1979. (Table 12.6).

Table 12.6 Percentage of hospital doctors born overseas, 1979-80.

	1979	1980
Consultants and SHMOs with allowance	15.8%	16.3%
Medical assistants	38.0%	40.0%
Senior registrars	25.0%	25.0%
Registrars	55.3%	53.5%
Senior house officers	51.0%	48.0%
Pre-registration house officers	10.0%	10.6%

Pre-registration house officer posts

Following the fears in the mid 1970s that there would not be enough pre-registration house officer posts to accommodate the increasing number of graduates leaving the medical schools, the Department set up a working group to advise on ways of ensuring an adequate supply. As a result targets were set for each Region to be achieved over a period of years. The 1979 figures showed that Regions were progressing very satisfactorily towards these targets. In addition, in 1978 the Council for Postgraduate Medical Education set up their "Safety Net". This is a central clearing system that collects and distributes information about pre-registration posts remaining unallocated after as many doctors as possible have been placed by local efforts. Provided that local systems operate in the final year the Safety Net should ensure that each student has a post allocated to him or her before he or she sits the final examination. The number of pre-registration house officer posts had risen to 2,817 in 1980 compared with 2,769 in

1979. 957 of these posts were held by women which reflects the increasing numbers of women graduating from medical schools.

Part-time training

For many years the Department has encouraged authorities to offer doctors with domestic commitments, disability or ill-health opportunities to train and work part-time in the NHS. Guidance on this, issued in 1969 was re-issued in September 1979. Under the new arrangements health authorities are free to establish personal part-time registrar and senior house officer posts without central approval. At senior registrar level doctors wishing to work part-time compete annually on a national basis for a limited number of approvals. This is to ensure that it is neither easier nor harder for a doctor only able to train part-time to gain a senior registrar post than it is for a doctor seeking a whole-time post. Once doctors have gained manpower approval they have to satisfy a local appointments committee in the normal way and the relevant region sets up and funds a supernumerary post for them. Part-time posts must also be given educational approval by the relevant Royal College, Faculty or Joint Higher Training Committee. At present about 20% of women registrars and 25% of women senior registrars are training part-time. The national intake of women to medical schools is currently about 40% and likely to rise to 50% by the late 1980's. This will inevitably mean an increased demand for part-time training posts.

For doctors who are unable to work even half time the doctors' retainer scheme remains in force. Under this scheme a doctor can work up to a maximum of 1 day per week and agrees to attend a minimum of 7 educational sessions a year. In September 1980 there were 252 doctors on the Retainer Scheme. Full details of these part-time schemes are contained in Personnel Memorandum PM(79)3. (Department of Health and Social Security, 1979b).

Medical students

There was overall a small increase in the intake to the UK Medical Schools in 1979/80. The number obtaining a first registrable qualification showed a further increase. Details are shown in Table 12.7. The number of women entering medical school in 1979/80 was 1,564 and the number graduating in 1979/80 has risen to 1,198.

Table 12.7 Intake of medical students and output of doctors

Academic Year		England	Wales	Scotland	N Ireland	Total
Intake	1978/79	2,973	152	694	160	3,979
	1979/80	2,986	150	705	146	3,987
Output	1978/79	2,609	133	532	151	3,425
	1979/80	2,676	153	541	130	3,500

Career structure

For many years in the hospital service there have been too many junior doctors in training for the number of career posts available. Following agreement with the profession in 1971 the Central Manpower Committee was set up to advise the Health Departments on measures to implement the manpower policies for

development of hospital medical and dental staffing agreed between the Departments and the profession's representatives aiming so far as possible at the setting of national and regional staffing targets; and to monitor progress towards their achievement. Even with a central control mechanism, the overall expansion of junior training posts has exceeded the consultant expansion and the imbalance between training grade and career posts has increased. A contributory factor here has been the uncontrolled expansion of academic posts. In June 1980 The Chief Medical Officer convened a conference of interested persons to seek views on how best to tackle the problem. Two important principles were reiterated and generally agreed; (1) that the majority of patient care should be delivered by trained doctors and (2) that there should only be sufficient doctors in training for the number of career posts available. These remain as valid now as in 1971. Initiatives were suggested as to how the principles could be achieved and these are now being explored.

Social Services Committee

The House of Commons Social Services Committee decided to conduct an enquiry into the field of medical education with special reference to the hospital career structure and doctor numbers during the Parliamentary session 1980/81. The committee is at present taking evidence and the report is expected to be published in the autumn of 1981.

Community medicine manpower

The Joint Working Group on Recruitment to Community Medicine reported in January 1980. (Department of Health and Social Security, 1980b). The Department, the Faculty and other bodies began consideration of its 28 recommendations and by the end of the year some progress had been made. Two of its principal recommendations related to the recruitment to community medicine of older doctors from other specialties, and the training of in-service trainers. On the first, the report recommended that such recruitment should be positively encouraged, that training suited to the needs of the individual (*ad hominem* training) should be provided and that arrangements for salary protection while in training should be kept under review. On the second, the report recommended that suitable courses should be made available to develop the training skills of in-service trainers. Among the report's other recommendations were the establishment of limited session career posts and part-time training posts, the establishment of posts at senior house officer level, and the setting-up of joint academic/NHS appointments.

The manpower difficulties of the specialty were emphasized in the autumn by the fact that whereas the report recommended a target for trainee recruitment to the specialty of 80 per year over the next decade, actual recruitment in 1980 once more fell far short of this target with only 34 entrants. This figure of 34 also represents the average number recruited to the registrar grade in England and Wales over the previous 4 years (29, 32, 35 and 41).

The number of established community physician posts in England at the end of 1980 was 695 and 141 of these were vacant. The total doctors in training in the specialty has shown a slight increase over previous years having reached 138 by the autumn of 1980. The number of career appointments advertised during the year continued to be more than sufficient to absorb the numbers of those who had successfully completed their specialty training.

Towards the end of the year the Manpower Advisory Committee (Community Medicine) was reconstituted with the task of advising the Health Departments for England and Wales on manpower and staffing problems and policies for the specialty.

Council for postgraduate medical education in England and Wales

1980 saw the retirement of the Council's distinguished chairman Lord Richardson who has done much to develop the status and role of the Council as the co-ordinating body in postgraduate medical education. He was succeeded by Professor R F Whelan, vice-chancellor of the University of Liverpool.

During the year the Department sought the Council's help in ensuring the quality of training in all junior hospital posts; the Council also offered the Department advice on a number of topics including the provision needed to meet the requirements of medical and dental practitioners in postgraduate education centres. The Council and the Department have been closely involved with the development by the Open University of a pilot course on topics in drug therapy which will use educational material such as video and audio tapes and course booklets.

Further progress was made in the co-ordination of the work on senior registrar training of the higher training committees and regional postgraduate medical education committees following a meeting between representatives of those bodies and of the Councils for Postgraduate Medical Education in the UK.

Following publication of a report on a study of Section 63 Activities, conducted by the Department of General Practice, University of Manchester (Wood and Byrne, 1980) the Council's Advisory Committee of Deans and others concerned started a review of arrangements for the continuing education of general practitioners aimed at ensuring that the education provided reflected the changing needs of general practice.

The General Medical Council

During the year Sir Robert Wright was elected President of the Council in succession to Lord Richardson who retired, having served as President since November 1973.

On 1 August 1980 the provisions in the Medical Act 1978 concerning professional conduct and fitness to practise came into effect. These required the Council to establish Preliminary Proceedings and Professional Conduct Committees (to replace the Penal Cases Committee and the Disciplinary Committee) and the new Health Committee. These provisions extended the Council's powers so as to enable the Health Committee to suspend, or impose conditions on, the registration of a doctor on health grounds, without the taint of disciplinary proceedings. Orders in Council were laid setting out the Rules for these committees (Statutory Instruments 1980 a and b).

The question of financial provision for a doctor whose registration is suspended by the Health Committee when it judges that his fitness to practise is seriously impaired by reason of his physical or mental condition was raised by the Department with the Council and with the BMA early in the year and discussions followed with representatives of the profession. The Minister of State (Health) wrote to the Secretary of the British Medical Association on 17 November to assure the profession that the necessary legislation to provide a

proper basis for payments, along the lines of sick pay, to doctors who are suspended by the Health Committee would be introduced in due course and that in the interim period applications by Authorities for approval to make payments in individual cases would be considered sympathetically.

All the remaining provisions of the Medical Act 1978 came into force on 1 December 1980. They related mainly to the full and provisional registration of practitioners with overseas qualifications. The reciprocal arrangements for registration previously existing between the United Kingdom and various countries overseas accordingly ceased to have effect. The equivalence of an overseas qualification to a UK primary qualification is now the criterion for recognition for the purposes of full registration.

The European Communities (EC) medical directives

Last year's report mentioned that the EC Commission had notified the Government that in its opinion the requirement for an EC doctor to satisfy the GMC that he has the knowledge of English necessary for the practice of medicine in the UK is contrary to EC law. On 3 September 1980 the Government announced its decision to amend legislation so that EC doctors, dentists and nurses would no longer have to satisfy the registering bodies for these professions as to their knowledge of English. Instead those wishing to work in the NHS would be subject to English language requirements imposed by the employing and contracting authorities relating to the post concerned. An Order in Council to make provision for the changes was laid before Parliament early in 1981.

The number of doctors from EC Countries other than the UK and the Irish Republic granted full registration during 1980 was 134, making a total of 452 since 10 June 1977 when the Medical Qualifications (EEC Recognition) Order 1979 (Statutory Instruments 1979b) came into operation.

During the year proposals for a draft directive on specific training for general practice were introduced and further discussions are due to take place in 1981. A further draft directive to make some technical amendments to the existing directives, including the addition of the UK to the list of member states that recognize child psychiatry as a specialty and the renewal of the provisions for the part-time training of specialists, was discussed.

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13

INTERNATIONAL HEALTH

Health for All by the year 2000

The policy decision taken in May 1977 by the member states of the *World Health Organization* to work together towards the achievement of Health for All by the Year 2000 subsequently necessitated the formulation of strategies for implementing this objective at national, regional and global levels. In concert with this, indicators have had to be devised to assess the effectiveness of the measures adopted and to monitor progress towards the objective.

The concept of Health for All is intended to mean that there will be an even distribution among the population of whatever health resources are available and that essential health care will be accessible to all individuals and families, in an acceptable and affordable way, and with their full involvement. In this context essential health care has been held to comprise at least an adequate supply of food, access to safe water and proper sanitation, health education, basic maternal and child health care including family planning and immunization against the major infectious diseases, prevention and control of locally endemic diseases, appropriate treatment of common local diseases and injuries, and thus the provision of essential drugs.

In 1979 the *World Health Organization* through its Executive Board issued guidelines to the member states for individual and collective action, indicating how the Organization itself would be providing support. It was recognized that the national and regional strategies would necessarily vary widely depending on the state of existing health systems and the capacity of countries to implement the necessary health developments. Equally, international collaboration and support for these strategies was going to be essential.

From these bases it was decided that strategies had to be formulated first by individual countries themselves and that regional and global strategies would then be developed collectively on, and in support of, national strategies. A large number of countries have since formulated their plans of action and the six Regions of the Organization have agreed their regional strategies, which are now in process of collation into a draft global strategy together with a list of indicators to monitor progress.

In formulating the guidelines for the strategies account had to be taken of the wider perceptions of health development. It was realized that an acceptable level of Health for All cannot be achieved by the health sector alone but requires effective support from other sectors, such as education, agriculture, water resources, housing and environmental protection. To ensure this support it is important that these other sectors be given a better appreciation of the important contribution which health makes to social and economic development. The health strategies will have to be integrated into the overall national development plan and political commitment in support of the strategies is essential.

Within the health sector emphasis is placed on primary health care, on prevention and on the promotion of more self-care. In many countries it will be necessary to extend progressively simple primary health care facilities both

geographically and in content to cover the entire population. Although most of the resources for this development have to come from the countries concerned there will nevertheless be the need for substantial and continuing international support, including co-operation not only between the more affluent and the developing countries but also among the developing countries themselves. For the latter it is intended that joint activities will cover health manpower development, biomedical and health services research, the exchange of information and experience on health care, evaluation of new technologies before their introduction on a routine basis, and the production, procurement and distribution of essential drugs and medical equipment.

Within the *European Region of the World Health Organization* the drafting of a regional strategy has been seen as the first real attempt to formulate a comprehensive and coherent policy for the area as a whole. A complete reorientation of health policies and programmes is proposed, with activities to achieve promotion of life-styles conducive to health, reduction of preventable conditions, and extension of the health care system to cover the whole population with comprehensive health care to the maximum degree possible for each country according to its stage of development. While recognizing the importance of indicators to monitor progress, it has been accepted that a limited list of relevant and reliable indicators is preferable to a mass of esoteric measurements. Furthermore, the use of national average figures is to be treated with caution as they frequently conceal pockets of gross inequality.

The promotion of more self-care was taken up at the triennial *Commonwealth Health Ministers' Meeting* which was held in Arusha, Tanzania, in mid-November 1980. The theme of the meeting was *Health and the Family* and the main recommendations arising from it were directed to giving stress to a comprehensive programme of health education appropriate to family and community requirements, national nutritional policy, family planning programmes and family life education (a preferred term to sex education). On community resources and their mobilization, emphasis was given to the importance of orientating training towards community health and promoting the concept of primary health care with special emphasis on the family. A deliberate policy now exists of linking Commonwealth activity to the general international objective of *Health for All by the Year 2000.*

Co-operation in Europe

Within the *European Communities* discussion continued on the steps presaging the admission of Greece as the tenth full member of the Communities on 1 January 1980 and on the future admission of Spain and Portugal. At the same time attempts have continued to improve co-ordination on procedures and resources available for mutual medical assistance in the event of major accidents or outbreaks of disease. On the basis of advice tendered by the Scientific and Technical Research Committee, and its subgroup the Committee on Medical Research, the promotion of programmes of medical and public health research has continued. Besides pharmaceutical research, projects are aimed at resolving major health care problems notably nutrition, stress, drug abuse, perinatal care, problems of the disabled and evaluation of medical technology. The terms of reference of the four working parties of the Committee on Medical Research were revised in 1980 and their coverage now extends to: epidemiology, medical statistics and clinical tests; biomedical engineering, technology evaluation, clinical and user trials; biomedical research; and health services research. Owing

to the differences between national policies, the emphasis for research co-ordination has been placed on joint projects in clearly defined research fields, occasionally extending outside the limits of the Communities. For example, one project on registration of congential abnormalities which began in 1979 with the active participation of five national registers, now covers fifteen registers and will increase to cover twenty registers by the end of 1981 using harmonized registration methods. Other projects include one on cellular ageing and a project on extracorporeal oxygenation.

Apart from these activities a number of other major tasks falling to the Directorates-General of the Commission of the Communities include strong health components. Examples of these other tasks include the education of medical and other professional health workers, the health aspects of designated occupations, health control of foodstuffs and health regulations relating to food handlers, social policy relating to health care, reciprocal health care agreements, environmental health, use of computers in medicine, and health aspects of overseas development through the European Development Fund. It is often not appreciated just how much work these tasks generate in the Department. United Kingdom official involvement, through participation in expert committees or working groups, or the provision of briefs for these bodies, occupies on average for each medical division within the Department the equivalent of three or four working days a month — a figure that is bound to increase as the Commission's interests in health matters enlarge.

In July 1980 the Parliamentary Under-Secretary of State signed the Third Plan of Co-operation under the health co-operation Agreement with the *Czechoslovak Socialist Republic.* The original Agreement facilitates exchanges of information between the two countries, as well as direct contact between institutions and organizations, and visits by health personnel for study and consultation. The Third Plan identifies areas for particular co-operation over the next two years, including cardiac surgery (with emphasis on paediatric cardiac surgery), transplant surgery, oncology, tropical medicine, the prevention and treatment of alcoholism, the organization and use of diagnostic laboratory services, screening as an aspect of preventive medicine, and the organization of primary care.

In relation to a similar but more recent health co-operation Agreement, the Minister of Health of the *Hungarian Peoples' Republic* came to London in October to discuss and sign a Plan of Co-operation with our Minister of State for Health. This provides for co-operation over the next two years in the fields of oncology, cardiovascular diseases, preventive medicine, information systems and the organization of health services.

The Far East

In furtherance of the aims of the Agreement on Scientific and Technological Co-operation signed between the United Kingdom and the *Peoples' Republic of China,* the Minister of State for Health visited Peking in March 1980 to open the British Medical Technology Exhibition and in the course of this visit signed a memorandum of understanding on health co-operation. Under the terms of this memorandum four groups of experts from the United Kingdom visited China during 1980 on lecture and demonstration tours. The teams covered respectively bioengineering, hospital management in large cities, immunology and transplant surgery of the liver and cardiovascular diseases with particular reference to hypertension, coronary heart disease and paediatric cardiology.

Table 13 Fellowship holders from World Health Organization regions and Council of Europe studying in the UK in 1980.

Subject Studied	Fellowship Holders commencing training in the UK in 1980 — World Health Organization region of origin							Council of Europe
	Europe	East Medit	Africa	SE Asia	West Pacific	Americas	WHO Total	
Public Health Administration	2	16	6	22	6	6	58	1
Environmental Health	43	2	—	33	5	1	84	7
Nursing	1	4	2	6	—	3	16	—
Maternal and Child Health	3	8	2	6	8	4	31	5
Communicable Diseases	6	8	3	21	8	4	50	—
Clinical Medicine	8	46	9	20	9	5	97	1
Basic Sciences and Education	13	10	2	29	7	4	65	2
Other Health Services	4	24	3	17	18	4	70	3
Total	80	118	27	154	61	31	471	1

Following the success of these visits discussions are proceeding with the Ministry of Health of China with the purpose of identifying areas of mutual interest for future collaboration.

Fellowships

The number of World Health Organization Fellows coming to the United Kingdom during 1980 showed a slight increase on the numbers during the previous year, although there was little change in the number of Council of Europe Fellows coming to this country. Over the years since the Fellowships scheme first started the proportion of Fellows coming to study for higher qualifications has reduced and the majority now come for six months or less, commonly on study tours covering several centres. Table 13 shows the distribution of students by sponsor, region of origin and broad subject.

14

SPECIAL SUBJECTS

Organization and management of the NHS

The year 1980 saw the groundwork laid for major changes in the shape of the NHS and its management arrangements.

The consultative paper *Patients First* (Department of Health and Social Security and Welsh Office, 1979) setting out the Government's proposals on the structure and management of the NHS, had been issued late in December 1979 and the process of discussion and consultation occupied the first four months of 1980. These proposals, designed to simplify the structure of the NHS and improve its management, particularly at the working level, attracted an unusually large response. Over 3,500 comments were received ranging from detailed papers which considered in depth all the proposals and sometimes other related issues to short letters supporting community health councils or seeking the creation of particular district health authorities.

The Government's decisions were published in July in Circular HC(80)8 (Department of Health and Social Security, 1980a). The main changes it announced were as follows:—

1. A re-structuring process would be set in hand to enable the integrated health services in every part of England to be managed by a single tier of authorities to be called District Health Authorities (DHAs). These new authorities would generally be more locally-based then the existing AHAs which they would replace, serving populations of up to 500,000, and would be based as far as possible on the boundaries of existing health districts (including single district areas). Each DHA would have a Chairman and, on average, 16 members, four of them nominated by local authorities.

2. Regional Health Authorities would remain for strategic purposes and be responsible for implementing the restructuring programme; their functions would be reviewed later.

3. The existing arrangements for administration of Family Practitioner Committees (FPCs) would be retained although it will be necessary in future for some FPCs to relate to more than one DHA. Consultation should take place on means of strengthening the links between FPCs and DHAs on the planning of services.

4. Community Health Councils would remain — one for each new district authority; their membership and functions to be reviewed.

Management of the NHS

A major aim of the changes to be introduced was to strengthen and improve management at hospital and community services level, or "unit" level as it was coming to be known. This concept of the management unit was becoming an increasingly important one not only for doctors but for all NHS staff. A unit of management, comprising perhaps a major hospital or a defined branch of the service (eg maternity or mental illness) covering the whole district, would generally be smaller then the former sectors or nursing divisions and would be managed by an administrator and a nurse directly accountable to the District

Administrator and District Nursing Officer respectively, in collaboration with the medical staff concerned.

The new health authorities are to have the greatest possible degree of autonomy. The July circular made it clear that only three constraints would apply to DHAs when considering their management arrangements:

1. A requirement to establish a district management team with the same constitution as the management teams of existing single-district areas, ie a district medical officer, district nursing officer, district treasurer and district administrator, together with two elected representatives of the medical staff of the district, one a consultant, the other a general practitioner. The district administrator would have a specific responsibility for administrative co-ordination.

2. A requirement to arrange their services into "units of management", as mentioned above.

3. A centrally imposed constraint on their costs of management.

The circular also made clear that wherever possible staff working within units in non-clinical support services (works, catering, domestic services, medical records and personnel) should be accountable to the unit administrator rather than to district level managers. Within this broad policy authorities in shadow form were to be able to formulate structures appropriate to local circumstances without having to establish large numbers of district level management posts in order, as in 1974, to satisfy Departmental requirements.

Medical teaching in the NHS

Any changes introduced into the management or structure of the NHS must take account of the Secretary of State's duty, under Section 51 of the NHS Act (1977) to ensure that health authorities make available to the medical schools such facilities as he considers are reasonably required for clinical teaching. In November 1980 the Department issued a discussion paper on the subject, HN(80)40 (Department of Health and Social Security, 1980b) inviting views on the implications for medical teaching of the forthcoming changes in the structure of the NHS, with particular reference to questions such as the need for additional university representation on some authorities and the appropriateness or otherwise, of the specific "Teaching" designation of authorities with significant teaching responsibilities.

Medical advisory machinery

While the day-to-day clinical work of doctors in direct contact with patients was likely to be little affected by the restructuring arrangements, their increasingly important role in health service management would be affected by the need to participate fully in the management of the unit in which they work and also, through their elected representatives, in the management of the district as a whole. In response to recommendations in the report of the Royal Commission on the NHS (1979) and the need to review doctors' roles in the restructured service, a Working Group under the chairmanship of the Chief Medical Officer was set up in June 1980 with the following terms of reference:

"In the light of possible changes in NHS structure, to consider the current arrangements for the involvement of the medical profession in the strategic planning and operational management of the NHS with particular reference

to the role of medical advisory and representative committees, and to make recommendations"

The Group's report on management arrangements at district level was circulated for consultation with interested parties in December 1980.

Community medicine

The medical specialty which would be affected by reorganization to the greatest extent was community medicine. Each of the new DHAs would appoint its own district medical officer but with the disappearance of the Area tier, new arrangements would be called for, permitting groups of community medicine specialists to share between them the epidemiological and demographic work forming the basis of health services planning, in addition to environmental health, liaison with schools and social services and clinical work in the community with client groups such as children, the elderly, the handicapped and the disabled. The Faculty of Community Medicine and other professional interests began to give careful consideration to the ways in which community medicine might be structured and organized in order to perform these duties most effectively.

As already stated, the Government made clear its determination to apply rigorous control to the expenditure by authorities on management. It was recognized however that many Specialists in Community Medicine (SCMs) although not undertaking clinical work as such, undertake work particularly in the fields of epidemiology, prevention, screening, and advising on the appropriate placement of certain types of patient, which should be regarded as operational. Accordingly it was decided to remove all SCMs at whatever level from management cost control in order to remove one obstacle to authorities appointing as many community physicians as they judged appropriate to their circumstances.

Health Service Planning in London

This Report for 1979 (Department of Health and Social Security, 1980c) — pages 128 and 129 — described the establishment and the work of the London Health Planning Consortium (LHPC) and its five specialty sub-groups which were established to consider how each service might be provided on a rational basis in the Thames Regions. All reported early in 1980. In general they felt that better clinical results and more effective use of resources could be achieved by concentrating work into fewer units, each of which had good supporting services.

The reports were passed to the parent bodies of the Consortium who undertook the necessary consultation. As a result the Consortium was then able to review the reports and produce revised plans in line with the Region's own plans.

The publication in February 1980 of the LHPC report on Acute Hospital Services in London, *Towards a Balance* (London Health Planning Consortium, 1980) and the simultaneous publication of the report on London Medical Education, *The Flowers Report* (University of London, 1980) started a controversial debate on the future of individual institutions. The complexity of the issues made it impossible for London University to come to immediate decisions, and at the end of the year a new working party was established to look more closely at the costs of various options for medical school reorganization.

The complex nature of some of the problems of health service planning and structure in London, and the need to settle the future district authority boundaries, led the Secretary of State to establish a London Advisory Group in May, whose terms of reference were:

> "To advise on matters relating to the development of health services and the restructuring of Health Authorities in London and on other matters as may be referred to it; and to report to the Secretary of State."

The group was chaired by Sir John Habbakuk and included representatives of the four Thames regions, the specialist postgraduate hospitals, the University of London, DHSS, the UGC and GLC, the London Boroughs Association and members drawn from the profession. The main tasks of the Group have been to advise on special criteria which RHAs might need to apply in formulating their proposals for districts in central London, to consider the proposals submitted by the four Thames regions when these were submitted to the Secretary of State; to review the work of the LHPC on acute and specialist postgraduate hospitals; and to review the work of the LHPC on acute services in London in the light of changes which had taken place since the Consortium's work had been undertaken.

Information and statistics

For many years there has been a volume of criticism about the statistical returns collected in the NHS. Accurate, relevant, timely information is required both to run and plan NHS services. In February 1980 a Joint NHS/DHSS Group, under Mrs Edith Körner, Vice-Chairman, South Western RHA was set up to review current systems with a view to improving and simplifying them. Work has started on statistics about hospital clinical activity and on community health statistics which will be the subjects covered by the Group's first recommendations.

Finance

Circular HC(80)11 (Department of Health and Social Security, 1980d) gave guidance to authorities on the use of the new powers conferred on them by Section 5 of the Health Service Act (1980) to engage in fund-raising activities. It is too early as yet to estimate the effect of this provision or to judge whether it will materially affect the balance of resources available to different forms of medical care.

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Committee on Safety of Medicines

Professor Sir Eric Scowen retired as Chairman of the Committee on Safety of Medicines on 30 June 1980. He had held the chairmanship virtually continuously since the Committee was established in 1971 and prior to that had succeeded the late Sir Derrick Dunlop as Chairman of the Committee on Safety of Drugs. Sir Eric has been succeeded by Professor Abraham Goldberg of Glasgow University.

Adverse reactions to drugs

It has long been recognized that however thoroughly new drugs may be tested before they are made available to doctors, a small proportion of patients will inevitably suffer adverse effects, some of them serious. The Committee on Safety of Medicines (CSM) before advising on the licensing of new drugs (and individual doctors before prescribing them) must therefore carefully balance any possible risk against the benefits to the patient. This calculation of what is known as the risk/benefit ratio is often a very difficult one though it is often easy with hindsight to criticize the decisions.

It is very difficult to quantify the risks to the community arising from adverse reactions to modern drugs. Some indication of the extent of the problem can however be estimated from the voluntary reporting of suspected adverse reactions by doctors through the "Yellow Card" system. About 10,000 such reports are received each year though not all concern serious reactions and many may not be caused by a drug. On the very broad assumption that only 1 in 10 suspected drug reactions are reported this would indicate that about 100,000 people each year might be expected to suffer some ill effects from a drug they are prescribed or purchase themselves. Nevertheless, few people would doubt that this burden to the community is far outweighed by the benefits of modern drugs.

If doctors are to be able to reach reasonable decisions on the risks and benefits of drugs it is essential that they should be kept as fully informed as possible of known or suspected adverse reactions as soon as possible after they have been detected. The earliest warnings are often published in professional journals but the CSM has felt it valuable to develop its own methods of communication with doctors. Serious reactions where the risk is well established are notified to doctors as a matter of urgency through leaflets in the *Adverse Reactions Series* commonly known as "Yellow Perils". One of these, Number 18, was issued in August 1980 relating to Clofibrate, a hypolipidaemic drug. The Committee on Safety of Medicines considered the findings of a WHO co-operative trial on the use of clofibrate for the primary prevention of ischaemic heart disease. This report indicated that men treated with clofibrate had a significantly higher mortality rate from many causes than the appropriate control group. The attention of doctors was drawn again to the fact that clofibrate is currently indicated only in the treatment of exudative diabetic retinopathy, xanthomata and specific hyperlipoproteinaemias where appropriate investigations have been performed to define the type and severity of the abnormality. On the evidence the Committee stated that it believed that the use of clofibrate for the prevention of ischaemic heart disease should be discontinued.

Where the risk is less serious or the evidence of a causal link between a drug and an adverse reaction is not particularly strong, doctors are advised of the position

and particularly requested to report on suspected reactions to the drug in the published series of leaflets known as *Current Problems.* For a number of reasons none was published in 1980 but 3 issues are planned for 1981. In addition, the Chairman of the CSM may issue a *Dear Doctor* letter or, exceptionally, Ministers may arrange for the CSM's advice to them on an issue of major public concern to be published, as happened in the case of '*Debendox*'.

Pertussis vaccine

In February 1977 the Secretary of State asked the CSM to examine information in the possession of the Association of Parents of Vaccine Damaged Children (APVDC), relating to cases of suspected adverse reactions to vaccines. With the agreement of the APVDC the CSM undertook to examine first the data relating to pertussis vaccine. In May 1977 the CSM established a panel chaired by Professor Dudgeon, Professor of Microbiology at the Institute of Child Health, University of London, to undertake a preliminary scrutiny of the best documented of these cases. This panel reported in June 1978.

While the work was proceeding the CSM felt there was a need for expert advice on the analysis of all the information available to them on suspected adverse reactions to pertussis vaccine. Accordingly, in November 1977, the Committee established a further panel under the chairmanship of Dr T W Meade, Director of the MRC Epidemiology and Medical Care Unit to advise on the interpretation of the data. Their task proved far more complex than at first anticipated and as a result the panel's report was only received in October 1980.

The CSM considered both reports and formed its own conclusions which it forwarded to the Secretary of State in December 1980 together with the reports of both panels. Subsequently it was decided that all the documents should be published. They were incorporated in a booklet on *Whooping Cough* (Department of Health and Social Security, 1981) which was published in May 1981.

Medicines and the media

Throughout 1980 there was a continuing interest by the media in medical matters, including those related to drugs. Generally such items were highly informative and were well received. Nevertheless, there were a number of reports in respect of a few drugs which went beyond the normal bounds of responsible reporting and these created serious problems for doctors in their relationships with patients.

Such reports were basically of two kinds. First, the presentation of a new and untried drug as a "wonder drug". The best example of this in 1980 was the well publicized use of Interferon in a few patients suffering from cancer. The second kind was the presentation in a sensational way, of anecdotal reports of adverse reactions to a drug. Perhaps the best example of this was the reporting of the court case in the United States involving bendectin (*'Debendox'*) where it was alleged that the drug was a teratogen. Many early press reports drew comparisons with the earlier thalidomide tragedy. The regrettable result of both kinds of report from the doctor's point of view is a stream of patients desperate either for treatment with supplies of an unobtainable and untested drug or to be taken off an existing drug when there is no real cause for anxiety.

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Prevention of Accidents

Accidents are the commonest childhood cause of death in children over one year. The majority of accidental deaths in both sexes and up to the age of 34 are due to road traffic accidents. Accidents are caused by clashes between people and their environment, but the majority are due to human error. Some improvement has come about through the efforts of those local authorities having transport and home safety responsibilities with the minimum input from health authorities, though the latter, faced with the results of injury – causing accidents, have had to develop highly sophisticated accident and emergency services. Much of the reduction in road accidents has been achieved through improvements in vehicle design, of restraint systems and in the road environment. In home accidents, product design and standards have made some contribution. And in both fields safety education has made a considerable impact.

Accidents and the Health Authorities

The cost of care. Improvements in the environment, coupled with advances in emergency clinical care and traumatic surgery, can result in the survival of more victims with consequences for health authorities in providing long-term care. The cost to the health services alone from road accidents is estimated at some £75 million a year, the cost from home accidents is about £87 million. The total annual cost to the community from accidents is assessed at well over £400 million; but it is not possible to express in monetary terms the cost in human misery, both to victims and to their families and friends.

Casualties from road accidents use hospital beds and require specialist health services badly needed by others. The specialties of accident and emergency medicine and orthopaedic surgery take a large part of the work resulting from accidents. Waiting times of people wanting operations, such as hip replacement for arthritis, and who may be in great pain, are lengthened because beds are occupied by accident victims.

The continuing high incidence of accidents results in the diversion of resources from other fields of health care. Health services should therefore concern themselves with the prevention of accidents. Health staff have knowledge of human factors in prevention of disease and have a part to play in identifying those factors which lead to accidents. Bodies responsible for transport and home safety policies should have support from the health services in the development of safety policies in the same way as the latter are involved in development of policies for environmental hygiene. To achieve a comprehensive and balanced approach health authorities may become involved in the prevention of accidents through supporting local authorities, whether as transport or home safety authorities. To achieve this, health authorities should initiate a dialogue with the relevant local authorities to establish active working relationships. Immediate input can be achieved in those areas of transport and home safety activities in which health authorities already have related preventive programmes.

The development of Information Systems. The success of programmes of prevention in this field, as in others, depends upon the availability of accurate and comprehensive information. At the present time most of the information is derived from the road transport authorities and home safety departments with a consequent under-reporting of accidents; and there are inadequate data on the

long-term effects of accidents on the victims. It is important that community physicians and clinicians should be involved in accident prevention and, in this connection the development of local information systems is important. Classification of accidents by severity should be developed (a) so that preventive measures can be applied where likely to have the greatest effect and (b) because of its value in examining long-term disability resulting from accidents. This would need the involvement of clinical staff. Linkage between the data supplied by transport, home safety, police and health authorities is important and discussions continue between the Department of Transport and this Department. An example of co-operation in developing the use of such statistics is given later in this chapter (page 140).

Human factors

Health of road users. The state of health of road users can play a part in increasing the risk of injury-producing road accidents. Advances in health care mean that many more patients on long-term therapeutic programmes, the handicapped and the elderly retain their mobility. It is important therefore that health personnel are made aware of the risks to their patients as road users when designing programmes of care for them so that they can best advise their patients. Health authorities can ensure that licensing authorities receive advice on health conditions which can affect drivers, especially professional drivers, and the Medical Commission on Accident Prevention's Booklet *Medical Aspect of Fitness to Drive* (Medical Commission on Accident Prevention, 1976) is a valuable contribution to the prevention of accidents.

Pedestrians. There are indications that despite increases in the numbers of road users and motor vehicles, pedestrian accident levels are not increasing, and may have declined in relative terms; but mortality and morbidity rates for pedestrians over the age of 65 are much higher than those for younger persons. However, the data available on morbidity patterns for pedestrians are inadequate. This is a further reason why health authorities should improve data collection in hospitals and also include this group of road users in prevention programmes.

Alcohol. There is widespread acceptance that the consumption of alcohol increases the risk of injury-producing road accidents. Attention has primarily been focused on its effect on driving, but a high proportion of pedestrians injured in road accidents are also found to have been drinking to excess. Health authorities have a responsibility for the prevention of alcohol-related harm and therefore have a direct interest in supporting measures which reduce drinking and driving, not only because they should be concerned about reducing road traffic accidents, but also to reduce other problems of alcohol-related harm. The Government has introduced legislation to improve the effectiveness of the law in an effort to reduce the incidence of drinking and driving (Transport Bill, 1981).

Drugs. Some drugs increase the risk of accidents. Close co-operation between health service staff, colleagues in transport and home safety departments can minimize this risk.

The health authorities can also play an invaluable role in health education and this is referred to on page 140.

The Child Accident Prevention Committee

The high incidence of accidents in children, both at home and on the roads, has already been referred to. The development of preventive programmes should

include all aspects of the accident problem, whether on the roads, at home or at play. The government has recognized this by giving strong support to the Child Accident Prevention Committee (CAPC). The Committee continued to act as a forum for those government departments, representatives of the health service and voluntary bodies concerned with the prevention of accidents to children.

In 1980 the Committee published two occasional papers. The first was entitled *Organizations concerned with Child Accident Prevention* (Child Accident Prevention Committee, 1980a). The second, *The Safety of Children in Cars* (Child Accident Prevention Committee, 1980b) was produced at the request of the Minister of Transport (now Secretary of State). This publication was followed by publicity in the press and on the radio and television.

During 1980 three seminars were arranged by the CAPC jointly with other bodies. In March, together with the King's Fund, a seminar was held on *"Information on Accidents"*. This was attended mainly by accident and emergency consultants and medical statisticians. Following the seminar, it was agreed that a working party should be set up to study this subject in greater depth. Also in March the CAPC collaborated with the Centre on Environment for the Handicapped in holding a seminar on *"Designing for Safety: Prevention of Accidents to Children"* which brought together architects, environmental health officers, road safety officers and others. In November a third seminar was arranged, in association with the National Children's Bureau, entitled *"The Injured Child: Towards a Wider Understanding of Child Accidents and Child Abuse"* and this was attended mainly by social workers and teachers. All the seminars were well attended and brought the work of the Child Accident Prevention Committee before a wide professional audience.

The traffic environment

Vehicle safety. The Department of Transport has a continuing programme for improvements in vehicle safety both in the primary field, eg brakes, tyres, etc and in the secondary field such as seat belts and crash helmets and anti-burst door locks.

Accident Investigation Project. The Department of Transport has undertaken an Accident Investigation Project with Birmingham University in which injuries to occupants of vehicles involved in accidents are studied in relation to the part of the vehicle which caused the injury, with a view to making recommendations for the improvement of such parts. The most common of these types of accident injury are facial injuries on windscreens, chest injuries on steering wheels and knee injuries on dashboards. Approximately 400 cases per year are examined and the data produced are useful in recommending areas for improvement, although this is usually in the long-term. However, the project also identifies defects which can be dealt with promptly via the Department's direct links with the car manufacturers who will, if necessary, recall vehicles. Health service personnel can help in designing research protocols in this field.

Education in the prevention of accidents. Education in this field contains several elements concerning the home and the environment and should be aimed at all age groups, but especially parents and young children and school children and the high risk groups previously mentioned. Health Authorities and their staff are in contact with most of these through their health education programmes.

During 1980 three major publicity campaigns were launched on road safety by the Government. These were on Child Pedestrian Safety, Drinking and Driving,

and Motor-cycle Safety. There were also regional test campaigns on seat-belt wearing and safety of pedal cyclists, and a regional campaign on pelican crossings.

During 1980 the BBC suggested that, as part of their education programme, they would like to produce ten, ten-minute programmes aimed at adults in general, and parents in particular, dealing with those accidents which were the main cause of death and disability in children. Dr Hugh Jackson, the Medical Secretary of the Child Accident Prevention Committee acted as adviser and filming was carried out in various parts of the country featuring parents and children who had been involved in accidents. By the end of the year this series was almost complete and Mr Jimmy Savile had agreed to present the programmes. The Department of Health and Social Security gave extra funds to the Health Education Council so that they could, jointly with the BBC, publish free booklets to accompany the programmes. In addition the BBC organized regional meetings which brought together local people from different professions and voluntary organizations to discuss how they could organize local support for the programmes.

Legislation. In addition to the introduction of legislation relating to drinking and driving previously mentioned, the Government has also introduced legislation to improve the safety of motor-cyclists, particularly those who are young and inexperienced (Transport Bill, 1981). There are 3 main measures: the reduction in the maximum size of machine that learner motor-cyclists are permitted to ride; the introduction of a two-part test for learner riders, the first part of which will be an off-the-road test to examine the candidates' machine handling ability; and a limit on the duration of the provisional motor-cycle licence.

Research. The Department continues to support the research programme of the Transport and Road Research Laboratory. In this connection the Transport and Road Research Laboratory has been designated a collaborating centre by the World Health Organization. It is hoped that more community physicians and clinicians will participate in research into accidents, especially in the investigation of human factors and safety measures relating to drugs, alcohol and bio-mechanics.

The Home Accident Surveillance System.

The third annual report of the Home Accident Surveillance System (Department of Trade, 1980) was published in October 1980. It gives the latest figure (1979) for home accidents recorded by a representative sample of 20 hospitals in England and Wales. The report provides summaries relating to 53,939 home accidents reported during the year and gives details of types of accidents, age-groups of victims and products involved. The report shows no discernible trend when compared with earlier years. Children again account for some 40% of the cases, the dominant age group being the under-fives.

The Home Accident Surveillance System can provide, on request, detailed summaries relating to particular groups of home accidents and this facility is used extensively by government departments, trade associations, manufacturers and organizations such as the British Standards Institution of the Royal Society for Prevention of Accidents

Because of the number of small children involved in home accidents, two new detailed in-depth studies were started towards the end of the year. The first is concerned with accidents involving nursery transport equipment (prams, carrycots on transporters, push-chairs and buggies) and the second relates to accidents involving nursery furniture and equipment (cots, cot-beds, high and low chairs, baby relaxers, baby walkers and baby bouncers.

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Smoking and health

Following protracted negotiations between the Health Departments and representatives of the tobacco industry, a new voluntary agreement was announced by the Secretary of State for Social Services on 21 November 1980. The main agreement on advertising and promotion will stand until 31 July 1982, whilst the supplementary agreement on product modification will stand until 31 December 1983.

The new agreement provides for a 30% reduction in spending on cigarette poster advertising, and introduces further restrictions aimed at minimizing the impact of advertising the promotional offers on children and young people. Apart from the care already exercised to avoid making cigarette advertising attractive to young people, poster advertising on sites adjacent to schools and playgrounds will cease, manufacturers of non-tobacco products will be discouraged from including tobacco brand names or designs on goods with a special appeal to young people, and promotional offers will be confined to adult smokers.

New and more varied Government health warnings have been agreed and, on advertisements these will take up 50% more space and be improved in clarity and legibility.

Under the supplementary agreement, average tar yields of cigarettes will continue to fall and the industry will provide up to £1 million per year for independent monitoring research into the effects of product modification.

On 5 December 1980, the Minister for Sport announced that it had been agreed with the tobacco industry that the voluntary agreement on the sponsorship of sport, due to expire at the end of 1980, should be extended to allow time for negotiations in 1981 on a new agreement.

These voluntary agreements with the tobacco industry form the backcloth to increased efforts to reduce the prevalence of diseases associated with smoking.

Health education initiatives in this field have been directed at young children and teenagers and specific Departmental funds were allocated to the Health Education Council for this purpose. Towards the end of the year the Health Education Council started its "Superman" campaign, directed at young children, based on TV and other advertising and distribution of 'class packs' of materials to schools.

Increasing public concern has strengthened the efforts of those active in the field of health education and prevention to reduce the number of smokers in the country. The prevalence of cigarette smoking was a subject covered by the 1980 General Household Survey (Office of Population Censuses and Surveys, 1981). The percentage of cigarette smokers among persons aged 16 and over was estimated to be 42 in males and 37 in females.

Although it continues to be active in many specific areas of concern, the Health Education Council has maintained its positive general approach to good health. The "Look After Yourself" campaign, seeking to promote a healthy lifestyle, has continued to stimulate an impressive response from the public. This approach includes information on the harmful effects of smoking and emphasizes how health can be greatly improved if the habit is stopped — or better still — never started.

Since 1978, the Laboratory of the Government Chemist has provided the Department with data on the carbon monoxide yields of cigarettes in addition to the tar and nicotine yields. These data are now available in confidence to *bona fide* researchers on application to the Department.

A development in the past year which may have great significance for the future is the growing evidence to suggest that passive or involuntary smoking may be a real health hazard to non-smokers rather than merely an annoyance. This evidence will be assessed by the Independent Scientific Committee on Smoking and Health. This Committee is reviewing the effects of smoke components on health which will form the substance of the Third Report.

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Office of Population Censuses and Surveys, 1981. *Monitor GHS 81/82.* London, OPCS.

The Committee on Medical Aspects of Food Policy, whose remit is to advise the Chief Medical Officer on nutritional matters affecting the public health, met twice in 1980. Professor Angus Thomson, Dr Elsie Widdowson FRS and Professor Sir Frank Young FRS retired from the Committee at the end of the year. The Department has found their advice and help invaluable during the many years they served as members, and continue to be indebted to the members of the Committee for their time and expertise generously given in the service of the public health. This section records the work of the Committee's sub-groups.

Infant feeding

The Report of the Working Party set up in 1979 to review infant feeding practice was published and entitled *Present day practice in infant feeding: 1980* (Department of Health and Social Security, 1980a). The report reaffirms the statement in the previous report with the same title (Department of Health and Social Security, 1974) that satisfactory growth and freedom from disease are more likely when an infant is fed human milk than when an artifical substitute is given. It emphasizes the importance of encouraging mothers to breast-feed their babies for the first months of life and points to the need for facilities for mothers to do so when away from home. Clear guidance is given on the need for vitamin supplements, the recommended dose being 5 drops of Children's Vitamin Drops per day from the age of one month to at least two years and preferably five years of age. Changes in feeding practice can be achieved only as a result of informed and consistent education of the public, and the working party was convinced that the principles and practice of infant feeding should be an essential part of the training of all professional staff who provide health education to the parents of the future, and who advise mothers both before and after their babies are born.

The 1974 report was widely read, and it is expected that its 1980 successor will prove to be equally valuable in promoting the healthy development of children in the crucial early months of life.

The Report of the Working Party on the Composition of Foods for Infants and Young Children, set up to advise the Food Standards Committee, was published and entitled *Artificial feeds for the young infant* (Department of Health and Social Security, 1980b). Its major recommendations, which have been submitted to the Food Standards Committee, are that guidelines should be set for the nutrient composition of artificial foods for healthy young infants and that all foods which are intended for sale as the sole source of nourishment for the young infant instead of human milk should be subjected to scrutiny by a panel of experts. At present only specified foods based on skimmed cows' milk to which non-milk fat has been added require exemption from the Skimmed Milk with Non-Milk Fat Regulations, 1960 and are submitted to the Panel on Child Nutrition for approval as fit for babies.

The Infant Feeding Survey carried out in 1975 in England and Wales by the Office of Population Censuses and Surveys on behalf of the Department provided baseline statistics for the continuous review of patterns of infant feeding (Martin, 1978). A second survey was started during 1980, in Scotland as well as in England and Wales, using a postal questionnaire after a pilot study had shown that a satisfactory response rate could be achieved. The main findings on

the incidence and duration of breast-feeding, age of starting solid food, infant feeding practice at six weeks and four months, whether the mother has an opportunity to discuss infant feeding during pregnancy, socio-economic factors, sources of help and advice after the birth and hospital practice affecting feeding will be compared with those in the 1975 survey.

The Working Party on Human Milk Banks set up in 1979 completed its work on guidelines for those wishing to set up human milk banks. Its report entitled *The collection and storage of human milk* was published in 1981 (Department of Health and Social Security, 1981a).

Rickets and osteomalacia

The Report of the Working Party on Fortification of Food with Vitamin D, entitled *Rickets and osteomalacia,* was published at the end of the year (Department of Health and Social Security, 1980c). It is concerned mainly with the problem of these diseases among Asian people, although there is some consideration of the more general problem of osteomalacia among the housebound elderly. There are sections in the report on the history and background to the present problems, the frequency of rickets and osteomalacia in the Indian subcontinent, recent trends in the incidence of these diseases in Britain, and on prevention. The main recommendations, which have been widely publicized, are that there should be no further fortification of foods with vitamin D and that prevention should continue to be based on the practice of health education and the use of vitamin supplements. The report emphasizes the importance of education of health professionals and of those groups of the population considered to be at greatest risk, and that the main responsibility for prevention should lie locally with Health Authorities. It is hoped that the Working Party's Report will be a useful foundation for health teams in prevention programmes.

During the year the Minister of State for Health convened a Committee of Asian community leaders to consider how information about rickets and osteomalacia and the measures available for their prevention could best be brought to Asian people. Plans were well advanced by the end of the year to launch a nation-wide campaign early in 1981, to assist health teams locally in making information about these diseases available to Asian people and to encourage them to take the necessary preventive measures.

Nutritional surveillance

The Sub-Committee on Nutritional Surveillance met twice during the year. Much of the surveillance work recommended in the Committee's first report (Department of Health and Social Security, 1973) and commissioned by the Department following the changes in 1971 in the provision of school and welfare milk and in the cost of school meals has been brought together in its second report which was published in the spring of 1981 (Department of Health and Social Security, 1981b).

In April the Education Act 1980 brought about important changes in the statutory responsibilities of local authorities for the provision of school meals. Authorities will no longer be required to provide a midday meal suitable in all respects as the main meal of the day. The provision of free school meals to children other than those whose parents are in receipt of supplementary benefit or family income supplement will also be discretionary. The sub-committee

began to give consideration to the question of further monitoring of any changes that might occur in the nutritional status of schoolchildren.

The fieldwork for the measurement of the heights and weights of adults aged 16 to 64 years in a representative sample of households in Great Britain was carried out in August and September. The survey was commissioned by the Department from the Office of Population Censuses and Surveys. This is the first time such information has been collected and it will provide important baseline statistics for the determination of future trends in height and weight. Preliminary findings were released in 1981 (OPCS, 1981).

Elderly people

The Working Group responsible for the analysis of surveys of the elderly continued its preparations for a report on the longitudinal study of a cohort of elderly people surveyed in 1967/68, 1972/3 and 1978.

Foods

The food industry has developed methods for isolating protein from vegetable sources and making it into new foods which look, smell and taste like meat and have a similar texture. These new foods are likely to replace the natural food in the diet to a variable extent. It is of concern for the public health that such replacement has no deleterious effect on the nutrient content of the diet as a whole. The Panel on Novel Foods was set up to review recommendations for the nutrient composition of vegetable protein foods which simulate meat, and its Report entitled *Foods which simulate meat* (Department of Health and Social Security, 1980d) was published during the year. The Panel reiterated the principle stated earlier (Ministry of Agriculture, Fisheries and Food, 1974) that any manufactured food which simulates a natural food should in all important respects have the same nutritional value as the food which it might replace.

The Panel on Bread and Flour and other Cereal Products completed its work and a report was published in 1981 entitled Nutritional Aspects of Bread and Flour (Department of Health and Social Security, 1981c).

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The Blood Products Laboratory

The Blood Products Laboratory at Elstree manufactures a variety of products such as Factor VIII (for the treatment of haemophilia), albumin (for burns, shock etc) and anti-D immunoglobulin (for the prevention of Rhesus disease in babies), from plasma provided by the National Blood Transfusion Service (NBTS).

Following an inspection by the Medicines Inspectorate in 1979, it became apparent that, by present day standards, the existing premises were in many respects inadequate for the task that was being performed and provided no scope for expansion to meet the steadily increasing demand for products. In the light of the Inspectors' report, Ministers authorized work to begin immediately on a programme of improvements, at a cost in excess of £1.3m, to rectify the shortcomings of the facilities as far as possible and to enable the production capacity to be increased. These improvements should be completed by the end of 1982, enabling the output of Factor VIII and anti-D to be doubled and albumin production to increase by some 60%.

These production targets will, however, be insufficient to meet all the NHS requirements. For the NHS to be self-sufficient in blood products, two inseparable conditions must be fulfilled. The first is that the new Blood Products Laboratory must be redeveloped, to modern pharmaceutical manufacturing standards, with the capacity to manufacture products to the required level; the second is that the NBTS must expand its plasma collecting capacity to provide a sufficient supply of plasma to enable the redeveloped laboratory to meet production targets. It will be several years before redevelopment of the Blood Products Laboratory can be completed but planning and design has already begun.

In 1980, a new Advisory Committee on the NBTS was set up, consisting of representatives of Regional Health Authorities and those directly concerned with blood products manufacture and the Regional Transfusion Services. This Committee will advise the DHSS and the Welsh Office on the co-ordination of the development and work of Regional Transfusion Centres and the Central Blood Laboratories in England and Wales and the English and Welsh Blood Transfusion Service with those of Scotland and Northern Ireland. Consideration will be given to the amount of plasma which will be necessary to meet national requirements for blood products, the means by which the increase in plasma supply may be achieved and the financial implications for the NHS of this expansion in the NBTS.

Biotechnology

The use of biological organisms, processes or systems for the manufacture of products used in the prevention, diagnosis and treatment of illness is not new. Penicillin, for example, has been produced on a commercial scale using fermentation methods since the 1940s. Vaccines have been produced over an even longer period. Recent interest and activity in biotechnology nationally and internationally, however, is leading to the development of processes and techniques offering the prospect of a wider range of more freely available diagnostic and therapeutic products of greater specificity and higher quality. It is possible also that some products will be cheaper.

Development of enzymes and enzyme systems is already increasing opportunities for the production of diagnostic kits, treatment of congenital enzyme deficiencies, treatment of disease, such as leukaemia with asparaginase, for degrading toxic drugs (e.g. paracetamol) and for the assay of serum antibiotic levels during treatment.

The hybrid cell technology developed with Medical Research Council backing for producing highly specific antibodies (monoclonal antibodies) should prove useful for the detection and immunoassay of drugs, hormones, specific proteins and antigens, e.g. hepatitis B, cancer cells and for anti-infective and anti-cancer treatment. There is considerable activity in the development of monoclonal antibodies in all these areas.

Manipulation of organisms by recombinant DNA techniques achieved much publicity during the year following announcements that insulin, human growth hormone and interferon can be produced in this way. Development of procedures for producing these substances commercially is proceeding along with trials in patients.

The Department is providing funds for work in some of these areas directly or indirectly; in other areas discussions are taking place with industry, research bodies and funding agencies with a view to facilitating and speeding up development. The Department, for instance, participated in negotiations which resulted in the agreement of the Centre for Applied Microbiology and Research and KabiVitrum Limited to join efforts in developing procedures for producing genetically engineered human growth hormone. The agreement also covers assistance provided by KabiVitrum in extracting human growth hormone from frozen pituitary glands.

Pituitary glands

Responsibility for the collection of pituitary glands was transferred from the Medical Research Council to the Department (advised by a joint DHSS/MRC Committee) in July 1980. The arrangements made for collecting glands from 130,000 autopsies carried out each year produced some problems initially but these have been overcome to a large extent. The number of glands contributed, however, falls short of that required to maintain the supply of human growth hormone for the NHS until hormone produced by genetic manipulation is freely available. Considerable effort is being expended to increase the rate of collection of glands.

Evaluation of equipment and supplies

Responsibility for co-ordinating the evaluation of equipment and supplies available for purchase rests with the Supply Council. The Council, however, which met for the first time in July 1980 under the Chairmanship of Mr Bernard Cotton and includes Dr E B Lewis as a representative of the Joint Consultants' Committee in its membership, is unlikely to be able to set up programmes of evaluation for some time. In the meantime, the Department in conjunction with the Scottish Home and Health Department is continuing its programme which now includes more than 70 projects at a cost of around £1m annually. During the year reports on the evaluation of surgical diathermy equipment, pathology laboratory equipment, defibrillators and real-time ultrasound scanners (Second Report) were produced in *Health Equipment Information* (Nos 84, 86, 87 and 89 respectively). Other major evaluations in progress include radiology equipment,

anaesthetic equipment, haemodialysis machines and dialysers, and several products for use by the disabled.

Safety testing of medical electrical equipment

There has been a demand for many years for a commercial facility for the type-testing of medical electrical equipment and electrically operated hospital laboratory equipment. The Department has now formally recognized the Test House of the British Standards Institution, with which there has been collaboration over a long period for testing equipment to standards laid down in Health Technical Memorandum No 8, The Electrical Safety Code for Hospital Laboratory Equipment and British Standard No 5724.

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