Health of the nation : a progress report seventeenth report, together with the proceedings of the Committee relating to the report and the minutes of evidence and appendices / Committee of Public Accounts.

HOUSE OF COMMONS SESSION 1996–97

COMMITTEE OF PUBLIC ACCOUNTS

Seventeenth Report

HEALTH OF THE NATION: A PROGRESS REPORT

Together with the Proceedings of the Committee relating to the Report and the Minutes of Evidence, and Appendices

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Ordered by The House of Commons *to be printed 5 March 1997*

LONDON: THE STATIONERY OFFICE
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The Committee of Public Accounts is appointed under Standing Order No. 122 viz:

Committee of Public Accounts

122.—(1) There shall be a select committee to be called the Committee of Public Accounts for the examination of the accounts showing the appropriation of the sums granted by Parliament to meet the public expenditure, and of such other accounts laid before Parliament as the committee may think fit, to consist of not more than fifteen members, of whom four shall be a quorum. The committee shall have the power to send for persons, papers and records, to report from time to time, and to adjourn from place to place.

(2) Unless the House otherwise orders, each member nominated to the committee shall continue to be a member of it for the remainder of the Parliament.

(3) The committee shall have power to communicate to any committee appointed under Standing Order No. 130 (Select committees related to government departments) such evidence as it may have received from the National Audit Office (having been agreed between that Office and the government department or departments concerned) but which has not been reported to the House.

The following is a list of Members of the Committee since its nomination on 22 May 1992. The present Members are those marked with asterisks.

*Mr Robert Sheldon (elected Chairman 10 June 1992)
Mr Michael Ancram (discharged 26 July 1993)
Mr D N Campbell-Savours (discharged 9 June 1992)
*Sir Kenneth Carlisle (added 16 February 1995)
Mr James Couchman (discharged 21 November 1995)
*Mr Denzil Davies
Mr Terry Davis (discharged 23 May 1994)
Mr Stephen Dorrell (discharged 18 October 1994)
Ms Angela Eagle (added 28 November 1995) (discharged 11 November 1996)
*Mr Mike Hall (added 9 June 1992)
Mr John Horam (discharged 31 March 1995)
Dr Kim Howells (discharged 10 December 1993)
*Mr Michael Jack (added 17 October 1995)
Mr Robert Jackson (added 26 July 1993) (discharged 17 February 1994)
*Mr Robert Maclennan
Mr Alan Milburn (discharged 28 November 1995)
Sir David Mitchell (added 22 February 1994) (discharged 2 March 1995)
Mr George Mudie (added 10 December 1993) (discharged 20 January 1995)
Mr David Nicholson (discharged 22 February 1994)
Mr Richard Page (discharged 16 February 1995)
*Mr Andrew Rowe (added 21 November 1995)
*Sir Michael Shersby
*Mr Tim Smith (added 2 March 1995)
*Mr Michael Stern
*Mr Gerry Sutcliffe (added 11 November 1996)
Mr Peter Thurnham (added 31 March 1995) (discharged 24 October 1996)
*Mr Richard Tracey (added 17 February 1994)
*Mr Charles Wardle (added 24 October 1996)
*Mr Mike Watson (added 20 January 1995)
*Mr Alan Williams
Sir George Young (added 18 October 1994) (discharged 17 October 1995)

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SEVENTEENTH REPORT

The Committee of Public Accounts has agreed to the following Report:

HEALTH OF THE NATION: A PROGRESS REPORT

INTRODUCTION AND SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

C&AG's Report, (HC 656 of Session 1995–96), Preface

1. The Health of the Nation is a wide ranging strategy, led and co-ordinated by the Department of Health and is the central plank of government policy on health in England. The aim of the strategy, which was launched in 1992, is to improve the health of people in England in five key areas. These are:

C&AG's Report, Table 1

* Coronary heart disease and stroke;
* Cancer;
* Mental illness;
* HIV/AIDS and sexual health;
* Accidents

The Department set 27 targets within these areas to monitor progress.

C&AG's Report, (HC 656); Evidence pages 1–11; National Statistics Monitor MB1 96/2 (Table 1)

2. On the basis of the report by the Comptroller and Auditor General, and memoranda from him and the Department updating data in that report, we examined what progress had been made towards the 27 targets, the limitations on the ability of the Department to monitor progress and the part played by the Health of the Nation strategy in the NHS planning framework.

3 Our main conclusions and recommendations are as follows:

Progress towards the 27 Health Of The Nation targets

(i) We are encouraged that good progress has been made towards 11 out of the 27 targets, particularly on coronary heart disease and stroke and some cancers. We note the extent to which the improvements reflect developments in medical techniques and health screening programmes, and that the causes of these diseases are complex. We encourage the Department to build on their success in making further progress towards achieving these targets (paragraph 33).

(ii) We are concerned that obesity in adults increased, when the targets are set to reduce obesity in men by 25 per cent and in women by 35 per cent by 2005. This is particularly worrying because obesity is known to be a risk factor in coronary heart disease, stroke and many other diseases. We note the Department's evidence that there has actually been a reduction in the number of calories people consume, and that the rise in obesity reflects a long-term decline in the amount of physical exercise people take on average. We note too that, with hindsight, the Department consider their targets were too ambitious. We recognise that progress in this area depends on individuals deciding to alter their life styles, and that the Department are co-operating with others to promote increased levels of physical activities and reductions in the consumption of fat (paragraph 34).

(iii) We are also concerned that the number of women drinking more than 14 units of alcohol a week had risen to 13 per cent by 1994, as against the target of 7 per cent by 2005, and by the effects this will have on the incidence of disease and alcohol-related accidents. We note that the Department do not have the evidence which links levels of household income with the consumption of alcohol. We consider that they will need to do more to assess the reasons for the increase in consumption before they can devise effective measures to counter it, through more closely directed health education programmes (paragraph 35).

(iv) We are dismayed by the rise in teenage smoking, and that the Health of the Nation target of reducing smoking amongst 11–15 year olds to six per cent by 1994 has been missed. The actual level in 1994 had risen to 12 per cent. Teenage smoking will have consequent ill effects on the population including the incidence of cancer and vascular disease, and this rise may impinge on other Health of the Nation targets in the future. We look to the Department, together with the Department of the Environment and the Department for Education and Employment to explore what further action can be taken to reverse this trend (paragraph 36).

(v) The Committee take note of the steep year-on-year rise to 1988 in cases of skin cancer and, although these trends appeared to have levelled off up to 1992, that the latest information showed a further rise. We also note the Department's evidence that changes in behaviour in this area would not show up in the statistics for another ten or 15 years, because these were very long-acting effects. As most of the cases are avoidable, we urge the Department to consider what more can be done to reduce the incidence of this disease, through further improvements in health education (paragraph 37).

(vi) We note that conceptions among girls under 16 fell by about 20 per cent following the peak in 1990, but that the 1994 figures showed a rise. We also note the continuing action being taken by the Department to make family planning available to under-aged girls, and that recent initiatives such as a freephone advice service called *Sexwise* had had a huge take-up. We look to the Department to continue to monitor the position and, if there is a further rise, to consider what further action could be taken to keep the trend moving downwards (paragraph 38).

(vii) We are concerned that important illnesses, such as prostate cancer, are not part of the Health of the Nation initiative and might therefore not attract sufficient attention and resources. We therefore urge the Department to ensure that health issues excluded from the initiative are not neglected and that opportunities are taken to develop and extend the strategy where new areas of concern emerge (paragraph 39).

(viii) We welcome the cooperation between Departments concerned with Health of the Nation, but we look to the Department of Health to ensure that they maintain and build upon this initiative, especially in those areas where progress against the targets is slow, or moving in the wrong direction (paragraph 40).

Limitations on the Department's ability to monitor progress

(ix) We are concerned that a working definition of severe mental illness has not yet been agreed, and at the length of time it is taking to gather data on the incidence and severity of mental illness. While we welcome the work of the Clinical Outcomes Group in this area, we are very concerned about the impact this lack of data could have on effective services for the mentally ill, and we urge the Department to take immediate action to agree a working definition and to provide national data on mental illness (paragraph 53).

(x) We are disturbed at recent reports of a rising number of suicides among Asian women. We note that the Department has started a special research project looking at deliberate self-harm, including suicide, among young Asian girls, to help guide the design of interventions to reduce deliberate self-harm in this group (paragraph 54).

(xi) We are disappointed that, as yet, there is no indicator which specifically monitors the development and spread of HIV and AIDS. We note that the number of new cases of AIDS has levelled off, reflecting the established trend in new HIV cases, and that the UK compares well with other European countries. We note too the Department's view that this con-

tainment in the United Kingdom is likely to be associated with a number of factors including the early introduction of a public education campaign in the mid–1980s. We also note that, because the projected number of cases of AIDS had fallen 10 per cent below the number forecast in 1993, spending on treatment and care was expected to fall from £195.1 million to £185.7 million in 1996–97, as would central spending on health education, from £6.45 million to £3.64 million. We consider it important that the Department complete their work on developing a suitable target in this area, to help them better target the funds available and their interventions at vulnerable groups (paragraph 55).

(xii) We are disturbed that no national data is yet available on a consistent basis to monitor trends of drug users sharing injecting equipment, an important mode of transmission of HIV, and that the lack of data could impair the planning and delivery of AIDS and HIV services. We look to the Department to review the target when data from their 1997 survey is available so that comparability may be achieved (paragraph 56).

Health of the Nation as part of the NHS planning framework

(xiii) We support the development of specific health targets, to help focus attention on health areas which most need to be addressed, and to set clear goals useful to the NHS and others (paragraph 67).

(xiv) We note that the Department is keeping under review the targets and action plans which underpin Health of the Nation, and we look to them to continue to be aware of the need to revise targets, or to set new ones, where new information emerges (paragraph 68).

(xv) We note that, in some areas, such as coronary heart disease, although good progress has been made towards the targets, the United Kingdom still has far higher death rates than many European Union countries: on coronary heart disease and lung cancer the United Kingdom is second highest amongst the 12 founder member countries of the European Community. We note too that increased European Commission activity, particularly in developing a health monitoring action plan, could lead to better informed comparability of data. This in turn, could help the Department understand the complex reasons for the variances and inform their target setting (paragraph 69).

(xvi) We note the Department's approach to piloting health promotion campaigns and evaluating the results, as well as to developing ways of better targeting action plans, such as developing links between targets and action plans and socio-economic data. This is an area at the heart of the Health of the Nation strategy and where substantial sums are spent: some £210 million on health education and promotion each year. We therefore look to the Department to ensure that their programmes are well targeted and effective (paragraph 70).

Progress Towards the 27 Health of the Nation Targets

C&AG's Report, para 8 and Table 3

4. There has been encouraging progress towards 11 out of the 27 Health of the Nation targets. However, there are three areas: obesity; drinking by women; and smoking by children aged 11–15 years, where the trend is moving in the opposite direction. There are other areas: for example, skin cancer and conceptions by girls under 16 years, where some progress has been made but there is cause for concern about the pace of change.

AREAS WHERE PROGRESS IS ENCOURAGING

(a) Coronary heart disease and stroke

C&AG's Report, Table 2 and pages 12–16

5. The target is to reduce the number of deaths from coronary heart disease in people aged under 65 by at least 40 per cent by the year 2000 (from the baseline of 1990), and by at least 30 per cent in those aged 65–74 years. The aim is also to reduce the death rate from stroke in people in both age groups by 40 per cent

Evidence, page 4, Figure 1 (A1, A2, A3 and A4)
Q2

over the same period. In practice, positive progress has been made against all these targets.

6. We asked the Department to what they attributed the decline in numbers. They told us that in all these cases the position was extremely complex and that they did not necessarily know all the factors at work. However, some of the factors at work, both before and after the targets were set, were the reduction in smoking, improvements in the treatment of coronary heart disease, and the introduction of new drugs, for example to treat heart attack victims. They also mentioned the frequency with which people with coronary heart disease could be operated on for bypass grafting or similar procedures. The Department added that they needed to go on improving and making these kinds of changes in the future in order to keep the line on the graph moving downwards: it would not move downwards on its own accord; it was a reflection of changes in society, changes in medical treatment and so on, on which they had to try and maintain the momentum.

(b) Cancer

C&AG's Report, Table 2 and pages 26, 27, 28 and 30–31 and Evidence, page 7 (B1, B2, B3, B4, B5)
Q6

7. The latest figures for breast and cervical cancer showed progress towards the targets set in Health of the Nation. However, we put it to the Department that, in view of screening procedures, one might have expected more significant improvements.

8. The Department told us that there had been a 13 per cent reduction in the death rate from breast cancer between 1990 and 1995 and that they were on target to achieve a 25 per cent reduction over a ten-year period. They were very pleased with the way the breast screening programme was going: there was a high level of coverage and a large number of cases were being diagnosed early.

Office of National Statistics (Monitor: Population and Health (MBI 96/2: Page 3)) (5.11.96)

9. On cervical cancer, the Department provided additional information for England which showed that the implied Health of the Nation target of 12.8 registrations per 100,000 population per annum by the year 2000 had been achieved in 1991.

Q8

10. On deaths from lung cancer in women under 75 years of age, we asked the Department whether they still expected to meet their target of reducing the death rate per 100,000 by 15 per cent by the year 2010, given that the rate had actually risen in 1994. The Committee were told that the general point about a lot of these conditions, and particularly the cancers, was that the results of doing certain things like smoking might take a very long time to come through in some noticeable effect on health. A reduction in lung cancer in women was being experienced but it was quite gentle. The Department hoped and expected that the reduction would continue to be fulfilled and might even accelerate a little.

AREAS WHERE PROGRESS IS LIMITED

(a) Obesity

C&AG's Report, para 8 and Table 3, and pages 20 and 21; and Evidence, page 5, Figure 1 (A7)
Qs 3–4

11. The target is to reduce the percentage of men aged 16 to 64 who are obese by 25 per cent and women by 33 per cent by the year 2005. In fact, the trend is rising. We therefore asked the Department why this was, given all the publicity concerning cholesterol and saturated fats.

12. The Department told the Committee that the statistics were a reflection of two factors: obesity and overweight. One was the issue of how much physical activity we take, and the other was the issue of how much we eat and drink. What we were seeing in our country and in a lot of other western countries was a long-term decline in the amount of physical activity we take on average. Although there was also a decline in the calories we actually consumed, there was a growing imbalance between what we expend in calories and what we take in.

Q5

13. We asked the Department how they expected improvements to be achieved. They replied that they could draw this issue to people's attention, which they did pretty rigorously. They had a serious campaign under way to try to persuade people to raise their levels of physical activity; they had given, and were giving, a lot of advice to people about diet and what they ate, and were working with a lot of the players in this field, with the food industry and others, to try to bring

about reductions in the consumption of fat. The Department added that essentially they were really bringing this issue to the attention of people and that individuals had to make their own decisions at the end of the day on what they were going to eat and how physically active they were going to be in their lives. However, the Department accepted that the overall health education programme in this area had had a very limited effect so far, although it was early days, and peoples' attitudes could not be changed overnight.

Qs 4–5 and 15

14. We asked the Department how these targets had been set. They admitted that, when the targets were set, they did not have up-to-date data: this came through afterwards. With hindsight, they would not have set such ambitious targets.

(b) Drinking by women

C&AG's Report, Table 2 and para 8, Table 3 and page 25

15. The target is to reduce to seven per cent by the year 2005 the proportion of women drinking more than 14 units of alcohol a week. In practice, by 1994 the figure had risen from 11 per cent to 13 per cent.

Q 106–108

16. We asked the Department whether there were any targets, alcohol consumption for example, where they would not meet the target. They accepted that on alcohol consumption, although the targets were a long way ahead, they were going to be very hard to achieve.

Qs 52–55

17. We enquired whether there was any evidence linking take-home pay and household income to alcohol use. The Department explained that they did not have the data to link the two issues together. They did, however, accept that, in trying to carry through some kind of health education programme, it would perhaps be sensible to target some activities on a particular group: it might be an ethnic issue or a socio-economic issue.

(c) Cigarette Smoking in children aged 11–15 years

C&AG's Report, Table 2 and page 34

18. The target was to reduce the prevalence of smoking among 11–15 year olds by at least 33 per cent, from eight per cent of children in this age group to six per cent, by 1994. In practice, the number had risen to 12 per cent by 1994.

Qs111–112, and 120–123

19. We asked the Department why they had missed this target by such a huge amount. They told us that, with hindsight, this was one of the examples where they had inherited the target from before the Health of the Nation initiative and it had just turned out to be very, very ambitious. They found the figures surprising, and did not understand why the increase had happened, or whether the figure would continue to increase.

Qs117–118

20. We enquired about the implications of this rise for health among adults in ten or 20 years time. The Department agreed this was a serious issue which might also put under threat targets such as adult smoking and smoking during pregnancy.

Q124

21. We asked the Department what new initiatives they were trying to address the problem. They told us that a lot of their policies were addressed to adults as well as children and that this was important because children were to some extent influenced by adults, by their parents and by others. The policy had many pillars to it but certainly, acting on the price front, which was probably the most important single factor in discouraging people from smoking, the Chancellor had adopted a policy in relation to tobacco duty, which had gone up in real terms by 17 per cent since 1993; and we now have very expensive cigarettes in this country: that was a very effective deterrent. The Department added that they had policies on advertising which were particularly related to not appealing to children; and there were laws about sales of tobacco to under-sixteen-year olds. The Department were also spending a lot of money on health education in relation to smoking, for example just under £1 million a year for three years on a programme called *Respect,* which was a health education programme aimed in particular at teenagers. In summary, they accepted that there was a very wide range of things they could do and that it was one of their highest priorities.

Q57

22. The Committee asked whether the Department encouraged child-to-child education. They told us that this was something they were developing in the field

of peer education, and that it was being used particularly effectively in the area of AIDS/HIV and sexual health education. They were also developing health promotion in schools covering such areas as healthy diets and smoking.

Q 125

23. We asked about the Department's liaison with the Department of Education in this area, and were advised that one of the really good outcomes from the Health of the Nation initiative had been greater working between Departments on health issues. The smoking issue was now dealt with in schools very extensively and the Department worked very closely with the Department of Education and Employment on it. More widely, having a Cabinet sub-committee which was concerned with the Health of the Nation strategy, chaired by the Lord President, and with Ministers from all the affected Departments, gave a tremendous lead to Whitehall.

Q 168

Qs 151—155

24. Asked about the effectiveness of their policies, given the increase in the number of young smokers, the Department told us that they believed they had a powerful set of policies aimed at dissuading both adults and children from starting, encouraging people not to smoke, and discouraging them from doing so if they did. Some of their policies were relatively recent and one needed to allow a little time to see how these measures took effect. However, the Department assured us that they were not complacent and took the issue very, very seriously. They accepted that tackling the problem of smoking, particularly amongst young children, would help with other targets in the Health of the Nation such as coronary heart disease, lung cancer and a number of other health issues in later life.

Q 157

OTHER AREAS OF CONCERN

(a) Skin Cancer

C&AG's Report, Table 2

25. The target is to halt the year-on-year increase in the incidence of skin cancer by the year 2005. In practice, over the period from 1986 (the baseline) to 1990 the incidence increased by 14 per cent and, although the trend appeared to have levelled off up to 1992, the latest available data showed a further rise.

C&AG's Report, page 29; and National Statistics Monitor MBI 92/2, page 2

Qs 162–164

26. The Committee asked what the rise in cases told the Department about spending on health education so far as this particular problem was concerned. They explained that changes in behaviour in this area would not show up in the statistics for another ten to 15 years, because these are very long-acting effects. They had, however, "got cracking" on the issue; for example the Health Education Council was running a *Sun Know-how* campaign which was costing £1.5 million over three years; and the Department paid the Meteorological Office to give sunburn forecasts in the weather forecast. They added that generally, public awareness of this as a problem was much greater than it was, and although this did not mean that people would necessarily change their behaviour, the Department were at least giving people the facts.

(b) Conceptions among girls aged under 16

C&AG's Report, Table 2 and page 40; and Evidence, page 10 (D3)

27. The target was to reduce the rate of conceptions among girls aged under 16 by at least 50 per cent by the year 2000 from the 1989 baseline rate. In practice, although the rate fell from 9.5 per cent to 8 per cent between 1989 and 1993, it rose again to 8.3 per cent in 1994.

Qs 58–59, and 87–96

28. The Committee enquired about the reasons for the fall in the years to 1993 and the rise since then. The Department admitted that they did not know whether the fall before 1993 was the result of a lower level of sexual activity or whether it was because people were taking precautions. They felt, however, that the efforts of the Health Service and the voluntary bodies to make available family planning in appropriate cases to under-aged girls were having a good effect. They mentioned, for example, a programme called *Sexwise,* which was a freephone advice service set up in 1995 and which had had a huge take-up.

29. The Department told us that they could not draw any conclusions about the subsequent rise in cases in 1994, in respect of that single year. They hoped it was just a blip and that they would see a continuation of the downward trend. And they assured us that the target of reducing the number of cases to 4.8 per cent by the year 2000 was still realistic.

(c) Areas not covered by the Health of the Nation Targets

Q 49

Qs 48–51, Evidence, Appendix 2, pages 36–37

30. The Committee asked about health issues not covered by the Health of the Nation strategy, particularly prostate cancer; and were told by the Department that they were aware of the serious threat to male health which prostate cancer posed. However, they pointed out that there was currently no method by which a man could reduce his risk of developing this disease and policy was, therefore, to encourage early reporting and ensure rapid referral when symptoms presented.

Q 48

Evidence, Appendix 2, pages 36–37

31. When asked whether there should be some kind of general population screening for prostate cancer, the Department confirmed that they did look at screening for various diseases from time to time, but that there was, as yet, no evidence that screening for prostate cancer would achieve a demonstrable improvement in health by increasing the length and quality of life.

32. The Department added that their Standing Group on Health Technology had identified carcinoma of the prostate as one of the priority areas for health technology assessment. The Department had commissioned two systematic reviews of diagnosis, management and screening of early localised prostate cancer which had concluded that screening could not be recommended because of unanswered questions in a number of areas. These included: the natural history of the disease (whether it would become apparent if not detected by screening); costs (financial, social and psychological), and effectiveness of treatments for localised disease. The reports found no justification for the routine use of testing for prostate specific antigen (PSA) in primary care and suggested that General Practitioners should be actively discouraged from using PSA tests for the purpose of early detection. In addition, there was at present no evidence about the number of prostate cancer deaths (if any) which could be averted by screening asymptomatic men. However, they assured us that the National Screening Committee would consider screening for prostate cancer as part of its programme of reviews and would consider any new scientific evidence as it became available.

Conclusions

33. We are encouraged that good progress has been made towards 11 out of the 27 targets, particularly on coronary heart disease and stroke and some cancers. We note the extent to which the improvements reflect developments in medical techniques and health screening programmes, and that the causes of these diseases are complex. We encourage the Department to build on their success in making further progress towards achieving these targets.

34. We are concerned that obesity in adults has increased, when the targets are set to reduce obesity in men by 25 per cent and in women by 35 per cent by 2005. This is particularly worrying because obesity is a risk factor in coronary heart disease, stroke and many other diseases. We note the Department's evidence that there has actually been a reduction in the number of calories people consume, and that the rise in obesity reflects a long-term decline in the amount of physical exercise people take on average. We note too that, with hindsight, the Department consider their targets were too ambitious. We recognise that progress in this area depends on individuals deciding to alter their life styles, and that the Department are co-operating with others to promote increased levels of physical activities and reductions in the consumption of fat.

35. We are also concerned that the number of women drinking more than 14 units of alcohol a week had risen to 13 per cent by 1994, as against the target of 7 per cent by 2005, and by the effects this will have on the incidence of disease and alcohol-related accidents. We note that the Department do not have any evidence which links levels of household income with the consumption of alcohol. We consider that they will need to do more to assess the reasons for the increase in consumption before they can devise effective measures to counter it, through more closely directed health education programmes.

36. We are dismayed by the rise in teenage smoking, and that the Health of the Nation target of reducing smoking amongst 11–15 year olds to six per cent by 1994 has been missed. The actual level in 1994 had risen by 12 per cent. Teenage smoking will have consequent ill effects on the population, including the incidence

of cancer and vascular disease; and this rise may impinge on other Health of the Nation targets in the future. We look to the Department, together with the Department of the Environment and the Department for Education and Employment to explore what further action can be taken to reverse this trend.

37. The Committee take note of the steep year-on-year rise to 1988 in cases of skin cancer and, although these trends appeared to have levelled off up to 1992, that the latest information showed a further rise. We also note the Department's evidence that changes in behaviour in this area would not show up in the statistics for another ten or 15 years, because these were very long-acting effects. As most of the cases are avoidable, we urge the Department to consider what more can be done to reduce the incidence of this disease, through further improvements in health education.

38. We note that conceptions among girls under 16 fell by about 20 per cent following the peak in 1990, but that the 1994 figures showed a rise. We also note the continuing action being taken by the Department to make family planning available to under-aged girls, and that recent initiatives such as a freephone advice service called *Sexwise* had had a huge take-up. We look to the Department to continue to monitor the position and, if there is a further rise, to consider what further action could be taken to keep the trend moving downwards.

39. We are concerned that important illnesses, such as prostate cancer, are not part of the Health of the Nation initiative and might therefore not attract sufficient attention and resources. We therefore urge the Department to ensure that health issues excluded from the initiative are not neglected and that opportunities are taken to develop and extend the strategy where new areas of concern emerge.

40. We welcome the cooperation between Departments concerned with Health of the Nation, but we look to the Department of Health to ensure that they maintain and build upon this initiative, especially in those areas where progress against the targets is slow, or moving in the wrong direction.

Limitations on the Department's ability to monitor progress

(a) Mental Health

C&AG's Report, para 8 and Tables 2 and 3

41. Although the Department had set targets to improve significantly the health and social functioning of mentally ill people (C1), and to reduce the suicide rate for severely mentally ill people (C3), it is not yet possible to monitor progress.

Q 17

42. We asked the Department whether there was any sign of getting closer to having a means of monitoring progress. They confirmed that the target for the general rate of suicides (C2) was being monitored. However, they admitted that when they set the targets they did not really have the analytical tools to quantify the picture on mental health and had done so almost in spite of themselves, because Ministers thought that mental health was such an important component of the whole picture. They told us that, since then, they had made good progress, using the Royal College of Psychiatrists, to develop a tool for measuring outcomes in mental health treatment. This tool, the Health of the Nation Outcome Scale, had been piloted in 23 sites and had been very well received. The Department intended to try to see that everybody used it in 1998.

Q 56

43. The Committee asked the Department whether it was true that suicide amongst Asian girls was rising and what action they planned to counter this. The Department confirmed that there was a higher suicide rate amongst Asian women. They pointed out that, on the general issue of health promotion and prevention of mental illness, there was quite a lot of work going on for the population generally: things such as the *Defeat Depression* campaign, partly funded by the Department, put into place by the Royal College of General Practitioners and the Royal College of Psychiatrists. The Department added that they had funded quite a lot of activities just to raise the general population's awareness of mental illness, to help people talk about it.

44. We were advised by the Department that they had focussed on particular population groups, such as farmers who had a high incidence of suicide. In the case

Q 158

Evidence, Appendix 2, page 48

of ethnic groups, they needed to look at the specific needs of those groups and in the case of young women it was a question of targeting them with appropriate information. They agreed that in respect of groups such as Asian women, the wider cultural problem had to be addressed. In a note, the Department informed us that a research project was underway looking at deliberate self-harm—including suicide—among Asian Women, to help guide the design of interventions to reduce deliberate self-harm in this group.

C&AG's Report, page 35

45. Mental illness accounts for about 14 per cent of NHS inpatient costs and 23 per cent of pharmaceutical expenditure, and it is the reason for about 14 per cent of certificated sickness absence from work. We therefore asked the Department whether in view of these costs they had given priority to research in this area in order to get them closer to the target. The Department confirmed that they do already fund a lot of research into mental health, and that the immediate way to attack the principal target in this area was to improve services. They had put a lot of effort into that in recent years.

Q 162

(b) HIV/AIDS and Sexual Health

C&AG's Report, Tables 1–3 and pages 38–40

46. One of the five key areas of the Health of the Nation strategy is HIV/AIDS and sexual health. The Department set three targets in this area covering reductions in the incidence of gonorrhea, in the percentage of drug users sharing injection equipment, and in conceptions among girls aged under 16.

Qs 26, 32 and 38–40

47. We questioned why figures on the development and progress of AIDS were not included in the Health of the Nation. The Department told us that the gonorrhea target was a proxy for HIV/AIDS. They did not have a target for HIV/AIDS because at the time they formulated the Health of the Nation targets they did not have the data to do it. However, they had been working in the meantime to try and get data on HIV in particular, from anonymised surveys; and a working group was looking at the data coming out of that exercise to advise the Department on whether they could develop a new target which would relate precisely to HIV.

C&AG's Report, page 39

Q 98–102

48. Sharing injection equipment represents an important mode of transmission for HIV/AIDS, but progress is not being monitored in a way which is comparable with the baseline used to set the Health of the Nation target. We asked the Department why this was. They told us that there had been problems in getting comparable data, but they would be doing another survey in 1997 and would then be able to look back on the data they had originally in 1990. As a result, they might revise the baseline so that they could get comparability. They added that one initiative which had been a huge success was the setting up of needle exchanges and there were now 500 of these schemes around the country.

Qs 28–41 Evidence, Appendix 2, pages 33–36

49. The Committee pointed out that official figures showed that annually reported new HIV cases have never since been as high as in 1986, which implied that AIDS cases would similarly stabilise. In the absence of figures on the development and progress of AIDS, we asked the Department what the latest information they had showed, in terms of the numbers of cases and forward projections. They told us that the numbers of reported HIV infections and AIDS cases were still increasing, albeit slowly. They added that, whilst past fears that HIV would spread throughout the whole population had not been borne out, the latest projections showed that new infections would continue, with over 2000 new AIDS cases forecast each year to 1999, including an increase from heterosexual contact, which would still be a small proportion of the total.

Qs 170–172

Qs 34–35

50. The Department pointed out that, compared with some other European countries, the situation in the United Kingdom appeared relatively controlled: for example new cases of AIDS in 1995 were 29.5 new cases per million population in the United Kingdom compared with 21.0 million in Germany; 89.4 in France; 103.4 in Italy and 183.2 in Spain. They considered that this containment in the United Kingdom was likely to be associated with a number of factors including the early introduction of public education campaigns in the mid-80s, targeted interventions among behaviourally vulnerable groups, and the availability of free-and-open access to Genito Urinary Medicine clinics and needle exchange schemes. They added, that they had tackled the issue very seriously and that the money—a lot of money—had been well spent because the problem was much less serious

than it could have been. However, this was not something about which they could be complacent.

PAC 18th Report, 1991–92

Qs 37–41

Evidence, Appendix 2, page 35

51. In view of the interest of our predecessor Committee in HIV and AIDS related health services, we enquired about the impact of the latest statistics on the planning of resources for HIV and in particular AIDS needs. The Department told us that the amount of money they were putting into AIDS services had stopped growing substantially, and it was adjusted each year in accordance with the latest projections. In a note, they informed us that, since 1990, the financial resources for HIV/AIDS treatment and care had taken into account the numbers of people alive with AIDS and severe HIV disease and estimated unit costs. In 1996 the projected numbers of AIDS cases in the current year was estimated to be some 10 per cent lower than that forecast in 1993, and as a result the amount allocated in 1996–97 was reduced by 7.7 per cent from £195.1 million to £185.7 million. At the same time, central spending on health education would fall, from £6.45 million to £3.64 million.

52. The Department added that most cases were treated in London and the South East, and this was reflected in treatment and care allocations. Recent epidemiology of HIV had become much clearer, enabling the identification of population groups most at risk and for them to be linked fairly confidently to geographical areas. Their *HIV & AIDS Health Promotion: an Evolving Strategy* published in November 1995, concluded that, although there remained a need for HIV prevention work for the general population, greater emphasis should in future be placed on developing work directed at vulnerable groups.

Conclusions

53. We are concerned that a working definition of severe mental illness has not yet been agreed, and at the length of time it is taking to gather data on the incidence and severity of mental illness. While we welcome the work of the Clinical Outcomes Group in this area, we are very concerned about the impact this lack of data could have on effective services for the mentally ill, and we urge the Department to take immediate action to agree a working definition and to provide national data on mental illness.

54. We are disturbed at recent reports of a rising number of suicides among Asian women. We note that the Department has started a special research project looking at deliberate self-harm, including suicide, among young Asian girls, to help guide the design of interventions to reduce deliberate self-harm in this group.

55. We are disappointed that, as yet, there is no indicator which specifically monitors the development and spread of HIV and AIDS. We note that the number of new cases of AIDS has levelled off, reflecting the established trend in new HIV cases, and that the UK compares well with other European countries. We note too the Department's view that this containment in the United Kingdom is likely to be associated with a number of factors including the early introduction of a public education campaign in the mid-1980s. We also note that because the projected number of cases of AIDS had fallen 10 per cent below the number forecast in 1993, spending on treatment and care was expected to fall from £195.1 million to £185.7 million in 1996–97, as would central spending on health education, from £6.45 million to £3.64 million. We consider it important that the Department complete their work on developing a suitable target in this area, to help them better target the funds available and their interventions at vulnerable groups.

56. We are disturbed that no national data is yet available on a consistent basis to monitor trends on drug users sharing injecting equipment, an important mode of transmission of HIV, and that the lack of data could impair the planning and delivery of AIDS and HIV services. We look to the Department to review the target when data from their 1997 survey is available so that comparability may be achieved.

Health of the Nation as Part of the NHS Planning Framework

C&AG's Report, para 4

57. Improving health through Health of the Nation has been highlighted in successive NHS Priorities and Planning Guidance, has influenced health authorities' plans to purchase health care and is reflected in local programmes carried out by hospitals, community health units and primary health care teams.

Q 161

Qs 173–174

58. We asked the Department about the relationship between reported progress against the Health of the Nation targets and funding priorities. They confirmed that there was a relationship in a broad sense, and gave the example of coronary heart disease where one of the reasons it was going down was that they were putting more and more resources into the way they treat people. They added that the Health Service was taking decisions every day, not just in this context, about priorities in relation to the benefits which would flow, and that the Health of the Nation targets were a very important part in that process.

Qs 1 and 159–160

59. In view of the importance of the targets we asked the Department how they had been set and whether some could have been made more stringent. They told us the strategy was long term, and when they set the targets they had been looking well ahead, in some cases well into the next century. In setting the targets, they had set themselves the objective of being challenging but at the same time realistic. They added that in setting the areas they should focus on and what targets they should choose, there had been quite a lot of consultation with experts, and in some cases they had looked overseas, for example, on coronary heart disease.

60. The Department told us that although some targets had been met already, for example, that for the incidence of gonorrhea, the numbers could go up as well as down and they had to be vigilant to try and make sure that the figures kept on going down.

C&AG's Report, para 3

Qs 108:110 and 128–130

Q 130

61. In each key area of Health of the Nation, the Department had set out action plans. We enquired whether they reviewed these plans in the light of progress. They confirmed that the Chief Medical Officer chaired a working group which reviewed progress three times a year. And they brought forward new actions where necessary; for example, on teenage smoking they had just launched a three-year initiative to improve understanding of this issue amongst teenagers. They accepted that, with hindsight, they might have set one or two targets at different levels, and that in some areas they were seeking to develop new targets, such as HIV/AIDS, but they thought the exercise had been a good one and would not wish to rethink the essentials.

C&AG's Report, para 5

62. The Health of the Nation White Paper stated that Regional Health Authorities would encourage District and Family Health Service Authorities to shift the focus towards health promotion, including changing the balance of resources as necessary.

Qs 10–14

Qs 131—132

63. We therefore asked the Department about the cost of implementing Health of the Nation, including health education. They told us that the overall investment on the Health of the Nation was a little under £3 million a year. They added that expenditure on health education by the Department and through the Health Education Authority was running this year at over £45 million, but pointed out that sums of that order—in deflated terms—were being spent before the initiative. In addition, there was an element in General Practitioner remuneration which was specifically about health promotion—£73 million—and spending by health authorities and trusts on their health promotion units was about £90 million. In total, therefore, some £210 million was being spent on health education and promotion.

Q 21 and 134–136

64. The Department was asked how they were measuring the effectiveness of these programmes. They told us that they had done a lot of work and had a disciplined approach. They did not run a big health education programme without piloting it very carefully; for example on breast screening. They also evaluated quite a number of their programmes as well to see whether they had worked or not, and to try and learn from them.

Qs 138–146

65. We asked the Department whether they had made any evaluation between health and poverty, in order to make health promotion more efficient and effective. They told us that this was a very complex issue. They had published a report which

Evidence, Appendix 2, pages 40–41

looked at what they knew about variations in health between different population groups in each of the Health of the Nation key areas, and information on the particular difficulties of different population groups was drawn on to inform health promotion activities. Several national health promotion activities specifically targeted those groups who had poorer than average health status, or who faced particular problems. Additionally considerable, even more closely targeted, work went on at a local level within the NHS, often working in partnership with local authorities, the voluntary sector and local communities themselves. Often this work was targeted on poorer communities which had particularly high rates of ill-health and premature death.

Qs 64–72 Evidence, Appendix 2, pages 37-39 and charts

66. Finally, we asked how the United Kingdom stood against other European Union Member countries. In a note, they provided us with comparisons in 20 areas against the 12 former members of the European Community. These showed that the relative position of the United Kingdom varied according to the disease in question. In particular, the charts showed that although in some areas such as coronary heart disease, the United Kingdom was making good progress against its targets, it still had far higher death rates than most European countries. For example, on coronary heart disease and lung cancer it was second highest in the number of deaths. The Department pointed out, however, that because different countries might have different systems of data collection and different conventions for recording data, the robustness of the comparisons varied from disease group to disease group. They noted, however that increased European Commission activity in this area associated with the development of a health monitoring action plan should, in due course, lead to better information on comparability of data.

Conclusions

67. We support the development of specific health targets, to help focus attention on health areas which most need to be addressed, and to set clear goals useful to the NHS and others.

68. We note that the Department is keeping under review the targets and action plans which underpin Health of the Nation, and we look to them to continue to be aware of the need to revise targets, or to set new ones, where new information emerges.

69. We note that, in some areas, such as coronary heart disease, although good progress has been made towards the targets, the United Kingdom still has far higher death rates than many European Union countries: on coronary heart disease and lung cancer the United Kingdom is second highest amongst the 12 founder member countries of the European Community. We note too that increased European Commission activity, particularly in developing a health monitoring action plan, could lead to better informed comparability of data. This in turn, could help the Department understand the complex reasons for the variances and inform their target setting.

70. We note the Department's approach to piloting health promotion campaigns and evaluating the results, as well as to developing ways of better targeting action plans, such as developing links between targets and action plans and socio-economic data. This is an area at the heart of the Health of the Nation strategy and where substantial sums are spent: some £210 million on health education and promotion each year. We therefore look to the Department to ensure that their programmes are well targeted and effective.

PROCEEDINGS OF THE COMMITTEE RELATING TO THE REPORT

WEDNESDAY 6 NOVEMBER 1996

Members present:

Mr Robert Sheldon, in the Chair

Sir Kenneth Carlisle	Mr Tim Smith
Mr Denzil Davies	Mr Michael Stern
Mr Mike Hall	Mr Charles Wardle
Mr Andrew Rowe	Mr Mike Watson
Sir Michael Shersby	Mr Alan Williams

Mr R N Le Marechal, CB, Deputy Comptroller and Auditor General was further examined.

The Committee deliberated.

Mr F Martin, Second Treasury Officer of Accounts was further examined.

The Comptroller and Auditor General's report on The Health of the Nation: A Progress Report (HC 656) was considered.

Sir Graham Hart, KCB, Permanent Secretary, and Dr D McInnes, Head of Health Strategy and Monitoring (Health Promotion Division), the Department of Health were examined.

* * * * *

[Adjourned till Monday next at half past Four o'clock.

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WEDNESDAY 5 MARCH 1997

Members present:

Mr Robert Sheldon, in the Chair

Sir Kenneth Carlisle	Mr Gerry Sutcliffe
Mr Andrew Rowe	Mr Richard Tracey
Sir Michael Shersby	Mr Charles Wardle
Mr Tim Smith	Mr Alan Williams

Mr R N Le Marechal, CB, Deputy Comptroller and Auditor General was further examined.
The committee deliberated.

* * * * *

Another draft Report (Health of the Nation: a Progress Report), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 and 2 read and agreed to.

Paragraph 3 postponed.

Paragraphs 4 to 48 read and agreed to.

Paragraph 49 read, amended and agreed to.

Paragraphs 50 to 54 read and agreed to.

Paragraph 55 read, amended and agreed to.

Paragraphs 56 to 70 read and agreed to.

Postponed paragraph 3 read, amended and agreed to.

Resolved, That the Report, as amended, be the Seventeenth Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order No. 116 (Select Committees (Reports)) be applied to the Report.

* * * * *

[Adjourned till Monday next at half past Four o'clock.

MINUTES OF EVIDENCE

TAKEN BEFORE THE COMMITTEE OF PUBLIC ACCOUNTS

WEDNESDAY 6 NOVEMBER 1996

Members present:

Mr Robert Sheldon, in the Chair

Sir Kenneth Carlisle	Mr Michael Stern
Mr Denzil Davies	Mr Mike Watson
Mr Mike Hall	Mr Charles Wardle
Mr Andrew Rowe	Mr Alan Williams

MR R N LE MARECHAL, CB, Deputy Comptroller and Auditor General, further examined.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL HEALTH OF THE NATION: A PROGRESS REPORT: HC 656.

PROGRESS TOWARDS HEALTH OF THE NATION TARGETS: NEW DATA (PAC 96–97/7)

Memorandum by The Comptroller and Auditor General

Introduction

1. This Memorandum updates the information and findings in *Health of the Nation: A Progress Report*, HC 656, Session 1995–96, to take account of new data available since publication of the Report on 14 August 1996.

Background

2. *Health of the Nation: A Progress Report* describes the Government's strategy for improving the health of the population. The strategy identified five key areas of ill-health:

- Key Area A: Coronary heart disease and stroke;
- Key Area B: Cancer;
- Key Area C: Mental illness;
- Key Area D: HIV/AIDS and sexual health;
- Key Area E: Accidents.

3. In each of these Key Areas, the Department defined objectives, and set targets for them. Progress to date towards these targets was assessed in *Health of the Nation: A Progress Report*, on the basis of data supplied to the National Audit Office by the Department of Health.

New Data

4. Data for more recent years than shown in the *Health of the Nation: A Progress Report* have now become available. In addition, data for some of the indicators have been revised and presented on a different basis. These revisions remove a discontinuity in the earlier data on mortality, which arose from a change in 1993 in the way that cause of death was recorded and coded by the Office of Population Censuses and Surveys, (now Office for National Statistics). As well as removing this discontinuity, these new data are expressed in the form of three year rolling averages, which smooth out short term fluctuations in the figures, in order to show trends more clearly. This also puts the data on the same basis as in the 1992 Health of the Nation White Paper, where targets were set on a moving average basis.

5. Table 1 shows the way in which each indicator has been updated. In total, more recent data for 20 of the 27 Health of the Nation indicators are now available. Eleven of these indicators are based on mortality

rates, and as described above, they have additionally been revised to remove the discontinuity and expressed as rolling averages. Some revisions of earlier data have also been made. New data for 1992, (for England only), for targets B2, Incidence of Invasive Cervical Cancer, and B3, Incidence of Skin Cancer are due to be published shortly by the Office for National Statistics. They are expected to show a further fall in the incidence of cervical cancer, and a rise in the incidence of malignant melanoma compared to 1991.

6. The new data are shown by Key Area and indicator in Figures 1–5, in the same format as adopted for *Health of the Nation: A Progress Report.*

Progress towards targets taking account of the new data

7. Table 2 reproduces the assessment of progress towards Health of the Nation targets made for *Health of the Nation: A Progress Report.* None of these assessments is altered significantly by the new data:

- for many indicators, good progress continues to be made towards targets. In particular, the new data for indicator D1, incidence of gonorrhoea, confirms that the target for 1995 has been met. Although not too much emphasis should be placed on one year's data, data for some indicators, for example, the deaths from accident indicators E2 and E3, show some levelling off in the downward trend towards the targets, while for others, for example, the lung cancer in women indicator B5, progress towards the target appears to be a little better than had previously been the case;
- for indicators where some progress towards targets was being made, the new data do not change the picture;
- trends for three indicators, A7 Obesity, A10 drinking by women, and B9, smoking by 11–15 year olds, were shown in *Health of the Nation: A Progress Report* to be moving in the wrong direction. New data for obesity show that the move away from the target may have stopped for both men and women. There are no new data for drinking or for smoking by 11–15 year olds;
- for some indicators, it was not possible to assess if trends were moving in the right direction. New data for indicator B2, incidence of cervical cancer, show a substantial improvement, and there may be some progress towards the target. There is insufficient new data to affect the conclusions about the other indicators in this group, for targets A6, blood pressure; B3, incidence of skin cancer; and B7, giving up smoking in pregnancy;
- for three indicators, no monitoring data consistent with baselines were available when the assessment for *Health of the Nation: A Progress Report* were made. Data for monitoring these indicators, C1 Mental Illness, C3 Mental Illness-suicide, and D2 Drug Misusers Sharing Needles, remain unavailable on a national basis.

Conclusion

8. New data available since publication of *Health of the Nation: A Progress Report* show some changes in trends, but it would be unwise to place too much emphasis on one year's new data. Overall, the new data do not significantly alter the conclusions reached in *Health of the Nation: A Progress Report*, summarised in table 2 of this Memorandum.

TABLE 1: UPDATES TO HEALTH OF THE NATION DATA

KEY AREA	CODE	TARGET	CHANGE
Coronary heart disease and stroke	A1	CHD mortality under 65	new data for 1995, new rolling average series
	A2	CHD mortality 65–74	new data for 1995, new rolling average series
	A3	Deaths from stroke under 65	new data for 1995, new rolling average series
	A4	Deaths from stroke, ages 65–74	new data for 1995, new rolling average series
	A5/B6	Cigarette smoking	no new data
	A6	Blood pressure	new data for 1994
	A7	Obesity	new data for 1994
	A8	Energy from saturated fat	new data for 1995
	A9	Energy from total fat	new data for 1995
	A10	Drinking	no new data
Cancer	B1	Deaths from breast cancer 50–69	new data for 1995, new rolling average series
	B2	Incidence of cervical cancer	new data for 1991, 1992 England data expected shortly
	B3	Incidence of skin cancer	new data for 1991, 1992 England data expected shortly
	B4	Deaths from lung cancer, men under 75	new data for 1995, new rolling average series

	B5	Deaths from lung cancer, females under 75	new data for 1995, new rolling average series
	B7	Giving up smoking in pregnancy	no new data
	B8	Cigarette consumption	new data for 1995–96
	B9	Smoking 11–15s	no new data
Mental illness	C1	Mental illness	no data available nationally
	C2	Suicides	revised data for 1993, 1994, new data for 1995, new rolling average series
	C3	Mental illness-suicide	no data available nationally
HIV/AIDS and sexual health	D1	Incidence of gonorrhoea	new data for 1995
	D2	Drug misusers sharing needles	no data available nationally
	D3	Conceptions, under 16s	new data for 1994
Accidents	E1	Deaths from accidents, under 15s	revised data for 1993, 1994, new data for 1995, new rolling average series
	E2	Deaths from accidents, 15–24s	revised data for 1993, 1994, new data for 1995, new rolling average series
	E3	Deaths from accidents, ages 65 +	revised data for 1993, 1994, new data for 1995, new rolling average series

TABLE 2: PROGRESS TOWARDS HEALTH OF THE NATION TARGETS

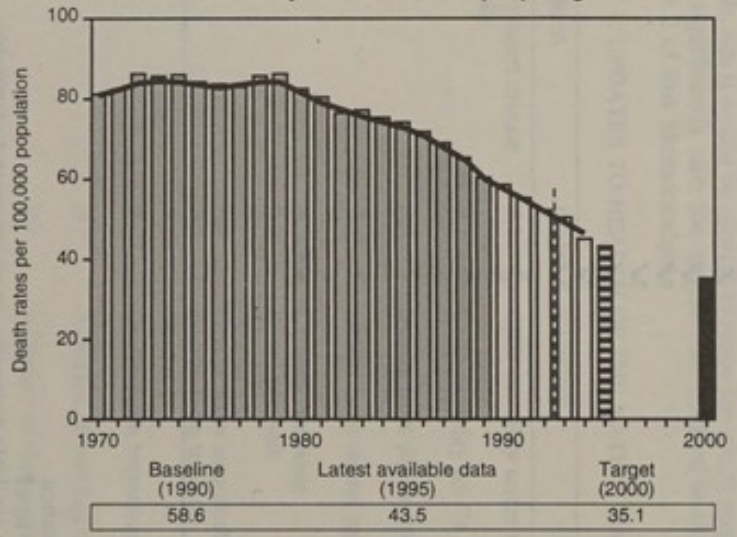
Code	Target	Progress towards target?
A1	CHD mortality under 65 years	✓
A2	CHD mortality, ages 65–74 years	✓
A3	Deaths from stroke under 65 years	✓
A4	Deaths from stroke, ages 65–74	✓
B1	Deaths from breast cancer 50–69 years	✓
B4	Deaths from lung cancer, men under 75 years	✓
C2	Suicide	✓
D1	Incidence of gonorrhoea	✓
E1	Deaths from accidents under 15 years	✓
E2	Deaths from accidents, 15–24 years	✓
E3	Deaths from accidents, ages 65 +	✓
A5/B6	Cigarette smoking—males	?✓
A5/B6	Cigarette smoking—females	?✓
A8	Energy from saturated fat	?✓
A9	Energy from total fat	?✓
B8	Cigarette consumption	?✓
D3	Conceptions under 16 years	?✓
A7	Obesity	X
A10	Drinking—females	X
B9	Smoking 11–15 years	X
A6	Blood pressure	?
B2	Incidence of cervical cancer	?
B3	Incidence of skin cancer	?
B7	Giving up smoking in pregnancy	?
B5	Deaths from lung cancer in females under 75	*
A10	Drinking—males	*
C1	Mental illness	–
C3	Mental illness-suicide	–
D2	Drug misusers sharing needles	–

Key to last column:
- ✓ = Making substantial progress towards target
- X = Moving in opposite direction to target
- ?✓ = Making some progress towards target
- ? = Not yet possible to assess progress in either direction
- * = No significant change from baseline or no clear trend
- – = No monitoring data consistent with baseline yet available nationally, so no assessment practicable

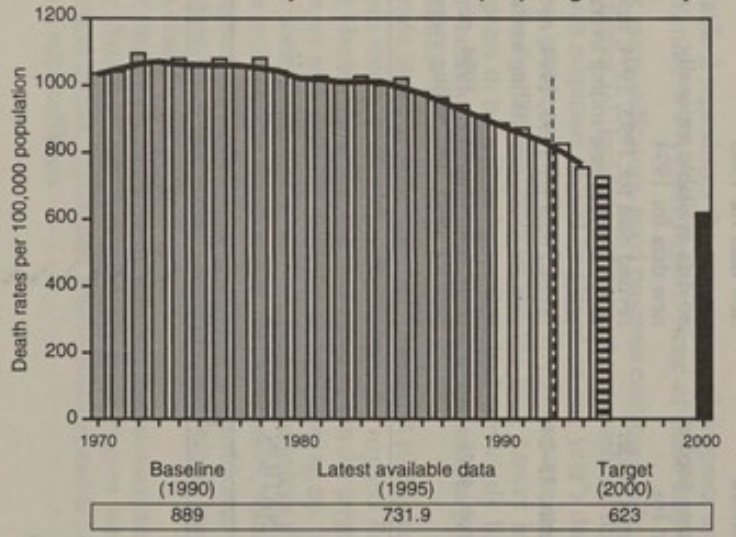
Source: Health of the Nation: A Progress Report, Table 3

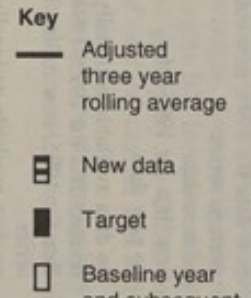
Figure 1: Coronary heart disease and stroke

A1: Deaths from coronary heart disease in people aged under 65

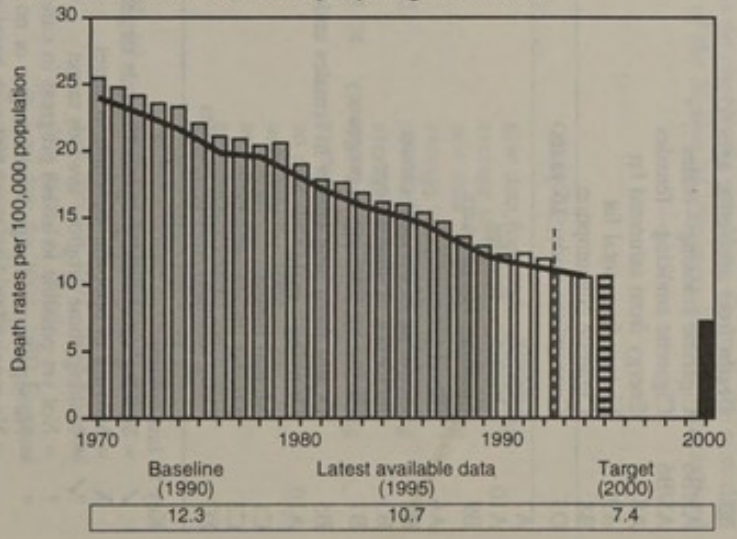


A2: Deaths from coronary heart disease in people aged 65–74 years





A3: Deaths from strokes in people aged under 65



A4: Deaths from strokes in people aged 65–74 years

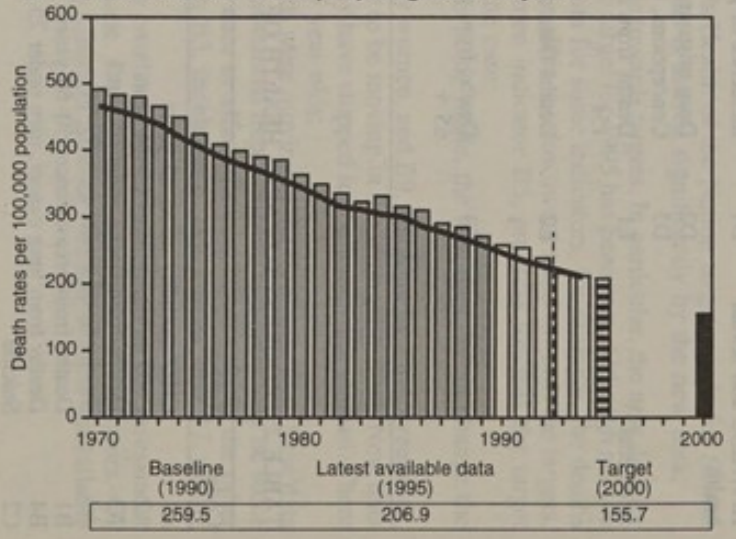
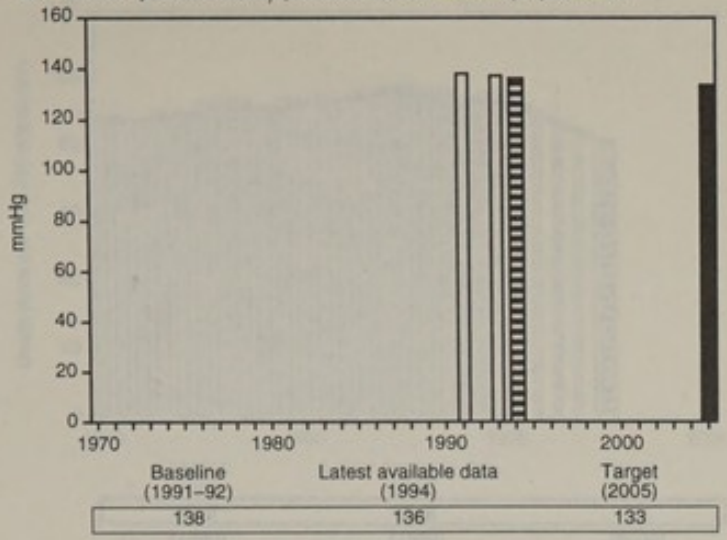
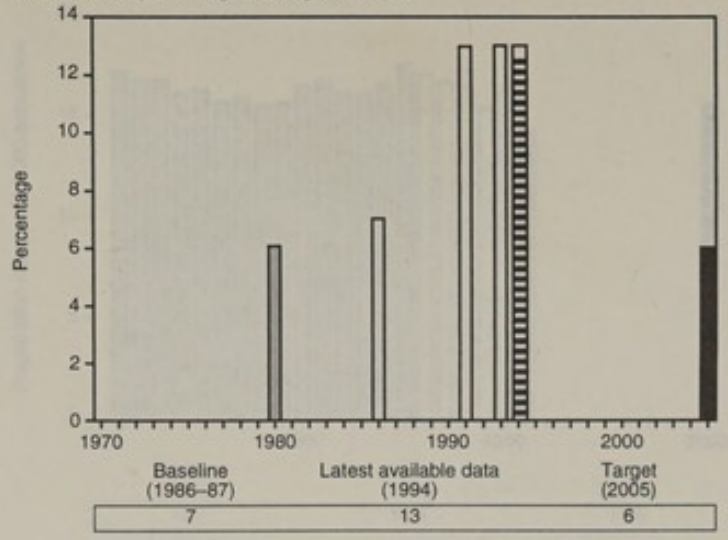


Figure 1: Coronary heart disease and stroke (continued)

A6: Mean systolic blood pressure in the adult population



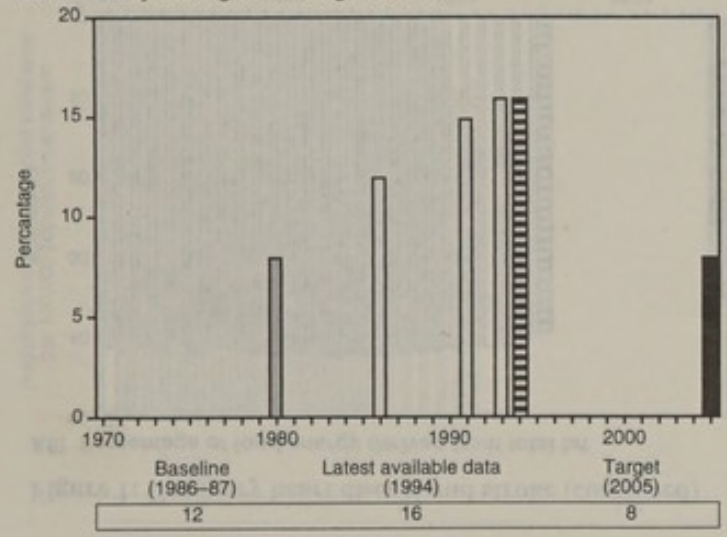
A7: Obesity among men aged 16–64



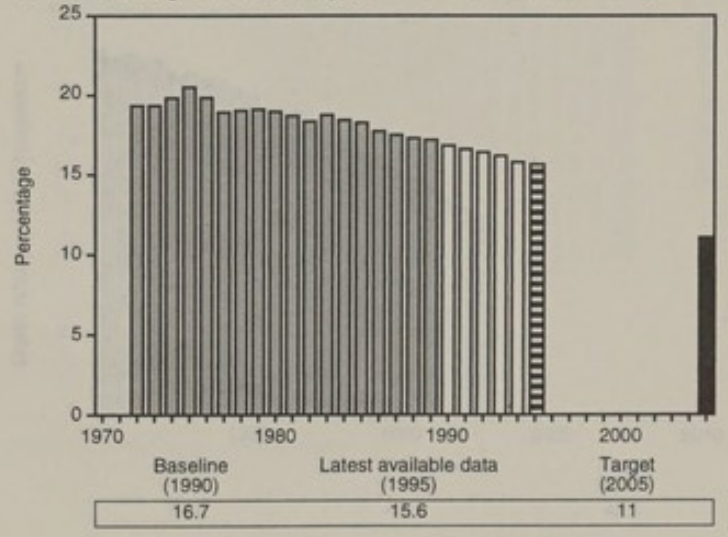
Key

- New data
- Target
- Baseline year and subsequent data

A7: Obesity among women aged 16–64



A8: Percentage of food energy derived from saturated fatty acids



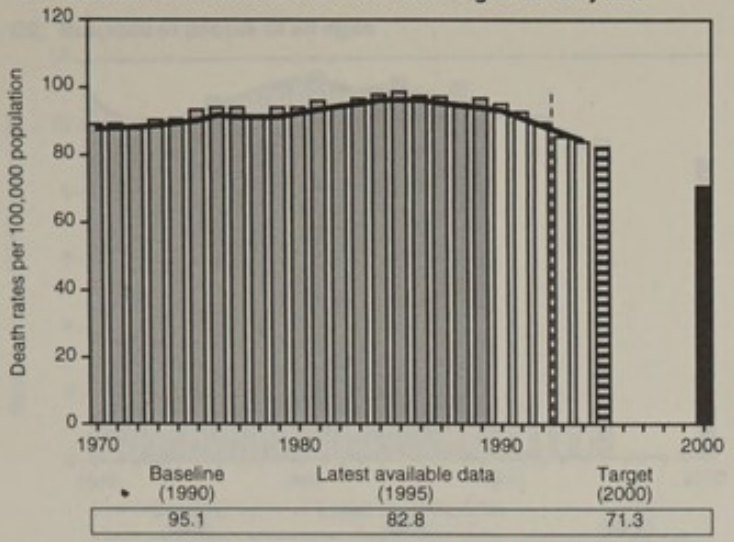
[Continued

Figure 1: Coronary heart disease and stroke (continued)

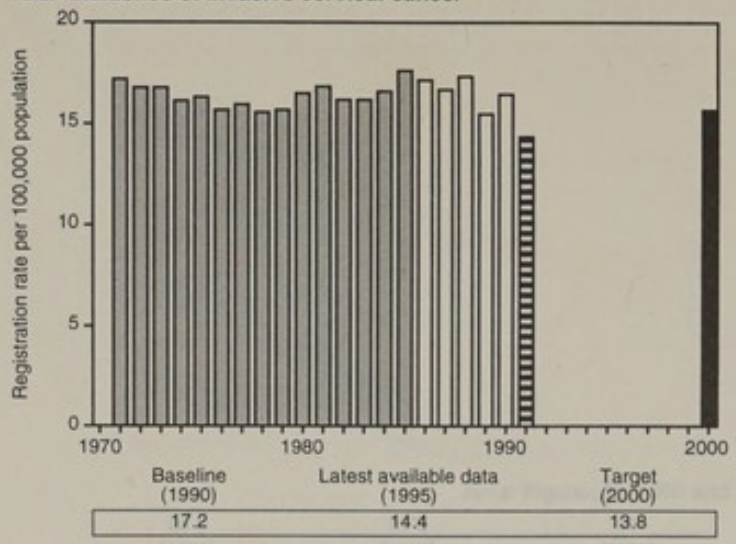
A9: Percentage of food energy derived from total fat

Figure 2: Cancer

B1: Deaths from breast cancer in women aged 50–69 years



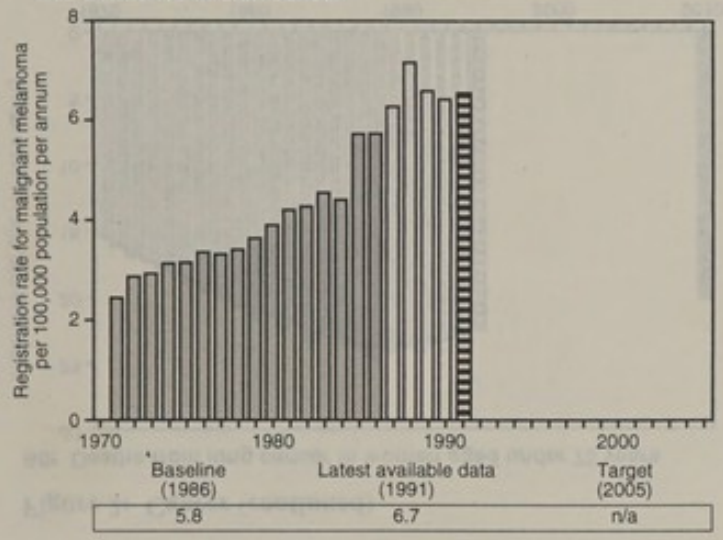
B2: Incidence of invasive cervical cancer



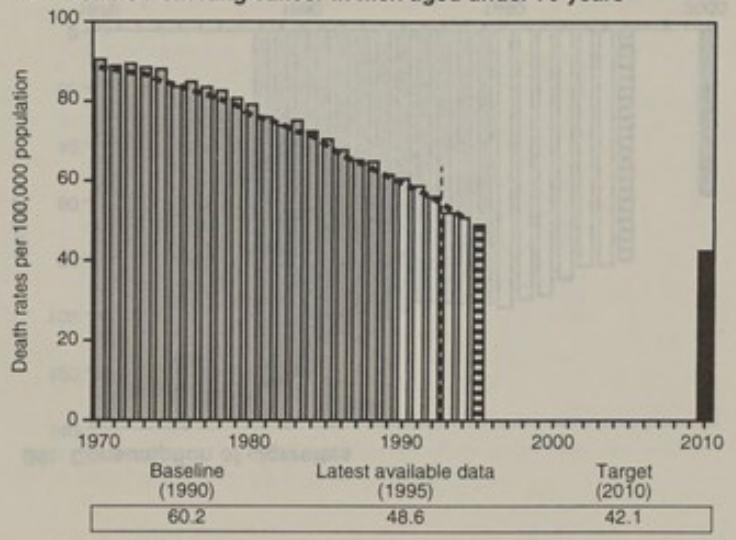
Key

- Adjusted three year rolling average
- New data
- Target
- Baseline year and subsequent data

B3: Incidence of skin cancer



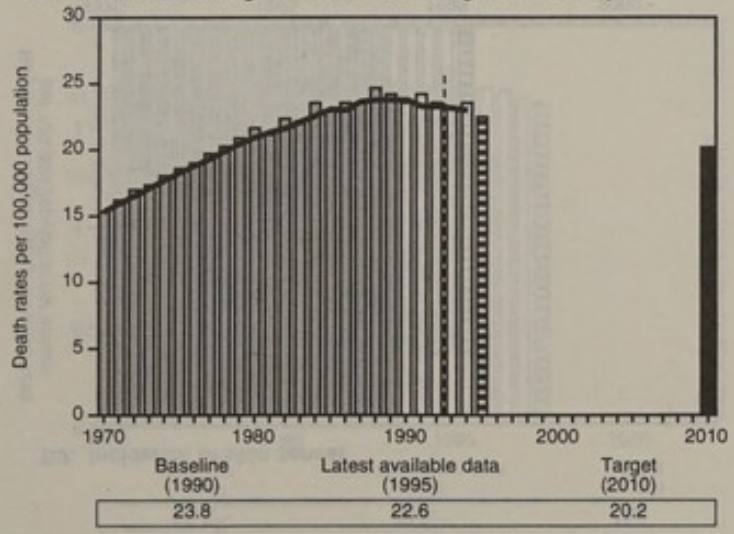
B4: Deaths from lung cancer in men aged under 75 years



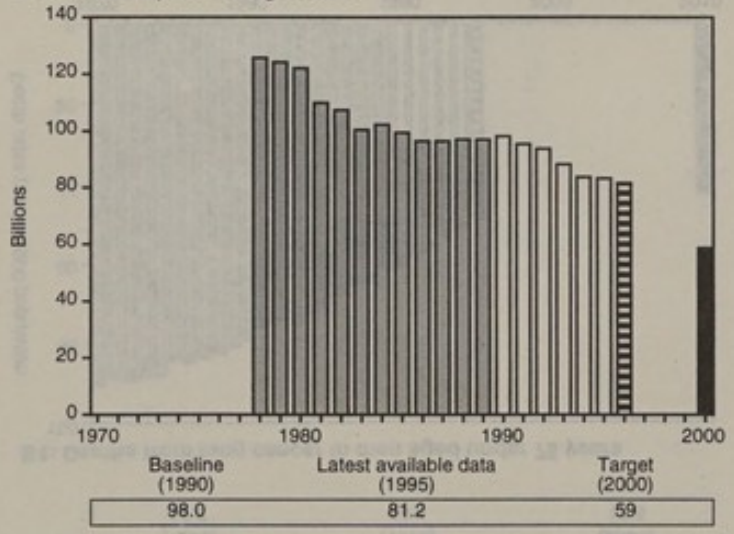
[Continued

Figure 2: Cancer (continued)

B5: Deaths from lung cancer in women aged under 75 years



B8: Consumption of cigarettes



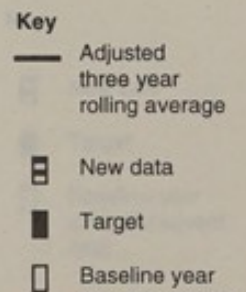


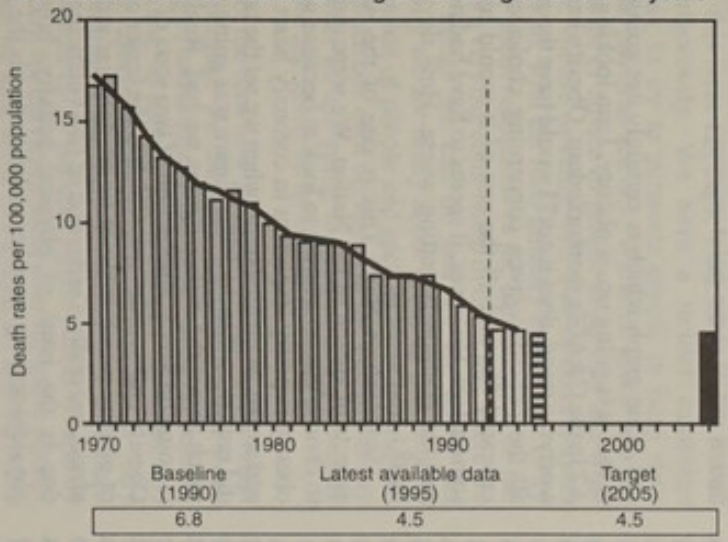
Figure 3: Mental illness

C2: Suicides in people of all ages

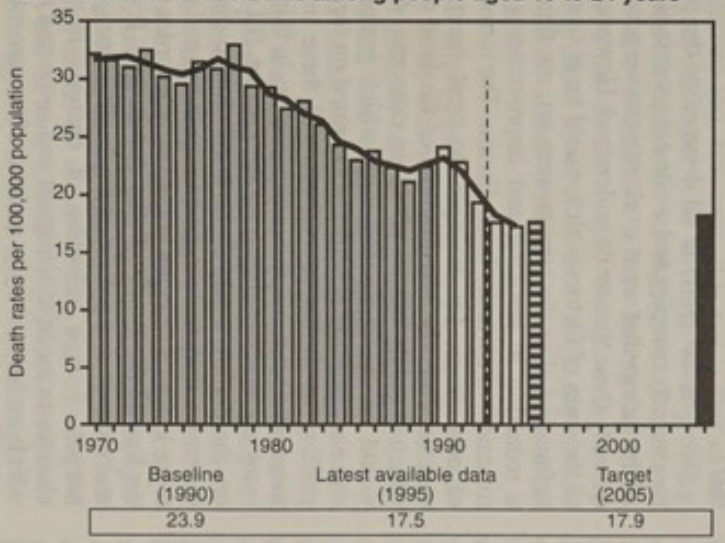
Figure 4: HIV/AIDS and sexual health

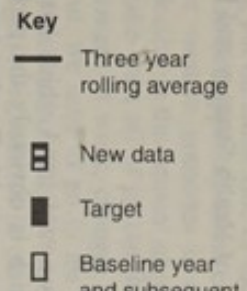
Figure 5: Accidents

E1: Deaths from accidents among children aged under 15 years

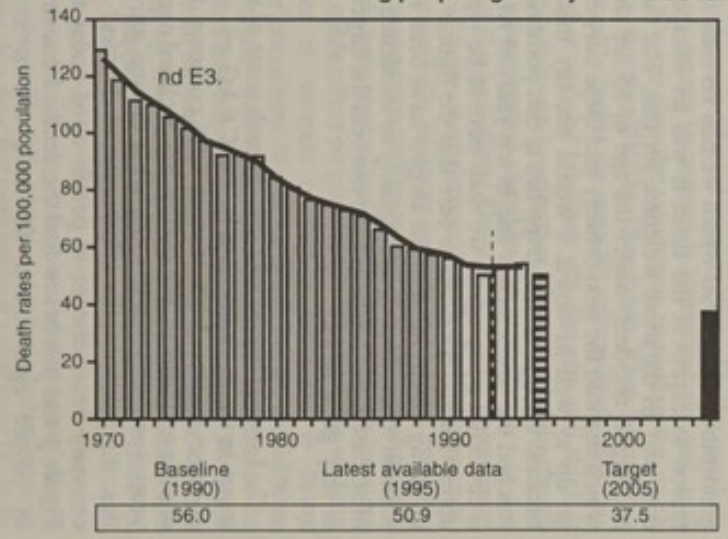


E2: Deaths from accidents among people aged 15 to 24 years





E3: Deaths from accidents among people aged 65 years and over



Note: Figures for 1993 and 1994 have been revised for indicators E1, E2 a
The target date for indicator E3 is 2005, not 2000 as shown in *Health of the Nation: A progress report*

[Continued

Examination of Witnesses

SIR GRAHAM HART, KCB, Permanent Secretary, DR D MCINNES, Head of Health Strategy and Monitoring (Health Promotion Division), Department of Health, examined.

MR F MARTIN, Second Treasury Officer of Accounts, further examined.

Chairman

1. Welcome to the Committee. Since the report of the National Audit Office we have received a further memorandum from the Comptroller and Auditor General as well as one through yourself, Sir Graham, on the report from the Office of National Statistics for which we are grateful. We see that a number of attempts were made, through the White Paper and subsequently, to improve the health of the nation. Some of these ideas were obviously very valuable but there are three targets which have already been met. In the case of the targets for accidents to those under the age of 65 these were met some ten years ahead of schedule. Would you say that the targets could have been made more stringent?

(Sir Graham Hart) This is a long-term strategy. When we set the targets in 1992 we were looking ahead in some cases well into the next century and I do think it is actually rather early to reach any general conclusions about how it is going. When we set the targets in 1992 we set ourselves the objective of being challenging in the way those targets were set but at the same time realistic. With hindsight one can say that one might have revised one's judgement at the time had one had 20:20 hindsight[1]. Of the targets which have been met there is only one which has actually been met in relation to the year for which it was set and that is the target about gonorrhoea which related to 1995 and which has been met. That is because there has been a drop in the incidence of gonorrhoea since 1990 which we had no reasonable reason to expect at the time; it was an unexpected drop and all the more welcome for that. The targets relating to accidents under the age of 65 are targets which run into the next century and these curves can go up as well as down. I would not say that just because the line on the graph has at this point nearly reached the target means that in ten years or so time it could not go up again; we shall have to be vigilant about that and try to make sure that the figures keep on going down. Most of the targets have been set in relation to a reduction in mortality or incidence rates of at least X per cent and if we can beat the target that is very good news.

2. I should like to take you through some of these items in the memorandum by the C&AG and some of these figures. I am starting with coronary heart disease and strokes. We see that has declined over the years very satisfactorily. To what do you attribute this: the publicity, the information to doctors? Both coronary heart disease in people aged under 65 in Figure 1 and just below that the deaths from strokes in people aged under 65 have shown a very satisfactory downward trend which has continued since 1991 which is obviously the period we are particularly concerned with. To what do you attribute that?

(Sir Graham Hart) In all these cases the position is extremely complex and we do not necessarily know all the factors that are at work, nor can we necessarily quantify those that we do understand. However, some of the sorts of factors which would be at work, both before and after the targets were set, are things like a reduction in smoking and improvements in the treatment of coronary heart disease. The introduction of new drugs, for example, to treat heart attack victims would be one example of the kind of thing which certainly has an effect on outcome. Another would be the frequency with which people with coronary heart disease can be operated on for bypass grafting or similar procedures. All these improvements in treatments and improvements in things like smoking rates certainly have their effect. If I may go on, the point I would make in relation to the future is that we shall have to go on improving and making these kinds of changes in the future in order to keep the line on the graph moving downwards. It will not move downwards of its own accord: it does not just happen, it is a reflection of changes in society, changes in medical treatment and so on and so forth which we have to try to maintain the momentum on; otherwise these lines on the graph will stop going down and will start to flatten out. They will of course flatten out at some point anyway.

3. One graph which is certainly not going down, in fact it is going up, is obesity. I am looking now at A7 in the C&AG's memorandum. Obesity has a very worrying trend, does it not? I would have thought that all the publicity given concerning cholesterol and saturated fats and all the rest of it would have had some effect. However, it seems to have had no effect and the position is getting worse. How do you see that?

(Sir Graham Hart) This is one of the worrying aspects of Health of the Nation. We were quite right to choose this as a target to look at because we think obesity is pretty important in coronary heart disease and stroke. With hindsight, when we set the target we did not know that the 1990[1] figure was going to be so much above the earlier figures we had. Really what is going on here is a reflection of two sorts of factors. Obesity and overweight, which is the lesser category of obesity which some of us are familiar with, I am afraid, are really a reflection of two balancing issues: one is the issue of physical activity, how much physical activity we take, and the other is the issue of

[1] *Note by witness:* The reference to "20:20 hindsight" should have been to "20:20 foresight" (See also Q 55).

[1] *Note by witness:* The reference to the 1990 figure should have been to the figure for 1991.

[**Chairman** *Contd*]
what we eat and drink. It is an equation, with the two things being put on either side of the equation, and what seems to be happening in our country and in a lot of other western countries is that there is a long-term decline in the amount of physical activity which we take—not all of us but on average—because of changes in work, changes in the way we move around, we tend to go in the car instead of walking and that kind of thing. We are actually using up on average fewer calories in our everyday lives and on the other side, what we eat and drink, there is also a decline too. However, it is not as fast as the decline on the other side so there is a growing imbalance between what we expend in calories and what we take in and that is now having the effect which you see on this graph. We are trying to do something about it but at the end of the day we are talking about issues which are very personal to individuals.

4. The target was to reduce the percentage of men aged 16 to 64 who were obese by 25 per cent and women by 33 per cent and it is not working like that at all; in fact with women it is going up.

(Sir Graham Hart) Yes, it is; it has done.

5. How was the target set? Did it not understand the way people were operating or were you hoping for a breakthrough in the kind of publicity or the new products which might come on the market and reduce the amount of fat which is going to be ingested?

(Sir Graham Hart) No, I do not think we thought there was some breakthrough to be had here. When we set the target, we did not realise that actually the position had already substantially deteriorated over what we thought it was at the time. With hindsight we would not have set a target as ambitious as the one we did set. You ask what we can do. What we can do is draw this issue to people's attention which we do pretty rigorously. We have a serious campaign underway to try to persuade people to raise their levels of physical activity. We have given and are giving a lot of advice to people about diet and what they eat. We are working with a lot of other players in this field, with the food industry and others, to try to bring about reductions in the consumption of fat, which is a very big component of this issue. There are lots of things we can do and we are doing but essentially we are really about bringing this issue to the attention of people and each of us as individuals has to make our own decisions at the end of the day about what we are going to eat and how physically active we are going to be in our lives.

6. Let me turn now to breast cancer and cervical cancer because we did have a report on this some years ago. I had assumed that the scanning procedures were going to reduce the incidence of breast and cervical cancer very considerably. This is very disappointing. I see that the target was to reduce breast cancer by 25 per cent by the year 2000 and by 20 per cent for cervical cancer over the same period. Yet when we look at the two graphs B1 and B2 in the memorandum from the C&AG we see that breast cancer over a longer period has not changed very much. Admittedly in the last few years it has come down a little and the same applies to cervical cancer. It has not been anything like as successful as I had anticipated or indeed the Committee probably anticipated.

(Sir Graham Hart) I would put a rather more optimistic gloss on events than that, if I may. On breast cancer, the position reached by 1995 was a 13 per cent reduction on the 1990 death rate and that does seem to me to be broadly on target for a 25 per cent reduction over a ten-year period. We are actually pretty pleased with the way the breast cancer screening programme is going; we think it is going extremely well, there is a very high level of coverage, a large number of cases are being diagnosed early and I would be reasonably optimistic that our target will be met. On cervical cancer, I did circulate, though I fear the figures may be a little confusing, this document which was published only yesterday by the Office for National Statistics[1] and which does relate to the Health of the Nation cancers. That actually does say, at the bottom right-hand corner of page 3, that so far as cancer of the cervix is concerned, it looks for England as though the target for the year 2000 has already been met. This is new data which the National Audit Office did not have when they did their original report nor indeed when they did their supplementary memorandum to you. On cervical cancer I am actually very agreeably pleased and a little surprised at the way the figures have come down and are now at about the level that we were aiming for in the year 2000.

7. The figures for breast cancer were not strictly comparable.

(Sir Graham Hart) Yes; absolutely, I apologise for that.

8. You are right of course on the cervical cancer and I take note of what you say there. On the question of lung cancer in women it is particularly sad, is it not? We see that the target was to reduce the death rate by the year 2010 by 15 per cent. It has been going up steadily and if we are a bit optimistic it seems as though it may be levelling off. Do you still think it is going to come down to that 15 per cent? Admittedly it is a long period ahead to the year 2010.

(Sir Graham Hart) There is a general point about a lot of these conditions and particularly the cancers, that the results of doing certain things like smoking or exposing yourself excessively to the sun may take a very long time actually to come through in some noticeable effect on your health. The position on lung cancer in women is that a reduction is being experienced now. It is quite gentle but we would hope and expect that that reduction will continue to be fulfilled and maybe even accelerate a little. We hope to see an increasing benefit from the effect of women giving up smoking and that is something which has been happening for a quite considerable period of

[1] *Note by witness: Monitor: Population and Health* (November 1996), Office for National Statistics (not printed): The new data show that there has been a significant fall in the rate of cervical cancer incidence since the 1986 baseline, whereas for malignant melanoma there has been a further rise in incidence in 1993 (PAC15).

[**Chairman** *Contd*]
years now. The effect on the mortality statistics will be delayed but I think that is what we are beginning to see on this graph already and what we shall hopefully increasingly see in the coming years.

9. The two great successes are over a longer period than that we are covering here: gonorrhoea and deaths from accidents. Those have definitely been most welcome. The gonorrhoea is presumably to do with general changes in sexual habits is it not?
(Sir Graham Hart) Yes, it is. We do not know exactly what the contribution of the various factors is but I would think that certainly increased use of condoms, because of concerns about various sexually transmitted diseases but particularly HIV and AIDS, would certainly be a very major factor there.

10. Paragraph 10 of the report tells us, "The Department of Health has invested time and resources in setting the strategy, developing indicators and frameworks" and so on. The effect of course has been useful. Do you think you have had value for that investment and how much do you reckon it cost you to mount this exercise?
(Sir Graham Hart) Yes, we have a very good return on our investment.

11. Have you been able to quantify the amount?
(Sir Graham Hart) Yes. The investment in the Health of the Nation initiative as such has been very modest because I am not going to include in the figure I give you the money we have been spending on a lot of health education programmes in relation to things like smoking, drinking and so on, because we were spending money before the Health of the Nation initiative started on those things and we would be doing it without the Health of the Nation initiative, if you see what I mean. What we added in 1992 when we launched the Health of the Nation initiative was a small central team in my Department, headed by Dr McInnes, of eight people which costs us in staff and associated costs about £230,000 a year. Dr McInnes has a central budget of about £0.5 million a year which she uses to pay for publications, conferences and the like. Then there is about another £2 million a year which is used to do similar things in the five key areas which you will be familiar with. The overall investment on the Health of the Nation initiative as such is running at a little under £3 million a year. Of course there is a vast amount of other expenditure going on in the Health Service and elsewhere to try to further the aims of the Health of the Nation initiative but most of that would have been going on anyway. What we have added through the initiative we have launched is that we have focused attention throughout the Health Service and amongst the public and local authorities and employers and a lot of parts of our society on the importance of health and health promotion. We have made a lot of the activities we were already doing a lot more effective as a result of that. We have engaged a lot of people in it now who were not engaged in this subject at all before, raised levels of interest and enthusiasm in it. I am confident that a lot more effort is going into health promotion than was before as a result of this initiative and we are seeing some of the results of that in the figures we have been talking about.

Mr Stern

12. May I follow on directly from the Chairman's last question? You say that the additional work generated in your Department by the Health of the Nation programme is costing a little less than £3 million. You said that excluded existing health education programmes. Certainly one of the factors which I believe led to the setting up of the Health of the Nation initiative was the fact that the results of existing health education programmes did not carry with them any element of measurement. Really I am not sure I accept your definition of the cost of the programme. Could you give us an amended cost figure which takes into account both the additional expenditure generated by the Health of the Nation programme on top of the existing expenditure on health education?
(Sir Graham Hart) Our expenditure in my Department and through the Health Education Authority is running this year at about £45 million. The point I was making was that sums of that sort of order—in deflated terms—were being spent before 1992 and would be being spent probably more or less if none of us had ever thought of the Health of the Nation initiative. We do spend that sort of money. May I address your point about value for money?

13. May I leave your answer just there because I will be coming on to value for money. Would I therefore be correct in saying, from your last two answers, that if we are looking at the Health of the Nation as an initiative designed to bring into focus what was being done on health education, then if we want to look at the effectiveness of the programme overall we are looking at a combined programme costing around £48 million?
(Sir Graham Hart) There is a lot more expenditure in the Health Service too. For example, GPs spent quite a lot of their time doing what you and I would call health promotion, that kind of thing. There is an element in their remuneration for that, they are expected to do it as part of their contract. Every health authority in the land either itself has a thing called a health promotion unit or it has a contract with a trust to provide the service; that is costing the Health Service something like £90 million in local health promotion. I do not want to mislead you: we do spend quite substantial sums of money centrally and locally on this.

14. Is it possible therefore to divide the cost up in a slightly different way? Most of us would distinguish between the sort of health promotion which is involved in each of us as an individual going to see our doctor or perhaps a consultant to obtain advice in relation to our own case and campaigns of the sort you have described which clearly can have no more than a scattergun effect. Could you possibly, either now or in a letter, give us some indication of the cost of the broad programmes within the Health Service for health promotion rather than the individual advice, which, as you say, is an essential part of the normal

[**Mr Stern** *Contd*]
work of the Health Service? Before you answer that question, may I add as a supplementary, that what I should very much like to see is such a breakdown of cost split if possible over the five areas indicated in the Health of the Nation programme.

(Sir Graham Hart) We will do the best we can. We will have the information for our national effort; it may be difficult to give it to you for the local effort because we do not necessarily collect it all in. I will very gladly give you a note[1].

15. May I now turn to some slightly more detailed questions? The background to these questions is that I always saw the Health of the Nation initiative as attempting to provide some mathematics to an art, in other words an attempt to measure from the point of view of control of public spending what exactly was being achieved by a programme which was previously based on faith alone. I am not sure whether it was your wording or the C&AG's wording in paragraph 9 of the report, which suggested that there are some areas in which it is clear that progress is limited. What this report does make clear is that that form of words is in itself something of an elision in that it is quite clear from the report that there are areas in which progress is negative. May I turn first to the areas where we have limited data and in particular the area of obesity? Am I correct in saying that we started with no reliable database and we still have no reliable database and that the evidence that obesity is in fact increasing is certainly in mathematical terms at least partial?

(Sir Graham Hart) Obesity is one of the areas where we have reasonable data. It is a new thing: we started in 1991, we launched something called the Health Survey for England which we do every year. Obesity is one of the things which is covered in that so we do have reasonable data about that. Unfortunately we did not have up-to-date data when we set the targets; this data came through afterwards. If we had had that at the time, we would have been a bit more realistic in how we set that particular target.

16. The initial target was probably incorrect: we now have slightly more reliable information. Clearly, however much information we have in this area, would it not be correct to say that so far the overall health education programme in this area has had very limited effect?

(Sir Graham Hart) It would but we are in early days. A lot of the things we set our hand to do, for example a campaign on trying to raise levels of physical activity, are new this year; that is a three-year programme which started this year. Some of the other campaigns we have been doing on nutrition are also relatively recent. These are profoundly difficult issues actually for all of us. We are primarily about giving people information but one hopes that from that people's attitudes will change and then their behaviour will change; that is the hope, it is not something we can order people to do or should try to but it is a hope that people will take note and change over a period of time. These things are slow: you do not turn them round overnight, you just have to keep on bringing it to people's attention.

17. There is one aspect of that I should like to come back to later but obviously I accept that we are talking about something that can only be effective over a period of time and that is probably particularly true if we look at groups C1 to 3 of the progress report when we are dealing with three parts of the campaign: health and social functioning of mentally ill people, suicides in people of all ages and particularly among the mentally ill, where the report accepts that the means to monitor progress were not available. Is there any sign that we are getting closer to having a means of monitoring progress?

(Sir Graham Hart) One of the targets is of course being monitored consistently and regularly and that is the general rate of suicide in the population; that is being monitored and is reported on here. The really important area is the one of trying to improve what we call the health and social functioning of mentally ill people. In a sense we chose this as a target almost in spite of ourselves in 1992 because Ministers thought that mental health was such an important component in the whole picture, accounting for such an amount of ill health and cost and so on, that we really ought to try to address it in a disciplined kind of way, even though we did not have then the analytical tools which would really enable us to do the quantification which you referred to. What we have been doing since then is trying to develop those tools into something which is usable and will actually tell us something real about what is happening in the world. We have made very good progress there. It has taken us a little longer than we had hoped but it is very hard stuff. We have used the Royal College of Psychiatrists to develop a tool for measuring outcomes in mental health treatment. This is something called the Health of the Nation Outcome Scale. That has now been piloted, it is a simple little scale with 12 individual elements in it and the idea is that the doctors or the nurses or psychologists who are treating patients can rate the mental health of the patient by using this scale. The art of it is to make it simple and easy to use because the resource consequences of having a complicated thing would be absolutely enormous. That so-called scale has now been developed and tested in 23 sites, it has been very well received, it is being used in some places regularly and routinely now. We are encouraging people to use it next year and it is our intention to try to see that everybody uses it in the following year. If I may modestly blow our trumpet, it is very exciting. I do not think anything like this has been done anywhere else in the world.

18. I am delighted to hear that, not least because it leads directly into my next question. May I turn to section D1, the incidence of gonorrhoea? Here we have an apparent success story in that having set a target you have discovered that it was being met a great deal more rapidly than originally anticipated. Would not one other way of assessing the effectiveness of what we are doing, particularly in an area like this where perhaps national characteristics are less important than in areas like obesity, be if we were able

[1] *Note by witness:* See Evidence, Appendix 2, page 31 (PAC37).

[**Mr Stern** *Contd*]
to draw up statistical comparisons with other developed countries? In other words, gonorrhoea has fallen in this country, has it fallen faster, as fast or more slowly than in other comparable countries?

(Sir Graham Hart) I defer to Dr McInnes who may or may not know the answer.

(Dr McInnes) I do not know the answer on that. The one point I would make is that we are using gonorrhoea as a proxy for the AIDS/HIV target area. What I would say is that the prevalence of AIDS and HIV in other countries, particularly Europe, is far higher than it is in England. One cannot draw an immediate comparison and say the gonorrhoea rate will also be higher in those other countries. All I would say is that gonorrhoea is a proxy for us for AIDS and HIV and that data is certainly lower in this country.

19. When you say the data is lower, do you mean that the speed of decline is lower or the actual incidence of cases is lower?

(Dr McInnes) The prevalence, the number of cases that we have in this country, is lower.

20. Do we have any comparators with other countries on speed of decline?

(Sir Graham Hart) The answer probably is that we do but we would have to take that one away[1]. The projections which I have with me of AIDS show that we think that the incidence of new AIDS cases is likely to peak around next year and then perhaps to be steady or even decline. That is AIDS, which takes a while to come through from HIV infections. We think the Health Service and the Department have done a very good job on HIV and AIDS in this country and certainly our record does stand very good comparison with most other countries.

21. You have developed the art of leading in your concluding remarks on to my next question. May I wrap up a number of my concerns as expressed in previous questions? Health of the Nation was designed, it seemed to me, to add some measurement to previous programmes. I deliberately mentioned comparisons with other developed countries last because it seems to me there is one area of measurement which is crucially lacking and which is particularly important to this Committee, namely, having measured what is happening have we yet developed any way of measuring the effectiveness of what our health education programmes are doing on what is happening? In other words, is all this measuring a complete waste of time or are we actually spending the money to some purpose?

(Sir Graham Hart) I am sure the measuring of the outcomes, which is in terms of illness and death rates and that kind of thing, is thoroughly worthwhile and is telling us something real about the real world. I take your point as being how do we know that these health education programmes in themselves are actually having an effect or whether it might be other things or whatever. All I can say is that we are very sensitive to that point: does it work, is it effective? We have done a lot of work and we have a disciplined approach to it that you do not run a big health education programme without piloting it very carefully to make sure that it is actually likely to reach the groups you are trying to reach and to have some positive impact on them. We are very careful about that, we do not launch into something without pre- testing. We do evaluate quite a number of these programmes as well in order to see whether they have worked or not and to try to learn from them. The one other point I would make is that our first responsibility in these matters is to inform people. Obviously what we would like to do in due course is to change their attitudes to certain things and for them then of their own accord to change their behaviour because that is what they have decided to do. The first step is essentially to give information. If people have the information and then they do not change their behaviour I do not regard that as a total failure, I regard that as having given people an opportunity to change their behaviour. If they do not wish to do so, that is their right.

Mr Williams

22. I should like to refer back to an earlier report we had and try to relate it to where we are at the moment. May I start with what may seem a rather odd question? When the cases were being reported of that dreadful illness which has been occurring where eating of flesh was referred to and so on, the Department quite rightly put out a response that we must not assume this is something absolutely new, it is something which occurs most years but it is not growing, it is not expanding and therefore it is not a matter of potential crisis. Do you recollect that?

(Sir Graham Hart) This is necrotising fasciitis, is it?

23. That is right; yes.

(Sir Graham Hart) Yes.

24. The reason I ask that question is because I want to establish a particular point. This is that in terms of whether we decide we have an epidemic or not, we take into account the rate of change in the new cases. If new cases are increasing rapidly you are moving into an epidemic, if they are constant, then there is less case to be made for an epidemic. Is that right?

(Sir Graham Hart) I am going to defer to my medical colleague.

25. Please do. I promise you I am not trying to trick anyone, I am trying to get at something here.

(Dr McInnes) Yes, you would look at the rate of increase. Similarly though there will be occasions where you will get a sudden burst of a few cases of something. It is a fine line when it becomes the epidemic.

26. May I then go where I intend to ask my questions. If I have missed it, I apologise. We have a figure in the C&AG's memorandum, Figure 4, HIV/AIDS and sexual health. But nowhere do we have a table on HIV/AIDS.

(Sir Graham Hart) That is correct; you have a table on gonorrhoea.

[1] *Note by witness:* See Evidence, Appendix 2, page 32 (PAC37).

[Mr Williams *Contd*]

27. Yet only a few years ago we were being warned and indeed are still being warned, what an enormous crisis we could face if HIV gets out of hand.
(Sir Graham Hart) Yes.

28. What I want to establish, and I promise you I am not trying to do any harm here, I am trying to get fundamentally at the truth of what is going on and for that reason I do not know whether I can crave your indulgence, Chairman. In fact I have asked the Clerk's Assistant to do some photocopies of a chart based on our earlier report on HIV/AIDS in 1991. She is doing some at the moment but I have one here which I will pass to you because it will make the questioning more comprehensible. What I want to get at is in the case of HIV and AIDS, AIDS is a derivative, is it not, it is the consequence of HIV?
(Sir Graham Hart) Correct.

29. Therefore the control statistic as far as you are concerned in your planning is the HIV one because if HIV goes down, given the constancy of percentage of HIV which converts to AIDS, one can assume that over the future and that is how you are making your forecast ahead at the moment ... In fact in 1991 I forecast that 1996 would be the peak year on the same analysis. What I want you to do is to look at the table I have given you. I would not do this if it were not what I regard as a very important incident. May I direct colleagues' attention to the higher diagram[1], the higher diagram is this diagram produced by the National Audit Office in its report to this Committee in 1991 and the basis of our study. Looking at it, what it is dealing with is new cases of HIV. If you look at the higher diagram you will see what seems to be an enormous escalation. The first figure in 1985 is 2,843 and you go to the final column and it is 15,166, five times as large. What I then did at that time and I put it to the Committee at that time, was to alter that diagram to the figure below, the trend chart[2]. Remarkably, despite the enormous escalation in the NAO diagram, the trend of new HIV cases was constant. Can I therefore take you through those figures—do bear with me—and if you want to interrupt and make a point in relation to this because you will see where I am going. According to the original figures we had, and at that date it was only up to 1990, you had to derive the new figures, they were not available, you had to work the figures out by taking the new cases which were the white section and separating them, in 1985 there were 2,843 new HIV cases, in 1986 there were 3,015. By the way, this actually is the highest figure ever recorded, ten years ago. If any of these figures are incorrect obviously do say.
(Sir Graham Hart) I do not have the means to check them.

30. They are figures which were provided to this Committee and to the National Audit Office. In 1987 it was 2,771, 1988 2,033, 1989 2,059 and 1990 2,445. Up to the time of the last NAO report is it not a fact that on this diagram there has been a remarkable constancy over the new incidence of HIV?
(Sir Graham Hart) Taking these figures there was a drop, a pretty big drop actually, between 1987 and 1988.

31. Between 1986 and 1990.
(Sir Graham Hart) Yes; absolutely.

32. I am puzzled that we have not had a more detailed report on HIV/AIDS as part of this major health study. You would have thought it would be one of the central issues. May I take you a stage further? In 1995 the Secretary of State for Health then gave the most up-to-date figures available for further new HIV infection; again, 1991 2,485, 1992 2,432, 1993 2,408. What we have is not an enormous escalation in incidence of this illness but astonishing constancy. I have talked and talked and I should not have but I needed to lay out the background. Could you comment on that before we go on to the AIDS side of it? Also, do you have the most recent figures?
(Sir Graham Hart) On the figures you have given—I do not have the identical figures with me but on the figures I do have here which probably relate to a slightly different group; it may be England rather than UK but on the figures I have too—the broad point you are making is borne out.

Chairman

33. You do not need to go further. As long as you accept that particular basis perhaps Mr Williams can continue the argument he is putting forward.
(Sir Graham Hart) Yes; of course.

Mr Williams

34. We then had an answer which I will not go into in detail on 31 October to the noble Lord Tebbit from the noble Baroness Cumberlege, Under-Secretary in the other place. This was dealing with new cases of AIDS. You have already partially referred to this in answer to an earlier question about trends. While there was an escalation in that answer, as you would expect for it takes some years for HIV to turn into AIDS, you therefore had the escalation expected between 1986, when it was 2,061 to 1991 when it was 1,013. Since then every year has been within close proximity to that figure: 1,013, 1,192, 1,236, 1,013. Can we assume, would it be reasonable to assume from the answer given previously and from these figures, that we are now able to work out (a) the ratio of HIV cases which turn into AIDS and (b) does it tell us anything about whether we have possibly reached a real peak in the incidence of new AIDS cases?
(Sir Graham Hart) On the second point, the Government does from time to time update the projections and we have not updated the projections very recently[1]. We will be doing it again in 1998. The

[1] *Note by Mr Alan Williams:* "I showed the witnesses the NAO Report diagram "A", which I feel is misleading visually about new HIV cases; I circulated "B" which is the same table, but with the new cases at the base of each column; this gave "C" which shows the constancy of annual rates of new cases". See Evidence, Appendix 1, figure A, page 30 (PAC90) for detail.

[2] *Note:* See Evidence, Appendix 1, figures B and C, page 30 (PAC90).

[1] *Note by witness:* The last AIDS Projections Report was published in January 1996 (PAC37).

[**Mr Williams** *Contd*]
very broad point which I think you are seeking to make, which is relative stability in the position, is borne out by the figures. That is not something which we can be at all complacent about.

35. No; no one is suggesting complacency.
(Sir Graham Hart) We have to work at it very hard to keep things at the level they are.

36. It is rather important. An awareness of AIDS and an awareness of HIV is extremely important, as you are rightly saying. Also, it does actually substantially condition the way in which some people organise their lives, therefore it is important we understand what the problem is. Is that not so?
(Sir Graham Hart) Yes.

37. It is even more important to you because you have to plan your resources ahead, do you not? You have to plan for future HIV needs and in particular the much more expensive future AIDS needs.
(Sir Graham Hart) Yes.

38. On the basis of these figures, which do seem to be a change in perception—not necessarily a change in fact but a change in perception of the nature of the HIV epidemic - is this having any significant effect on your current and future planning?
(Sir Graham Hart) No, because the situation you describe is one which really has been our perception for quite a while now. Our feeling is that we do need to update the projections from time to time but essentially we are in a situation where we need to keep on with a reasonable level of health education, with providing what are on the whole very good services, preventive and treatment, for this group. The amount of money we put into AIDS services has stopped growing substantially; it is adjusted each year in accordance with the latest projections.

39. What I am getting at is that this was, if anything, the most dramatic medical fear, probably of the post-war period. Yet here we are dealing with the strategy for the health services of this country and we actually do not have a single figure in this report on HIV and on AIDS or nothing which is worthwhile mentioning in terms of giving us any guidance.
(Sir Graham Hart) May I make a supplementary point? We are of course being examined on the Health of the Nation targets. As we explained at the beginning, the gonorrhoea target is a proxy for HIV/AIDS. The reason we did not have a target for HIV/AIDS was that at the time we formulated the Health of the Nation targets, we did not have the data to do it on. We have been working away, as I am sure you know, in the meantime, to try to get data about HIV in particular from the anonymised surveys which are now carried out. A working group is actually looking at the data which is coming out of that and is going to advise us on whether we can develop a new target which would relate precisely to HIV.

40. But a study of the health of the nation which does not include a study of the development and progress of AIDS is hardly meaningful. I think you will agree that this diagram which you produced is actually utterly irrelevant to the figures I have been putting forward to this Committee. It is actually misleading rather than helpful as far as HIV and AIDS are concerned, indeed it does not purport to be that, yet you have related it in your verbal evidence here. My time is running out; I know I have been a nuisance on very detailed stuff. There are important planning considerations here. First of all, when you were initially dealing with the allocation of resources it was HIV dictated and mainly based in London because that was where most people came to have their HIV test. Have we changed since then and has a regional map begun to emerge of the actual incidence of AIDS? Has that in any way altered your planning of availability of resources?
(Sir Graham Hart) The distribution of resources for treatment is related precisely to the data about what is known about the incidence in the different parts of the country so the allocation does reflect that. I do not have the detailed figures with me but actually the broad point you were making about the concentration of people in London does continue to be the case. It may be slightly less than it used to be but that is broadly still the picture.

41. Chairman, you have been very generous in time. May I ask for something to be put in which might be of help to the Committee? In view of the line of questioning which I have developed, could you put in a memorandum to us on your latest thinking with statistics in relation to the development of HIV/AIDS and the impact of those figures on your planning? Would that be possible?
(Sir Graham Hart) Yes; of course[1].

Mr Rowe

42. In sharp contrast to Mr Williams I shall be using rather a scattergun approach to this. There are several things I want to ask you. Clearly the diagnosis of cause of death is crucial in all this. I wonder how accurate it is. My experience of seeing admittedly a number of elderly relatives die is that the cause of death is almost hit or miss. There is a kind of concatenation of symptoms and the doctor chooses at will. I wonder whether this is a problem for you.
(Sir Graham Hart) May I ask my colleague who has probably done this herself on a number of occasions to answer your question.
(Dr McInnes) It is a very valid point which you make. With the very elderly population there is that risk. One is not allowed to write down on a death certificate that the patient has died of old age[2], which is basically in fact what they do when they are 90, 95 perhaps. On the targets which we have in the report, one of the things we look at is premature mortality, so it is people dying under the age of 65 or in some cases 65 to 74. For most of those I would say that the death certificates will be accurate. If there is any slight

[1] *Note by witness:* See Evidence, Appendix 2, pages 33–36 (PAC37).

[2] *Note by witness:* Following an amendment to the instructions to doctors completing death certificates during the mid-1980s it is, in certain circumstances, now acceptable to assign deaths to "old age" in people aged 70 years and over. This is however relatively unusual (PAC37).

[Mr Rowe *Contd*]

bias or inaccuracy, there is nothing to suggest that would be fluctuating year on year. In view of the fact we are looking at trends, then we will have an accurate reflection of what is going on in the country.

43. Do your tables have cross referencing? For example, extreme obesity causes all sorts of other symptoms. If somebody dies of a heart attack, the proximate cause of that is obesity, so do they appear twice in your tables or do they only appear as one or the other?

(Dr McInnes) One or the other. What we are looking at are several of the risk factors which lead to the coronary heart disease death. What we are aiming to do is to reduce those risk factors so that ultimately the coronary heart disease deaths will come down.

44. Do you have any figures on what I believe is called iatrogenic disease, disease caused by treatment itself? I ask this because I have just come from a somewhat harrowing meeting with a group of women who believe that they have been severely damaged by unnecessary radiotherapy, for example. Do you have figures on that kind of problem?

(Dr McInnes) No, it is not the type of information that would be routinely collected.

45. Should it be?

(Sir Graham Hart) I am not sure how you would do it actually. Are you suggesting this should be entered as a cause of death?

46. For example, it is perfectly clear that you have over time in the Department collected information on thalidomide. That was clearly medication induced. Therefore if you can do it for thalidomide, presumably you can do it for victims of radiotherapy if that were to be defined as one of the things you wanted to collect.

(Sir Graham Hart) It might be a matter of some dispute, of course, in many cases whether there had been wrong treatment or not.

47. I understand that. All I am asking is whether you are sensitive to that kind of possibility.

(Sir Graham Hart) Yes, it does happen from time to time undoubtedly.

48. It does not sound as though you are very sensitive to it, I have to say. Perhaps you should be. I have an interest to declare. I was cured two years ago of prostate cancer and one of the things which is extraordinary is how low the priority for example of PSA testing, which is a simple and relatively effective monitor of the onset of prostate cancer, is compared to the resources you pour in to breast cancer whose incidence I understand is not that far ahead now.

(Sir Graham Hart) If you are suggesting that there should be some kind of general population screening for prostate cancer, we do not have a closed mind on this. We do look at screening for various diseases from time to time.

49. It is the third largest killer of cancers among men judging from the figures you have just given us.

(Sir Graham Hart) My understanding is that we are going to look at this again; we have a new committee which is looking at screening across the board and we are going to look at this one again. The position we have had so far is that it has not been demonstrated to be cost effective actually.

50. But PSA testing is cheap and therefore I would have thought you could actually—it may not be cheap in National Health Service terms but I would have thought you could do a great deal of education towards people of the vulnerable ages being encouraged to pay for their own test.

(Sir Graham Hart) I imagine that is something which people can do now.

51. Of course they can do it: the question is whether you actually inform them of the need. I thought you said earlier that what you were interested in was giving people the opportunity to make a choice. This is one of the choices they could be encouraged to make.

(Sir Graham Hart) I think that is something which we could consider.

52. When you have thought about it a bit could you let us have some indication of what you are going to do in response to that particular set of questions?[1] In terms of predicting your likelihood of reaching targets do you have, for example, any evidence of the relation between take-home pay and alcohol use? It would seem to me that household income and the use of alcohol *prima facie* would have a link. I just wondered whether they do and if so is that the kind of predictive information which would allow you to refine your target setting?

(Sir Graham Hart) I am afraid I do not know the answer to that.

(Dr McInnes) We do not have the data to link the two together.

53. Would it be helpful? What I am interested in is perhaps generalising.

(Sir Graham Hart) What we are looking for all the time in choosing targets are areas where we can actually do something useful about a problem. I do not know what the data would show. If the data showed—I do not know what your hypothesis is—that higher income meant more drinking ——

54. Yes, higher income means more drinking, I would have thought.

(Sir Graham Hart) I do not quite know what we would do about that.

55. The point is you select targets. It seems to me that the reality of those targets—you talked earlier about 20:20 hindsight, I am talking about foresight—must be relevant in the setting of targets, if you can put into the mix various social indices which are likely to extend or diminish the vulnerability of a section of the population to a particular condition.

(Sir Graham Hart) The general point is absolutely

[1] *Note by witness:* See Evidence, Appendix 2, pages 36–37 (PAC37).

[**Mr Rowe** *Contd*]
right. These are general targets that we are choosing and different parts of the population, different groups within the population, will have different susceptibilities for one reason or another. Therefore in trying to carry through some kind of health education campaign it would perhaps be sensible to target some of your activities on a particular group; it might be an ethnic issue or there might be a socio-economic group issue as you imply, that is correct.

56. Can I then in that case move on to an ethnic group issue? Suicide among Asian girls is allegedly rising, for reasons which I think many people understand. If it is true, what steps do you propose to take to try to diminish it? May I link with that the rather surprising omission in the report of any attempt to bring preventive measures for mental illness? We do not necessarily have to have the details now but could you supply the Committee with the kind of strategies you have for diminishing mental illness and whether or not you are aware of a problem among Asian women? It may be a false perception but I understand the figures are slightly dismaying.

(Dr McInnes) The figures are in fact correct; it is not a false perception that there is a higher suicide rate amongst Asian women. Looking first at the general issue of health promotion and prevention in the field of mental illness, there is in fact quite a lot of work going on for the population generally, things such as the Defeat Depression campaign, partly funded by the Department, put into place by the College of General Practitioners and the College of Psychiatrists, which does do a lot in that area. We have funded quite a lot of activities just to raise the general population's awareness of mental illness, to help people talk about it. We focused on particular population groups. One good example at the moment is farmers which is a particular population group with a high incidence of suicide. We have done a lot of work there and it is showing rewards. In the case of the ethnic groups, again we need to look at the specific needs of those groups and in the case of young women it is a question of targeting them with appropriate information for that population group. It would depend very much even on the locality within the country but appropriately translated leaflets, videos, opportunities for them to talk to people who will understand the problems which are within their culture, those sorts of developments are happening across the country.

57. As part of your information campaigns how much do you do using children as informants? My wife, for example, works for the Centre for International Child Health which has a long established programme of child to child education. It seems to me that this is one of the areas in which developed countries like our own could actually learn from what is being tried in less developed countries where children are being seen to be very effective carriers of health messages both to parents and to themselves and also extraordinarily effective identifiers of health and disability problems among their own contemporaries. It seems to me that is not very highly developed in this country.

(Dr McInnes) The actual work children do in educating each other is something we are developing in the field of peer education. It is being used in schools particularly effectively in the area of AIDS/HIV and sexual health education where they can cope with the education far better; also with children working in youth clubs or in pop-in centres. Similarly we are developing things such as health promotion in schools where we would hope within the environment of the school the children will learn health messages which will be taken home, that they will be able to say to their parents—going back to obesity—things about healthy diets, issues such as smoking. There is activity in that area.

58. I am delighted but actually, I must confess, faintly surprised, that there has been a gratifying fall in the conceptions in girls under 16, given that my understanding is that girls become pubescent earlier than they used to do, the length of time between reaching puberty and the age of 16 is therefore longer. This is a great triumph on your part if this is what is happening. I wonder to what you attribute this welcome reversal of a trend which those of us who moralise in Parliament can believe.

(Sir Graham Hart) I do not think honestly we know whether it is a lower level of sexual activity or whether it is people taking precautions. The efforts of the Health Service and the voluntary bodies to make available family planning to under-aged girls in appropriate cases where all the safeguards have been met are having a good effect.

59. Am I right to note that you have chosen the word "conception" carefully?

(Sir Graham Hart) Yes; absolutely.

60. There is no increase in abortion is what I am saying.

(Sir Graham Hart) Conception is what we are measuring here.

Mr Watson

61. This report obviously only refers to England. Are there reports for other countries in the UK as well going on at the same time, strategies like this?

(Dr McInnes) Yes.

(Sir Graham Hart) All the other three parts of the United Kingdom have their own strategies but I cannot ——

62. I know they are not your responsibility but I assumed they would be going on.

(Sir Graham Hart) Yes.

63. Are these figures aggregated at any stage to get a UK picture?

(Dr McInnes) Yes, in fact quite a lot of these figures are disaggregated from some of our UK data or England and Wales.

64. How many other comparable countries, say G7 or EU countries, have undertaken or are undertaking similar strategies which you are aware of?

(Dr McInnes) If one takes the European region of the World Health Organisation they developed a strategy called Health for All 2000 which some

[Mr Watson *Contd*]
countries adopted. When we published Health of the Nation in 1992 we were regarded as one of the leaders in that we developed numerical targets and identified action we would take to achieve those targets. One or two countries within Europe are now following suit and we certainly have quite a lot of visitors from other countries.

65. You are regarded as leaders in the strategy. Where do we fall in the league table of comparable health statistics?
(Sir Graham Hart) Do you mean in terms of particular ——?

66. The sort of subject areas you have here. Where does the UK stand against, say, other European Union countries?
(Sir Graham Hart) Would you like to give me a for-instance? Do you mean coronary heart disease for example?

67. Yes, any subject you like; I do not have any particular one in mind. It is just a general picture. How healthy are we in the United Kingdom compared say to France, Italy or Germany? Presumably you make those comparisons so you know where we stand. There are nodding heads behind you so maybe that information will be forthcoming.
(Sir Graham Hart) We have data about the mortality rates from coronary heart disease in other countries. Are you asking where we stand?

68. League tables are rather popular just now. Where do we stand in the league table of European Union major countries' health statistics?
(Sir Graham Hart) In this country, to use the example—one cannot generalise the answer—we have a higher level of coronary heart disease than in many of the EU countries, particularly the southern EU countries. France, Spain, for example, have very low rates of coronary heart disease compared with ours. Exactly why that is is a matter of some discussion.

69. Diets presumably. You do not have a picture where you can rank the countries of the European Union.
(Dr McInnes) Yes, there are.
(Sir Graham Hart) Yes.

70. Where does the UK fall is what I want to know?
(Sir Graham Hart) For the standardised death rate under 65 from coronary heart disease the UK stands at the head virtually or the worst.

71. That is bad.
(Sir Graham Hart) Actually Ireland is just above us and then Finland and so on down.

72. I do not want to put you to too much work and I realise you cannot give the answer just now but I wonder whether you could prepare for the Committee for the five headings in this report a note to let us know where we stand against the other EU member countries?
(Sir Graham Hart) We will give you what data we have; we may not be able to make it exactly[1].

73. May I move on specifically to the question of smoking? I note if we look at the report on pages 17 and 18 that there has been a steady downward trend which is obviously to be welcomed. It seems to me that the target of 20 per cent of the population, both male and female, not being exceeded in terms of smokers is a bit unrealistic now for the year 2000. Do you accept that?
(Sir Graham Hart) No, not yet.

74. You think it is achievable; given the sort of curves we have seen since 1990 you think we are on target as a nation?
(Sir Graham Hart) Who knows whether we will do it or not but I am reasonably optimistic.

75. You still think it is achievable.
(Sir Graham Hart) I still think it is achievable.

76. One of the things which strikes me as surprising and which is something which comes up in various places in the report is on page 17 under comments, "Because little data are available after 1990, it is difficult to tell whether that decline has continued". The same is said for men and women. I must say I find that one of the most surprising comments in the whole report. Surely there is no shortage of data on smoking and its effects? It is a regular subject of discussion in the media, there are court cases ongoing in which tobacco companies are being sued. Surely there should not be any shortage of such information. Why is that stated?
(Sir Graham Hart) The data we have on smoking, the percentage of people who smoke, is produced every two years and has been for a long time and is going to continue to be provided every two years.

77. In the updated information we have had, which would include 1994 on that basis, judging by the additional information we have been sent, there are two headings: cigarette smoking, no new data; giving up smoking in pregnancy, no new data. Where is the 1994 information?
(Sir Graham Hart) That is because the 1996 data is not yet available. That will be done in the general household survey. It is actually being done now in 1996 so that will be available hopefully next year.

78. That will be fine when it arrives but the figures we have been looking at here cover 1994 in terms of general population but they do not cover that in terms of giving up smoking in pregnancy: latest available data 1990.
(Sir Graham Hart) That is something which is obviously a comparatively small population which you need to survey in order to find pregnant women.

79. That makes it easier rather than harder does it not?
(Sir Graham Hart) The point I am making is that

[1] *Note by witness:* See Evidence, Appendix 2, pages 37–39 (PAC37).

[**Mr Watson** *Contd*]
it is not done in the general household survey which is a survey of the whole population. It is done in a specialised particular survey which we are doing[1].

(Dr McInnes) The nutrition feeding survey is the survey where we look at how women are feeding the babies and we use the opportunity to get information on smoking in pregnancy. The data should be available next year.

80. It is not something which is monitored through health authorities or trusts or GPs.

(Dr McInnes) In fact we have now introduced, and data will be available from next April, following on from Health of the Nation, information from health authorities; they will collect it from the ante-natal clinics.

81. In future you will get it on more than a six-yearly basis is what you are saying.

(Dr McInnes) We will get data in order that health authorities can monitor their activity in that area, yes.

82. That will be a gap in your information which will be filled.

(Dr McInnes) Yes, it will be filled.

83. You say that it may prove increasingly difficult to persuade those who continue to smoke to give up during pregnancy. It seems to me that the link between smoking in pregnancy and the effect on the child is fairly clearly demonstrated. Do you not think you should be having some kind of hard hitting campaign which would get that message across to pregnant women who smoke?

(Sir Graham Hart) It is put across pretty powerfully.

84. It is not powerful enough obviously because it is not having an effect. It seems to me that if there is that sort of harm to a baby, should there not be a harder hitting campaign done through doctors or information sent out?

(Sir Graham Hart) It is done through family doctors and through ante-natal clinics and so on and so forth. It is a message which is very, very clearly understood by all the health professionals in this area and it is put across.

85. What you are saying is that it is being ignored by a significant number of pregnant women.

(Sir Graham Hart) Yes. It is hard to give up smoking.

86. Yes; you need to have the will to do it before you give it up obviously.

(Sir Graham Hart) Yes.

87. May I move on to the question of under-age conceptions? I would have to take issue. My colleague Mr Rowe asked you a question a few minutes ago and he mentioned the downward trend. In looking at the additional information you have sent us that trend has been reversed, has it not, it has gone up in the last year, which is pretty depressing but we are now up from 8 per 1,000 in 1993 to 8.3 per 1,000 in this last year. Some of the gains made have been lost. You said you had no idea why that downward trend had happened, in answer to Mr Rowe. Does that therefore mean you have no idea why it has begun to turn up again?

(Dr McInnes) No, it is a single year. What we say is that we cannot draw any conclusions on that single year, we hope that it is just what we would call a blip and that we will see a continuation of that downward trend. At the present time we do not have an indication of the cause of it.

88. It is the first upward turn since 1990 is it not and there was a significant reduction? I have really asked you this question before but am I right in saying that the UK compares rather badly with the incidence of under-16 conceptions compared to most other European countries?

(Dr McInnes) Certainly compared to the Netherlands which was the country we used as our comparator when we set the target, yes, we do perform badly.

89. The target is 4.8 which is going to involve a massive reduction. Do you still see that as a realistic target, given what you describe as the blip of 1994? Is it achievable?

(Sir Graham Hart) Yes; it is still realistic. I should be very reluctant either to give up or start revising these targets or anything like that.

90. Surely the point of this progress report is if you think the targets are unrealistic you should revise them. What I am saying to you is that you are quite some distance away from it, we are now half way through that particular period over which you hope to achieve the reduction. If you do hope to achieve it what is going to happen that has not been happening at that pace up to now? What sort of campaign do you have ongoing? Is there a campaign through health authorities or schools or how is any campaign conducted?

(Sir Graham Hart) There is quite a lot of activity locally in the NHS through family planning clinics and so on. There is a programme called Sexwise I understand which is a free advice service.

91. Where is this available? You mentioned family planning clinics but some girls of 13 to 15 are a bit wary about going to family planning clinics. If they do not go how would they get the information? Where is Sexwise made available? Through schools, youth clubs?

(Sir Graham Hart) It is a phone line.

92. A freephone.

(Sir Graham Hart) Yes.

93. Is that a recent initiative?

(Sir Graham Hart) Yes; 1995 we started that.

94. You think that is going to contribute to the fall.

(Sir Graham Hart) I think it is.

[1] *Note by witness:* The title of the survey from which the figures for smoking in pregnancy are derived is the Infant Feeding Survey (PAC37).

[Mr Watson *Contd*]

95. Has there been a big take-up in the period since it was introduced?

(Dr McInnes) Huge take-up. They have been quite surprised by how prepared young people are to use the phone line. It has the advantage that it is anonymous and that is the advantage over going to a family planning clinic.

96. Yes, it is. I do not want to doubt your hopes, I very much hope you can reach that target and I look forward to hearing of further movement downwards. One final question. Mr Rowe also drew attention to the fact that you have headed that section D3 conceptions rather than births. I understand why you have done that. Then lower down it states that you do not include spontaneous abortions. That seems to me to be illogical, given that conceptions must have taken place. Does that not distort the figures? That is the first question. The second question is what would the figures have been had spontaneous abortions been added in?

(Dr McInnes) Many spontaneous abortions will not be known to the Health Service. Quite a lot of women will naturally abort a pregnancy very early, will not require medical attention within a hospital where we would get that data so the normal method of actually collecting the data on conceptions would be as described here.

97. So it would be incomplete; you could not give me a complete picture.

(Dr McInnes) No, it would not be comprehensive.

98. The last subject I should like to cover concerns drug injectors. Unfortunately having a city centre constituency I have had quite a number of contacts with drug injectors and the effects of their habits, including quite a number of deaths. The first thing which struck me on reading page 39 of the report was that the statement, "Sharing injecting equipment therefore represents an important mode of transmission for HIV/AIDS" is hardly a revelation. It seems to me that an obvious way of reducing that, certainly it is something which has been tried in Glasgow and Edinburgh and other places in Scotland, is to provide needle exchanges. They have been very successful in Scotland.

(Sir Graham Hart) Yes.

99. Controversial but in general successful. There is no mention of that in here and I just wondered what the position is in England.

(Sir Graham Hart) Absolutely. There are now 500 of these needle exchange schemes around the country.

100. They must be having an effect.

(Sir Graham Hart) I think they are having a huge effect on this problem.

101. It would be helpful to show the effect they are having. I cannot talk in detail about the position in England but the funding for these needle exchanges is in some doubt in Scotland and I think if you can show that they are being effective it does not just inform your report but it would be helpful in wider terms. The report also says, "At present, progress towards achieving this target is not being monitored in a way which is comparable with the 1990 baseline". I simply have to ask why? If you cannot monitor it meaningfully what is the point? What are you measuring it against? That is under "Progress" on page 39. It seems to me rather odd if you are trying to measure the progress you have made. I wonder why that is not possible?

(Dr McInnes) We will be doing another survey in 1997, in fact one of the things we will be doing is actually looking at take-up of needle exchange. There have been problems in getting comparable data and when we get the information in in 1997 we will then be able to look back on the data we had originally in 1990 and we may need to look at the target again, possibly revise the baseline, when we can get the comparability. That will be available once we have the information in and we can then adjust the 1990 baseline.

102. So it is a temporary position.

(Dr McInnes) Yes.

Sir Kenneth Carlisle

103. Is this the first time we have had health targets in this country?

(Sir Graham Hart) No; indeed one or two of the Health of the Nation targets were carried forward from an earlier thing, but nothing on this scale before.

104. The advantage of this, you said previously, is that it focuses your attention very much on areas which need to be addressed.

(Sir Graham Hart) Yes.

105. You find that useful.

(Sir Graham Hart) Yes, and the Health Service and a lot of other people find it helpful.

106. Obviously some of the areas are making very encouraging progress. There are some areas which are not and which I really want to concentrate on. You said it was too early to know whether you would hit the target for most of them but are there any where you are sure you will not hit the target now?

(Sir Graham Hart) There is one where we have already missed the target which is the teenage smoking target. That is the only one we actually know for sure we have missed but there are one or two others which are not looking good.

107. Alcohol consumption for example.

(Sir Graham Hart) Alcohol consumption, the obesity targets, as we have already established, are a long way ahead but they are also going to be a very hard thing to do.

108. It seems that the building block for each of these challenges is what you call your action plan. We do not have those action plans but presumably the action plan addresses each area in quite some detail and sets out how you are going to tackle the problem.

(Sir Graham Hart) There is a whole set of actions on each target; yes, that is correct.

[Sir Kenneth Carlisle *Contd*]

109. As far as you are concerned you are following those action plans quite closely are you?
(Sir Graham Hart) Yes.

110. Have you had to rewrite or adjust any of those action plans or are they set in cement?
(Sir Graham Hart) No, they are not set in cement. We do review progress on the Health of the Nation initiative regularly. The Chief Medical Officer chairs a working group which reviews progress three times a year, something of that sort. We keep the thing under pretty constant review and we do bring forward new actions where we think it is necessary. For example, on teenage smoking we just launched this year a three-year initiative to improve understanding of this issue amongst teenagers. That is new this year.

111. I wanted really to concentrate on that because it seemed to me one of the most disturbing of all the things in front of us. You missed the target by a huge amount.
(Sir Graham Hart) We did.

112. Why do you think that was the case?
(Sir Graham Hart) With hindsight this was one of these examples where we inherited the target from before the Health of the Nation initiative and it just turned out to be very, very ambitious. I have to say that in preparing for this hearing I was looking at the figures over a long run of years; we have figures since 1982 for teenage smoking. They are very surprising to me actually, I do not frankly understand. What happened was that the percentage of teenagers admitting regular smoking in 1982 was 11 per cent, it fell in 1988 to the low point which we used as our baseline, which was eight per cent and it is now back in the latest year at 12 per cent. It seems to have gone down and then up again and unless there is a kind of rogue year in the statistics, that is rather puzzling to me.

113. Is there any understanding why this has happened?
(Sir Graham Hart) No, not on my part.

114. None at all.
(Dr McInnes) No.

115. It has just happened. How addictive is smoking? If you smoke at 14, how likely are you to be smoking in your 20s or 30s or as an adult?
(Sir Graham Hart) I do not want to get into a technical definition of the word "addictive" but probably a number of us in this room know that it is jolly hard to give up smoking. If you start as a teenager, you are quite likely to smoke throughout your life.

116. We do not know what the proportion is.
(Sir Graham Hart) We possibly do.
(Dr McInnes) The majority, most adult smokers, will have started as teenagers before the age of 20.

117. In fact the implication for health among adults in ten years' or 20 years' time is more serious.
(Sir Graham Hart) Yes.

118. That again presumably will put under threat some of your targets for adult smoking and smoking during pregnancy and so forth.
(Sir Graham Hart) Yes, it could be. This is a very important area, this teenage smoking.

119. There are no grounds for complacency on the other areas of smoking if this is deteriorating.
(Sir Graham Hart) You are quite right. We have to keep on. There is a whole range of things which can be done about it; it is not a hopeless case at all. Great progress has been made over the years in reducing smoking; it has come down very, very markedly. The further the line goes down probably the harder it gets.

120. Do we know what the figures are for 1995? Has it got worse still?
(Sir Graham Hart) Teenage smoking?

121. Aged 11 to 15.
(Sir Graham Hart) No, we do not.

122. There is no reason why this should be the peak, is it? It could in fact continue to increase.
(Sir Graham Hart) It could.

123. Which will make the problem even worse. We are in uncertain territory.
(Sir Graham Hart) Yes; we are in uncertain territory.

124. You have your action plan which is the base of all your activities and you have missed the target for children smoking and you now have a new action plan. Can you tell us about that and what the new initiatives are to try to address this problem?
(Sir Graham Hart) A lot of our policies on smoking are addressed to adults as well as to children and this is important because children are to some extent influenced by adults, by their parents and by others. The broad range of policy on smoking is helpful in relation to youngsters as well as in relation to adults. The policy there has many pillars to it but certainly acting on the price front, which is probably the most important single factor in discouraging people from smoking, where the Chancellor has adopted a policy in relation to tobacco duty which has gone up in real terms by 17 per cent since 1993 and we have very expensive cigarettes in this country, that is a very effective deterrent. We have policies on advertising which are particularly related to not appealing to children and for example to not having posters around schools, that kind of thing. There are laws about sales of tobacco to under-sixteen-year olds. As I mentioned earlier, we spend a lot of money on health education in relation to smoking, in particular we are spending just under £1 million a year for three years on a programme called Respect, which is a health education programme aimed at teenagers in particular. There is a very wide range of things we can do and we are doing and it is one of our highest priorities.

125. Obviously I know you depend on other departments and you have close relations with the Department of Education on this.

[**Sir Kenneth Carlisle** *Contd*]

(Sir Graham Hart) We do. One of the really good outcomes from the Health of the Nation initiative has been the greater working between departments on health issues and the DFEE are very helpful to us. The smoking issue is dealt with in schools now very extensively and we work very closely with them on it.

126. Are you happy with your relations with other departments like Transport for example and so on?
(Sir Graham Hart) Yes; not on smoking.

127. Not on smoking obviously but on other issues.
(Sir Graham Hart) Absolutely. They are, as it were, the star performers on accidents.

128. That is good. There are some very good trends but there are areas of great concern.
(Sir Graham Hart) There are indeed.

129. The important thing for us to know is that you are recreating your action plans to try to meet any new challenges and make use of new information and new developments as they come along.
(Sir Graham Hart) We are.

130. If you had to start up again or have a new set of targets what are the main lessons you think you have learned from your experience during this period of three or four years?
(Sir Graham Hart) Of course there are one or two of the targets which with hindsight we would have set at a different level. Of course we have suffered a bit from not having a specific target on mental illness and setting our hand to trying to develop one. In those respects we do it slightly differently now than we did it in 1992. In general I do not want to sound complacent but I do think it has been a good exercise and I would not want to rethink it in any essentials.
Sir Kenneth Carlisle: I am certain of that.

Mr Hall

131. How much does the National Health Service spend as a percentage of its budget on health promotion?
(Sir Graham Hart) No, I do not think I can tell you that because it depends very much on how you define health promotion. As I said earlier, it depends on whether you include things like the payments to general practitioners and so on. I am sorry if that sounds rather unhelpful.

132. Is it going to get better?
(Sir Graham Hart) I will try to make it a bit better. If we add together the three elements I mentioned earlier, £45 million on the health education, the element in GP remuneration which is about health promotion specifically, which is £73 million, and the spending by health authorities and trusts on their health promotion units which is about £90 million, we are up to something like £210 million a year. You could put a lot more things into this pot if you wanted to such as immunisation, vaccination and so on and so forth, but the figures I have given you so far will be somewhere rather less than one per cent.

133. The obvious point to make here is that clearly prevention is better than cure, is it not?
(Sir Graham Hart) Yes.

134. But the Health Service does not direct its resources in that way for obvious reasons.
(Sir Graham Hart) It is not right to say and you would not be very pleased I think if I as accounting officer were party to any amount of spending on promotion. It has to be health promotion which has a payback, has to represent value for money. We have to be disciplined about this.

135. Have you worked out the actual payback the amount of money which is spent on health promotion gets you in good health and savings to the National Health Service?
(Sir Graham Hart) This is into very, very difficult territory. You have to look at these programmes one by one and try to put the best value on them that you can. We are better at that now than we used to be. For example, when the breast screening programme was introduced some pretty careful evaluation was done first of what it would cost and what we expected the benefits to be and it was thought on the whole to be a beneficial and cost effective programme.

136. One of the figures for health spending which intrigues me is that the bureaucracy in the Health Service costs about 12 per cent of the total spent; we spend 12 per cent on bureaucracy and less than one per cent on health promotion. Do you think that is about the right balance?
(Sir Graham Hart) It depends on how you define bureaucracy, or how you want to look at that but the Health Service has to have managers, it has to have administrative staff helping to run the organisation, providing essential services. I do not think that the balance of spending between prevention and promotion on the one hand and treatment and care on the other is seriously out of line.

137. I made a distinction between treatment and prevention. In an earlier question I made it quite obvious that you have to treat people who are ill as well as trying to make sure you get the right balance on preventive approaches. The distinction I am making here is about the bureaucracy costs within the Health Service and not health promotion.
(Sir Graham Hart) Whether you are running health promotion and prevention programmes or whether you are running treatment and care programmes the enterprise has to be underpinned; if you want, call it bureaucratic overheads but it has to be underpinned by people who do the essential task of helping to run it.

138. I find the number of targets within this particular report very helpful and quite interesting. Have you done any evaluation? If you want to make health promotion efficient and effective we need to know the correlation between health and poverty, do we not, or the correlation between ill health and poverty?
(Sir Graham Hart) That is a subject of some difficulty.

[Mr Hall *Contd*]

139. I thought there was almost agreement on this now.

(Sir Graham Hart) There has been a certain amount of academic work done on relationships between a variety of social factors and health but it is too simple probably. These are matters of real ——

140. I do not think the BMA would agree with you on that.

(Sir Graham Hart) It is too simple to say that poverty causes ill health.

141. But it is not too simple to say that there is a correlation between poverty and ill health.

(Sir Graham Hart) There is some kind of statistical association.

142. It is not "some kind", it is proven and it is absolute fact.

(Sir Graham Hart) A statistical association; yes.

143. The BMA do not see it in the terms you do. What about ill health and living conditions, if you want to be a little more precise, quality of accommodation?

(Sir Graham Hart) I do not know what the scientific evidence on that subject is. I would not find it surprising if there were some sort of connection between health and housing.

144. If we want to improve the health of the nation then if we understand there is a link between ill health and poverty and there is a link between ill health and living conditions then there ought to be some way of looking at that in a way which can be appreciated and then acted upon, surely.

(Sir Graham Hart) We do of course work closely with other departments and there are things which we can do in the social environment broadly defined that will almost certainly have a beneficial effect on health. For example, in environmental issues there is scope for inter-departmental activity there. If you were seeking to argue that the Government ought to redesign its tax and benefit policies, for example, in order to have some beneficial effect on health, that is a very, very broad issue indeed.

145. When I look at the health statistics for my constituency, the most affluent part of my constituency is a village called Lymm where the life expectancy is the highest. The most deprived part of my constituency is an area in Runcorn and surprisingly mortality rates there are the highest in my constituency. I am surprised that we are not prepared to acknowledge that and then perhaps do something more effective about it.

(Sir Graham Hart) We do acknowledge that it is a fact and nobody is trying to deny it at all that the higher socio economic groups have better health outcomes, that is certainly true. The causes for that or the explanation for that are quite complex actually and difficult to determine. Certainly the Government's policy in relation to that is that resources both in terms of prevention and in terms of treatment should be targeted on the areas of greatest need. I cannot vouch for your constituency but it should be the case that the allocation of funds and the use to which those funds are put does reflect areas of highest need.

146. Does that sort of analysis inform your activities on health promotion or is health promotion directed at target groups who are more able to receive it?[1]

(Sir Graham Hart) No, we do try, where there is clear evidence that it would be beneficial to do so, to target health education at the groups which need it most.

147. Can we go back to the point where Sir Kenneth left off on deaths from lung cancer? What are the actual total mortality figures for lung cancer for the last year that is available? The number of people who died from lung cancer in the last year as opposed to the rate per thousand.

(Dr McInnes) About 23,000 men and 11,000 women; that gives you a total of 34,000.

148. There is a direct link between cigarette smoking and lung cancer. I am acutely aware that the tobacco companies have sophisticated means of recruiting new smokers because that is the only way they can keep their profitability up. If we say that 34,000 people are dying per annum then they have to recruit 34,000 new smokers a year, do they not, to keep their cigarette sales level?

(Sir Graham Hart) I do not know.

149. The point is broadly made, is it not? You are actually not combatting the tobacco companies because the number of 11 to 15-year old children smoking is on the increase, dramatically on the increase. They are beating you, are they not?

(Sir Graham Hart) If you look at the adult figures, the adult figures are still coming down.

150. This is the recruitment at the younger end, is it not? They already have the adult smokers, the aim now is to try to get the adult smokers to stop. Their aim is to recruit young smokers as soon as they can, is it not?

(Sir Graham Hart) I do not know what their aim is. I cannot speak for them.

151. You must surely have an opinion on it. One of the most profound things about the health of the nation is the problems caused by cigarette smoking.

(Sir Graham Hart) What I can say is that I believe we have a very powerful set of policies aimed at dissuading people from starting, encouraging people not to smoke and discouraging them from doing so if they do, aimed both at adults and at children.

152. It is obviously not powerful enough, is it, because the number of young smokers is actually on the increase.

(Sir Graham Hart) I entirely accept and agree that the position on young smokers is a matter of great concern.

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[1] *Note by witness:* See Evidence, Appendix 2, pages 40–51 (PAC37).

[Mr Hall *Contd*]

153. What about the correlation between the increased price of cigarettes and the increased number of young people who are smoking? Have you looked at that?

(Sir Graham Hart) We have reason to think that price is the most effective instrument for acting on smoking, for discouraging smoking.

154. That is not working because we have had that since 1993 and it is not working.

(Sir Graham Hart) We only have 1994 data and we will have to see what the long-term effect of those increases is. We think that price is a pretty effective deterrent to younger people as well as to adults actually.

155. It is obviously not working. An equally worrying trend is that we see domestic sales of cigarettes are going down yet the number of young smokers is going up. We have the price increase which has not worked, there has been a ban on tobacco advertising near schools which has not worked, the health promotion which goes on in schools is not effective.

(Sir Graham Hart) These are relatively recent things you are now mentioning and I am absolutely not complacent about it and I agree we take it very, very seriously. However we must allow a little time to see how these recent measures take effect.

156. The graph shows a dramatic drop in the consumption of cigarettes since 1990–91 in terms of the billions of cigarettes which are sold annually in the UK. It is quite rightly pointed out in the preamble that this coincides with the open market in the European Union so an equal number of cigarettes is being imported yet cigarette sales are still very, very high. What would you think to a total ban on tobacco advertising?

(Sir Graham Hart) As I am sure you know, this is something which is frequently urged on Ministers and it is a matter which they have considered very seriously from time to time. They have concluded very clearly that they do not wish to go that far, they wish to rely on the voluntary agreements which we have with the tobacco industry and make those agreements effective. They do not believe that any added benefit which might flow in terms of a drop in smoking would be commensurate with the disadvantages that they see in the ban.

157. I do not agree with the analysis which the Minister has reached but I am not actually disagreeing with the way you have presented it. We perhaps need to be far more effective in the way we deal with cigarette advertising and I am very concerned about the way that sport is linked with the promotion of cigarettes. Every time you watch a Grand Prix you see five different brands of cigarettes advertised on the BBC—it will be ITV next year, will it not?—when they speed round the various tracks in Europe and in the UK. I am very, very alarmed about cigarette smoking, particularly amongst young people and it is even more alarming amongst young females. We should be doing far more to tackle that problem and then the other targets in the Health of the Nation which are in this document for coronary heart disease, lung cancer and a number of other health issues in later life would be tackled as well.

(Sir Graham Hart) You are quite right.

Mr Wardle

158. May I refer to an answer which Dr McInnes gave to Mr Rowe when the question was about the incidence of suicides amongst Asian women?[1] I thought I heard, as a sort of aside from Dr McInnes, that what mattered in addressing this problem was looking at the wider culture rather than Asian women on their own. Let me illustrate what I mean. Is it not the case that there are a great many, particularly Moslem, Asian women—I make no value judgements—who go through one culture in the British schooling where the group norms, the social mores, the aspirations are one thing and when they finish school and the door shuts the family door, the front door shuts on that schooling, they are then confronted with a full-time culture that is alien to the one in which they have spent their school days? Therefore if that has any bearings on tensions, on stress amongst young Asian women and has any relationship to suicide levels, surely the wider cultural problem has to be addressed and the whole family culture has somehow to be addressed. Is that right or am I making the wrong enquiry?

(Dr McInnes) No, that is absolutely right.

159. In the first two sessions of this Committee which I have attended I sought to probe the lack of practical commercial acumen in the application of financial controls on the spending of taxpayers' money. Now comes along a report which drives that bee from my bonnet for the time being—only for the time being—and even drives out the prejudice when I first heard about the Health of the Nation White Paper that it was a sign of the nanny state. I think it a fascinating, absolutely fascinating paper. We have heard a lot of reference to targets. On page 4, fairly early on, there are two references to targets being set. Perhaps the answer to my question is in the earlier progress reports but how were those targets set? What experts did you assemble in order to set those targets? How arbitrary are they and was there any Euro influence?

(Sir Graham Hart) There was quite an elaborate exercise. There was a Green Paper before there was the White Paper: a Green Paper in 1991 and the White Paper in 1992. Between the two there was quite a lot of consultation with experts about which areas we should focus on and what targets we should choose. A lot of thought was given to setting the actual targets. We had regard to things like what the trends were, how much scope our expert advice suggested there was for modifying those trends through further action in one way or another. We also looked in some cases at the overseas evidence because we talked earlier about coronary heart disease. Interestingly, countries which in that respect we tend to draw a parallel with in the UK are the USA and Australia where their rates are not terribly different from ours but they had

[1] *Note:* See Q 56.

[Mr Wardle *Contd*]
started to go down before they did here. We looked at them and we thought in the case of coronary heart disease maybe there is scope for us to keep on going down because these other countries which are fairly comparable to us started going down earlier and are still keeping it up. We looked at some international comparisons. At the end of the day you take a judgement: is it realistic, is it nevertheless challenging?

160. Has it been your experience that not just the C&AG but most interested laymen are convinced as to the reasonableness of those targets? Yes, or no, from your experience.
(Sir Graham Hart) The targets were well received when they were published.

161. Looking at reported progress here against those targets, if I am allowed to I should like to probe a little bit into the murky world of the PES round. Is there a relationship between your measured progress against these targets and funding priorities in these particular areas of health care? Is there any correlation there generally? I am not talking about this year in anticipation of a big event later this year.
(Sir Graham Hart) Of course you would not be asking me about this year. In a very broad sense yes, there is because it is not only about prevention, it is also about treatment. Take something like coronary heart disease, the biggest killer of the lot, one of the reasons that is going down is because we are putting more and more resources into the way we treat people with coronary heart disease. We are doing more and more operations, we are seeing that people who are brought into the accident and emergency departments with a heart attack are given the right drugs when they get there. These are expensive drugs. All this costs money, it is not free, so obviously there is a link between growth in resources and an improving service.

162. To what extent has that focused attention on the need for research in specific areas? I look at page 35 and look at the figures you quote there for the cost of mental illness in the first paragraph on page 35 and I ask myself whether this has turned into any sort of priority for research in this area, particularly when you look at medication costs as a percentage of the total drugs project, and whether it would not be fruitful to say there should be priority research in this area in order hopefully to get closer to your targets.
(Sir Graham Hart) There is a lot of Government spending. I am afraid I do not have the exact figures with me on mental health research but we do fund a lot of research into mental health already. The immediate way to attack the principal target here, which is to improve the health and social functioning of mentally ill people, is actually through improving the services. It would be nice if we had research breakthroughs, but it is through improving the services. A lot of effort has been put in in recent years to doing that, a big effort, through a variety of initiatives which I could expand on at great length but I do not suppose you would wish me to.

163. No, but that is interesting, thank you. In another area where the figure is startling you estimate that 80 per cent of cases of skin cancer, which is 28,000 cases a year, are in theory avoidable. What does that tell you for spending on health education so far as that particular problem is concerned?
(Sir Graham Hart) Yes, avoidable but of course the trouble with something like this is the change in behaviour now will not show up in the statistics for another ten or 15 years because these are very long acting effects.

164. All the more reason to get cracking I should have thought.
(Sir Graham Hart) Absolutely. We have got cracking. We have something called the sun know-how campaign, which the Health Education Authority runs, which is costing £1.5 million over three years. We pay the Meteorological Office to give the sunburn forecasts in the weather forecasts. I could go on but I will not. Generally public awareness of this as a problem is much greater than it was. It does not mean that people necessarily change their behaviour but at least we are giving people the facts and we must not get into nanny state but we must give the facts.

165. I think I hear the bee returning to my bonnet but only faintly. Is what you learn from this report helpful in asking yourself the question: can we begin to have standard costings in some aspects of medical treatment? Is that feasible?
(Sir Graham Hart) In what context were you thinking of standard costings?

166. Let me illustrate it quickly with the sort of example which shocks the layman. If somebody says in a television programme this is what such and such an operation tends to cost, it is mind boggling to the layman, not just this layman but a lot of laymen I have met who are constituents of mine. To what extent can you proceed from there and, without turning the whole thing into an accountant's dream or nightmare, to what extent are you able to use that sort of financial information in terms of planning health care, particularly against the measured targets?
(Sir Graham Hart) We do know an awful lot about it. We do know an awful lot about what treatment costs and we do take those sorts of facts, when we have them, into account in deciding for example whether you want a screening programme, whether you want to launch a general screening programme. These things can often be technically possible but actually not cost effective. You would take into your equation there what the cost of treatment would be, also hopefully some kind of valuation of the improvement in people's health.

167. It helps your planning to that extent.
(Sir Graham Hart) Yes; absolutely.

168. How is coordination with other departments going? I appreciate your answer has to be a careful one. The Committee will expect you not to be so careful.
(Sir Graham Hart) No, it is going well. The great advantage, if I may put it this way, is that we have a

[**Mr Wardle** *Contd*]
Cabinet sub-committee which is concerned with this programme, chaired by the Lord President and with Ministers from all the affected departments in it. That of course does give a tremendous lead to Whitehall.

169. Does that filter down so that there is a good read-across at official level as well as those lofty circles?

(Sir Graham Hart) Yes, there is an underpinning of officials. I can honestly say—everything I say is honest—genuinely say that it goes very well. We have a lot of support and goodwill from other departments.

170. I have to tell you I am very concerned. You were about to say "hand on heart" and your hand went across but it went to the wrong side. What does that tell us? I listened with interest to your answers to Mr Williams about HIV/AIDS. Are you able to express an opinion, hopefully not shackled in any sense by political constraints? In your view has the spending on HIV/AIDS been disproportionate when one looks at all the challenges and demands that your department and the NHS face?

(Sir Graham Hart) No, I do not think it has. We faced in this country in the 1980s what could have been the most serious public health problem for decades.

171. Could have been.

(Sir Graham Hart) Could have been. It still is a very serious problem; it is a very serious problem.

172. I am sure it is.

(Sir Graham Hart) What has happened—I am sorry this is trumpet blowing again—is that we have tackled it very seriously, very positively, we have spent a lot of money on it, you are quite right to imply that. It has been money well spent because the problem—we cannot be complacent about it but—is much, much less serious than it could have been and indeed would have been if we had not addressed it seriously. That is not simply a function of money, it is also about attitudes, about professionalism of people, it is about the willingness of people to talk about these issues, it is a whole range of factors. Certainly the spending, both on prevention and on treatment, has been money well spent.

Mr Rowe

173. You said something which alerted me to something which I should have understood long ago. What you actually said was that the determination of these targets in relation to your perception of cost-effectiveness is actually the principal method of rationing health care in this country and as such this is clearly a central issue, not only for this Committee but for the nation. I do not think I had realised that until your penultimate reply. That is what you are doing, is it not? You are rationing health care by making decisions about whether a target is worth pursuing.

(Sir Graham Hart) We are taking decisions every day, not just in this context. The Health Service takes decisions every day about priorities and we try to take those decisions rationally in relation to the benefits which will flow. It is not always very easy to do that.

174. These targets are very important in that process.

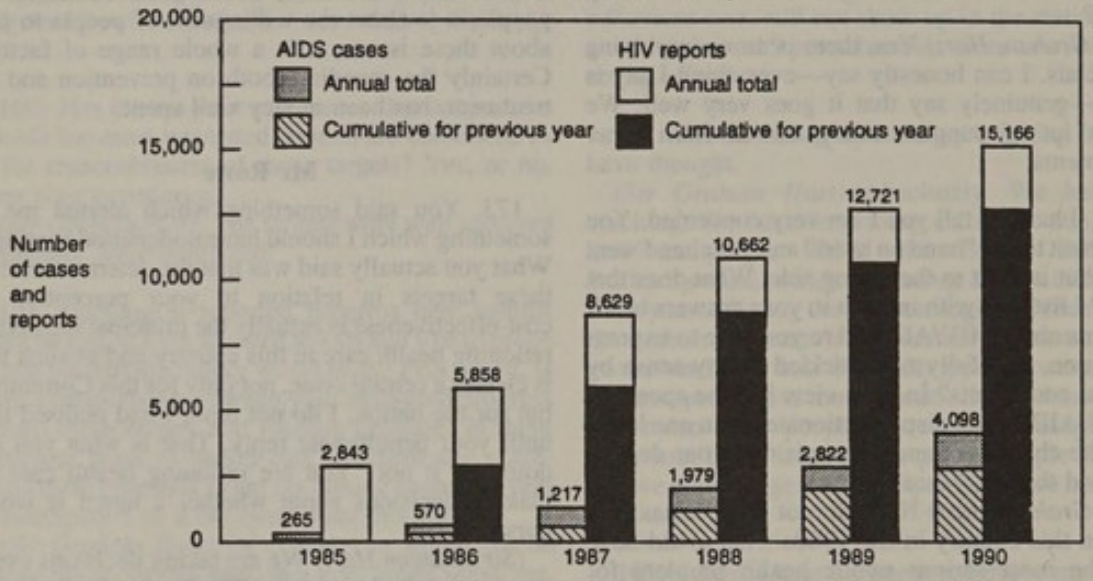
(Sir Graham Hart) They are.

Chairman: Thank you very much for coming along and answering our questions today.

APPENDIX 1

Comparative charts showing incidence of HIV reports and AIDS cases in the United Kigdom from 1985 to 1990

Fig. A: Diagram published with C&AG's Report HC 658 (90/91), page 8 (PAC 96-97/90)



Source: Data published by the Communicable Diseases Surveillance Centre

This graph shows the cumulative number of HIV reports and AIDS cases since 1985. The majority of the AIDS cases will have been included in the figures for HIV reports.

Fig. B: Re-ordered diagram of Fig A

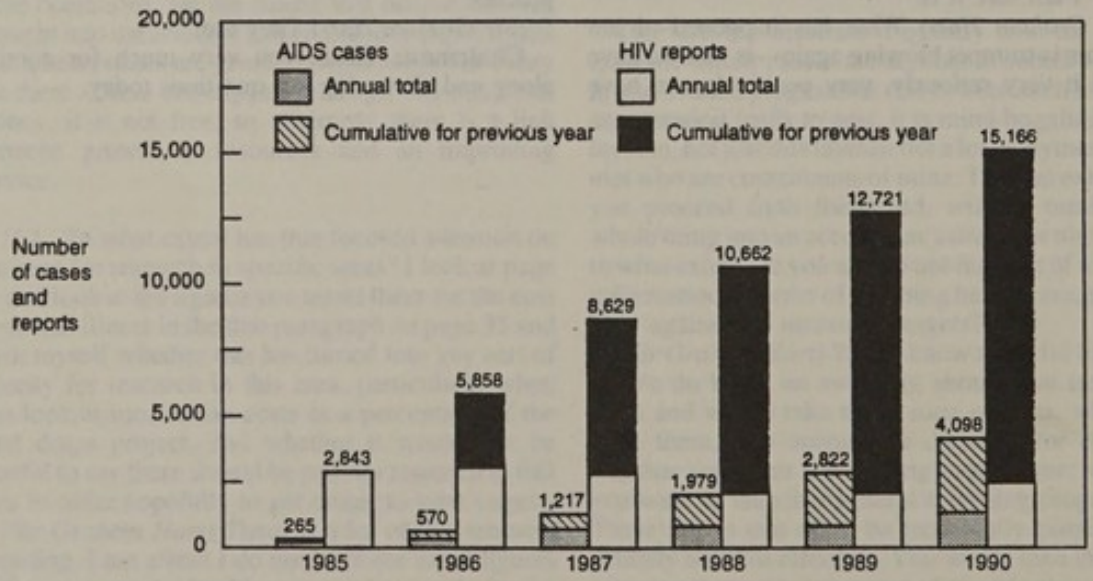
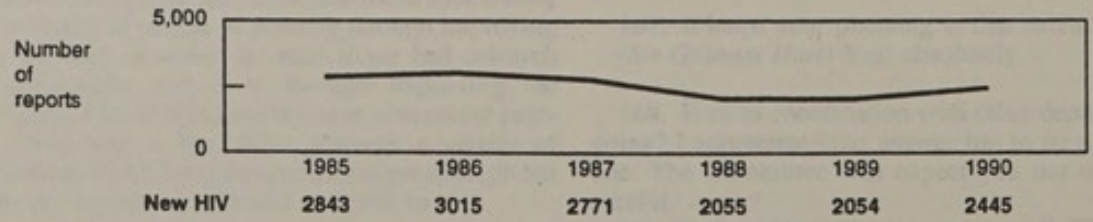


Fig C: Trend Chart



New HIV	2843	3015	2771	2055	2054	2445

Total increasing is arithmetic progression

APPENDIX 2

HEALTH OF THE NATION: A PROGRESS REPORT (PAC96–97/37)

Supplementary Memoranda from the Permanent Secretary, Department of Health

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QUESTION 14

Costs of Health Promotion in the five Health of the Nation key areas

The Department of Health funds a variety of nationwide and targeted health promotion programmes which contribute to progress in the five Health of the Nation Key Areas. A summary of current annual expenditure on such centrally funded health promotion initiatives is attached below. These figures, rounded to the nearest £1,000, include grants given under Section 64 of the Health Services and Public Health Act, centrally funded campaigns, and central support to such initiatives as Europe Against Cancer. However, this exercise cannot so readily be done for health promotion expenditure in the NHS. The appended table identifies those elements of NHS spending which can most easily be isolated and which relate in whole or in part to health promotion activity.

Current annual expenditure on such centrally funded health promotion initiatives

Coronary Heart Disease	£4,804,000
Cancers (includes anti-smoking campaigns)	£11,395,000
HIV/AIDS and Sexual health	£3,640,000
+ Unwanted pregnancy	£1,839,000

(Note: Health Authorities are allocated funds for HIV prevention work which would include local health promotion work.)

Accidents	£206,000
Mental Illness	£3,714,000

The following table illustrates spending on identifiable health promotion activities by the NHS in the Health of the Nation Key Areas in 1996/97

Key Area	Health Promotion Activity	Cost £K
Coronary Heart Disease and Stroke	Anti-Hypertensive drugs	350,000
	GP Banding scheme	54,000
Cancers	Breast Cancer Screening	27,000
	Cervical Cancer Screening (GP Target payments)	60,800
	National cervical and breast cancer co-ordinating team	2,500
HIV/AIDS & Sexual Health	Family Planning Services	163,000
	Local HIV prevention	51,300

QUESTION 20

Comparisons with other countries on the speed of decline of gonorrhoea incidence

1. Data on gonorrhoea incidence across EU member countries are *not* directly comparable for a number of reasons, including:

(a) Surveillance systems vary in the completeness of their ascertainment of data. Figures for Southern European countries are notably less complete than those for Northern European countries, and so are not strictly comparable.

(b) Data for England and Wales are collected from Genito-Urinary clinics. Most other countries do not have exactly equivalent clinics. In England and Wales there is also a separate laboratory reporting system of microbiological diagnoses of gonorrhoea. In other countries, gonorrhoea can be treated in a variety of other settings, and it is therefore difficult to ensure that all cases are recorded centrally.

2. Bearing these caveats in mind, the attached chart illustrates the trends for such data as are available on gonorrhoea incidence in EU countries. It shows that, between 1983 and 1992, the gonorrhoea incidence rate in England and Wales declined by 75%. This was not quite as great as the declines experienced in the Netherlands and Denmark over the same period (the only two other EU countries to have complete data up to 1992).

3. Recent data from the USA suggest that their rates have fallen during the period 1991 to 1995.

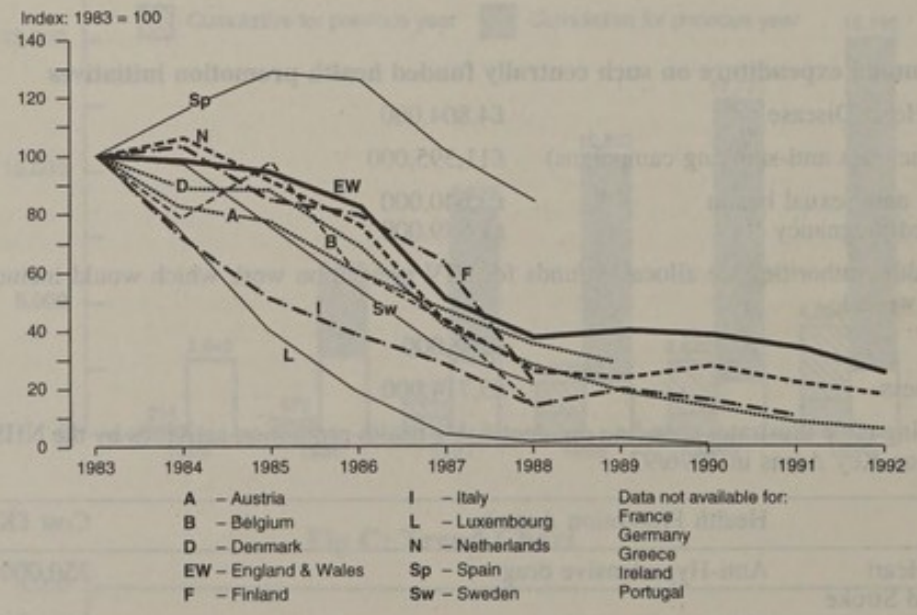
4. Since 1992, the rate of gonorrhoea incidence in *England* has fallen by a further 15% (to 1995), thereby more than achieving the Health of the Nation target. However, the 1995 data indicate that the downward trend may have levelled off.

Department of Health

November 1996

Trends in Gonorrhoea incidence

Persons all ages, European Union, since 1983



Source: WHO European Coordinating Centre for Communicable Diseases, Rome
Collaborators in EU Concerted Action on HIV and STD, Brussels

QUESTION 41

HIV/AIDS epidemiology and its role in planning

Background and International comparions

1. AIDS is caused by the Human Immunodeficiency Virus (HIV) which is transmitted by three main routes. These are unprotected intercourse, sharing injecting equipment and from mother to baby. Neither a vaccine against HIV infection nor a cure for AIDS exists and prevention through health education and health promotion remains the most effective weapon to help control the spread of HIV infection.

2. Compared with some other European countries the situation in the UK appears relatively controlled. New cases of AIDS and the rate per million population in selected countries in 1995 are shown below and more data are given in Chart D1.

UK—1,721 new cases = 29.5 per million
Germany—1,715 new cases = 21.0 per million
France—5,329 new cases = 89.4 per million
Italy—5,914 new cases = 103.4 per million
Spain—7,259 new cases = 183.2 per million

3. This containment in the UK is likely to be associated with a number of factors including the early introduction of public education campaigns in the mid-1980s and targeted interventions among behaviourally vulnerable groups and the availability of free and open access Genito Urinary Medicine (GUM) clinics and needle exchange schemes.

Epidemiology

4. The UK collects information from voluntary named testing and unlinked anonymous HIV surveys to inform public health decisions. Surveillance of AIDS and HIV infection in the UK is chiefly undertaken by the PHLS Communicable Disease Surveillance Centre (CDSC) and the Scottish Centre for Infection and Environmental Health. CDSC publish surveillance data regularly but the figures, especially for recent years, are affected by under-reporting and reporting delays and thus, can change with time.

5. In the UK to 30 September 1996, a cumulative total of 13,394 AIDS cases have been reported of whom 9,447 have died. Of these cases 9,603 were probably contracted through sexual intercourse between men, 1,920 through heterosexual intercourse, 811 by injecting drug use, 719 by contaminated blood or blood factors, 204 by mother to child transmission and the remainder are either uncertain or still under investigation.

6. To the end of September 1996 a cumulative total of 27,845 HIV infections were *reported*. Of these 16,909 were probably contracted through sexual intercourse between men, 5,260 through heterosexual intercourse, 2,938 by injecting drug use, 1,450 by infected blood, 395 by mother to child transmission and the remainder are either uncertain or still under investigation. However, these figures are an underestimate of HIV infections as individuals are only likely to come forward for testing if they believe themselves to have been at risk.

7. Figures on reported HIV infections and AIDS cases by year of report are given in the Annex and show that reports are still increasing, albeit slowly. Data on probable transmission routes show that most cases are transmitted through sex between men but that heterosexual transmission is increasing. (Recent media reports suggested that mortality from AIDS decreased in 1995. The articles were based on a written Parliamentary Question and although the reply explained that the figures were affected by under and late reporting this qualification was not mentioned in the articles. Figures from recent years are especially affected by reporting delay and the final total is likely to be close to the 1994 figure or perhaps higher. Thus, AIDS mortality figures are flattening rather than decreasing.)

Projections

8. Whilst past fears that HIV would spread throughout the whole population have not been borne out, the latest projections show that new infections will continue, with over 2,000 new AIDS cases forecast each year to 1999. These forecasts for the incidence and prevalence of AIDS and prevalence of other severe HIV disease in England and Wales for 1995 to 1999 were published in January 1996[1]. The 1996 Report forecast an increase in new cases of AIDS from heterosexual contact, but stressed the uncertainty about the long term nature of the heterosexual epidemic. The report confirmed that men infected through sex with other men will continue to be the largest component of the epidemic in England and Wales up to 1999.

[1] Communicable Disease Report Review 1996 6(1)R1–16.

9. The planning figures for new AIDS cases in 1997 and 1999 are 2025 and 2010 respectively. New AIDS cases in homo/bisexual men may fall by 7% from the 1995 total of 1330 but this group will continue to be the most affected by HIV. New AIDS cases are expected to increase over the same period by 25% in those exposed heterosexually from 420 in 1995 to 525 in 1999 and by 29% in injecting drug users from 120 new cases to 155 new cases annually. At the end of 1999, it is projected that 4010 AIDS cases will be alive in England and Wales and approximately the same number of people with severe HIV disease will require care and treatment. Tables in the Annex show that incidence and prevalence are expected to increase during the rest of the century.

10. The above forecasts were made when the results of clinical trials showing significant benefit from using more than one anti-HIV drug (combination therapy) were being released. The results of these trials are promising and the treatment may prolong the survival of AIDS patients. Thus, total numbers of people living with HIV/AIDS may increase beyond the levels forecast in the latest projections report. The Department is monitoring the uptake of combination therapy.

Unlinked Anonymous surveys

11. These surveys provide information on HIV prevalence and are a key plank in our surveillance for HIV infection. The results which provide a true, unbiased measure of HIV prevalence (number of people alive with HIV infection) are used to plan services, inform policy and develop HIV/AIDS projections. Reports of AIDS cases and HIV infections based on voluntary confidential named testing do not provide a complete measure of prevalence because the long incubation period for HIV infection means that AIDS cases reflect patterns of transmission several years ago and not all those infected with HIV come forward for testing. Unlinked Anonymous Survey results confirm that HIV infection is widely disseminated throughout the country and is found in all survey groups and regions where surveys are underway but HIV prevalence rates are much higher in London than elsewhere.

Strategy for health promotion

12. Surveillance aims to provide information for planning, public education and evaluation of control programmes and health services. At the start of the epidemic, when very little was known about the pattern of the epidemic, it was only prudent that information on prevention of HIV should be made available to the general population in order to safeguard public health. As more information has become known about the epidemic we have reviewed our strategy. A recent review of the UK Health Promotion Strategy for HIV and AIDS ("HIV & AIDS Health Promotion: an Evolving Strategy", published in November 1995), emphasised the need to continue sustained health promotion work in the UK and for better targeting of those groups most vulnerable to infection. The key groups to be targeted at the present time are; gay men, bisexual men and other men who have sex with men, men and women who have links with high prevalence countries, people diagnosed with HIV and AIDS, injecting drug users and women partners of men in these groups.

13. In line with its HIV/AIDS strategy published last November, the Department is channelling funds (£800K in 1996/7) to the voluntary sector for targeted health promotion for gay and bisexual men.

14. The funds were previously part of the HEA's allocation for HIV/AIDS health promotion: no new funds are involved. The HEA will continue to do HIV/AIDS health promotion work for the general population.

15. The HIV/AIDS strategy also identified the need for targeted health promotion for people who travel to or have links with countries with a high prevalence of HIV/AIDS where the predominant mode of transmission is sex between men and women (currently countries in sub-Saharan Africa). The Department is presently considering how best to develop targeted health promotion for these groups.

Treatment and Care

16. Since 1990, the financial resources for HIV/AIDS treatment and care have taken into account the numbers of people alive with AIDS and severe HIV disease (estimated by the Projections Group to be on a 1:1 ratio with those of AIDS) and estimated unit costs.

17. In 1996 the projected numbers of AIDS cases in the current year was estimated to be some 10% lower than that for the same year as forecast in the 1993 report, (on which the 1995/96 allocations were based). As a result the amount allocated in 1996/97 was reduced. The reduction was however limited to 7.7% to allow for new drug combination therapies which were just coming on stream and which had been found to offer clinical benefit in trials. The total allocated to health authorities in England in 1996/97 is £185.7m. Information on past expenditure is given in the Annex. The Department continues to monitor the uptake of

combination therapies. Although these funds are not ring fenced they are allocated on the basis of where cases are treated. Most cases are treated in London and the South East and this is reflected in the treatment and care allocations. Allocations for 1997/98 are expected to be announced shortly.

18. The allocation for local HIV prevention work has historically been distributed on a general population basis with no weighting for risk factors or age bands. This was because at the beginning of the epidemic in England, there was no way of determining the future spread of the disease or of identifying the groups most at risk. Faced with a new communicable disease with no cure or vaccine whose epidemiology was unknown, it made good sense to fund Health Authorities to provide HIV prevention services for the whole population on an equal basis. The effect of this was to raise awareness, educate the general population on safer sex, and upgrade GUM facilities so as to attract people to them for testing and counselling for HIV and other STDs.

19. Recently the epidemiology of HIV has become much clearer, enabling us to identify the population groups most at risk and to link these fairly confidently to geographical areas. The UK Health Departments' "HIV & AIDS Health Promotion: an Evolving Strategy", published in November 1995, concluded that, although there remains a need for HIV prevention work for the general population, greater emphasis should in future be placed on developing work directed at vulnerable groups.

20. The Department has been considering the appropriate distribution formula for the prevention allocation and hopes to make an announcement on this shortly.

ANNEX

UK AIDS cases and HIV infections per year of report* (reported data to end of June 1996)

	1989	1990	1991	1992	1993	1994	1995	1996
AIDS cases	841	1266	1355	1479	1606	1779	1580	1113
HIV infections	1714	2185	2472	2405	2377	2385	2684	1517

Source PHLS–CDSC
*Figures for 1996 are incomplete and due to reporting delay figures for recent years are likely to increase

Projections of AIDS incidence, mortality, prevalence and the number of persons with other severe HIV disease (adjusted for under reporting) in England and Wales

Year	New AIDS Cases (incidence)	AIDS Deaths	Cases alive at year end (prevalence)	Other severe HIV disease*
1994	1780	1570	3210	3210
1995	1950	1680	3485	3485
1996	2000	1790	3690	3690
1997	2025	1870	3845	3845
1998	2025	1925	3945	3945
1999	2010	1950	4010	4010

Source projections report
*Persons alive at year end and requiring care. The last two columns are the same as the projections report estimate that there is likely to be one person alive with other severe HIV disease (and requiring care) for each living AIDS case.

For planning purposes a figure of 2025 new AIDS cases is projected for 1997 and 2010 for 1999. The distribution between the main exposure categories is shown below

Exposure category	1997	1999
homo/bisexual males	1305	1235
heterosexuals	490	525
Injecting drug users	140	155
Year Total	2025	2010

Homo/bisexual men will continue to be the main group affected by the epidemic, incidence of new cases in children of mothers infected with HIV is expected to rise steadily from 30 new cases in 1994 to 45 in 1997 and 55 in 1999. New cases in recipients of contaminated blood or blood products are expected to fall to 35 in 1997 and 30 in 1999 compared with a peak 10 years earlier of over 70 new cases per year.

Expenditure on health promotion and treatment and care

Health Education Spending (£m) on sexual health campaigns including sexually transmitted diseases (STDs):

92/3	93/4	94/5	95/6	96/7
9.78	7.31	7.77	6.45	3.64

Prior to 1996/97, health education & promotion was undertaken by the HEA and the figures cover health education on HIV/AIDS, sexual health and some contraceptive education, and include a proportion of HEA's overhead costs. Trends also include the move to new contracting arrangements from 1996/97 under which HIV/AIDS health promotion for the general population will continue to be undertaken by the HEA, with targeted work being contracted through voluntary and community groups.

Additionally, the National AIDS Helpline offers free confidential advice, 24 hours a day, 365/6 days a year at a cost of

92/3	93/4	94/5	95/6[1]	96/7[1]
£2.1m	£2.1m	£2.1m	£1.61m	£1.61m

[1]A new three year contract was signed from 1995/96 following a competitive tendering exercise.

NHS Budgets

Local HIV Prevention

92/93	93/94	94/95	95/96	96/97
£51.3m	£52.3m	£47.6m	£49.6m	£51.3m

In addition to locally targeted primary and secondary prevention work, this allocation can also be used to pay for HIV testing, counselling and prevention work in GUM settings and elsewhere, the control of infection and staff training.

TREATMENT AND CARE

92/93	93/94	94/95	95/96	96/97
£132.7m	£132.7m	£164.3m	£195.1m	£185.7m

QUESTION 52

SCREENING FOR PROSTATE CANCER

1. The Government is aware of the serious threat to male health which prostate cancer poses. There is currently no method by which a man can reduce his risk of developing this disease. Policy is, therefore, to encourage early reporting and to ensure rapid referral when symptoms present.

2. There is, as yet, no consensus of medical opinion about the correct management of early localised tumours. As many prostate cancers are found in very elderly men, with other pathology, there arises the further question of whether it would be right to intervene clinically where prostate cancer is diagnosed; treatment could impose an unnecessary burden on the individual whilst having no effect on preventing death because of other conditions affecting the indivdidual's health such as stroke and coronary heart disease, for example. Studies have shown a survival rate of 90 per cent over 10 years with no treatment.

3. Autopsy evidence in a patient dying from other causes suggests that symptomless and unsuspected prostate cancer is not uncommon in men aged over 50 (30–50 per cent). Virtually all men aged over 80 have histological evidence of this condition but its clinical relevance is uncertain. It is arguable, therefore, that screening and early diagnosis of such cancers may offer no direct benefit to the patient.

4. The key aim of any screening programme must be to secure a demonstrable improvement in health by increasing the length and quality of life. There is, as yet, no evidence that this would be achieved in relation to prostate cancer. Any potential screening programme must also be sensitive (not have a large number of false negative results), specific, acceptable to the general population and workable within the context of the NHS. Tests which are seen as too interventionist may deter people from coming forward. It is also vital that screen tests do not give rise to a substantial proportion of false positives which could cause unnecessary anxiety.

5. One screening method is measuring levels of prostatic specific antigen (PSA) in the blood. Other possible methods are ultrasound and digital rectal examination which may detect a proportion of cancers, but may also prove unacceptable to some men.

6. The Department's Standing Group on Health Technology has identified carcinoma of the prostate as one of the priority areas for health technology assessment. The Department commissioned two systematic reviews of the diagnosis, management and screening of early localised prostate cancer which were recently completed. This work concluded that population screening for prostate cancer could not be recommended because of unanswered questions in a number of key areas. These are the natural history of the disease (whether it would become apparent if not detected by screening); costs (financial, social and psychological) of a screening programme; and the effectiveness of treatments for localised disease.

7. The reports found no justification for the routine use of PSA testing in primary care and suggest that GPs should be actively discouraged from using PSA tests for the purpose of early detection. There is at present no evidence on the number of prostate cancer deaths (if any) which could be averted by screening asymptomatic men. This, combined with the lack of evidence about the optimum treatment of early disease, makes it impossible to estimate the cost-effectiveness of screening at present. Screening may also lead to unnecessary physical and psychological morbidity from biopsy and treatment side effects.

8. For these reasons the Government does not believe it would be right at present to encourage ad hoc screening for prostate cancer, whether by the NHS or purchased privately. The National Screening Committee will consider screening for prostate cancer as part of its programme of reviews of a wide range of screening programmes in the NHS and will consider any new scientific evidence as it becomes available.

QUESTION 72

A comparison across the five Health of the Nation key areas on where the UK stands against the other EU member countries

GENERAL COMMENTS

1. The Health of the Nation strategy on which the Department was examined on 6 November relates specifically to *England*—however, the other countries of the United Kingdom do have health strategies which cover broadly similar areas.

2. Much of the data shown in the attached charts have been extracted from World Health Organisation sources—WHO Annuals of Statistics or the WHO Health for All (HFA) Indicators system. The data are collated and presented in order to be as comparable as possible across countries. However, exact comparability cannot be guaranteed on all indicators. Different countries may have different systems of data collection, and different conventions for recording of data. For example, registrations of specific causes of death are prone to differences in ascertainment, certification, registration and recording practices. Cultural, administrative and legal factors will all be relevant. The robustness of the comparisons will vary from disease group to disease group. Increased European Commission activity in this area associated with the development of a health monitoring action plan should, in due course, lead to better information on comparability of data.

A. CORONARY HEART DISEASE AND STROKE KEY AREA

3. Chart A1 shows *death rates for Coronary Heart Disease* among persons aged under 65 years. The data are for the latest available year (circa 1992) from the WHO HFA database, and show the UK as having the second highest death rate among the EU member countries, with Ireland having a slightly higher rate, and the rate in Finland being slightly lower. Generally the Northern European countries have higher death rates from CHD than those in the South. France has the lowest rate of all EU countries—their rate is just over one quarter that of the UK. However, the cautionary note on direct comparability of data definitions across countries in para 2 above applies here. Since 1992, death rates from CHD in *England* for this age group have reduced by 17%. (Figures are available up to 1995, and the percentage is adjusted for the effects of coding changes introduced by the Office for National Statistics in 1993).

4. *Death rates for Stroke* among persons aged under 65 are illustrated in Chart A2. These show that the United Kingdom rate, while fourth highest among the 15 EU member countries, is not markedly different from those in the majority of the other countries (a group of nine countries having a difference of less than 2 deaths per 100,000 population in their rates). Portugal has the highest rate in the EU, France has the lowest. Again, these comparisons should be treated with some caution. Since 1992, death rates from stroke in *England* for this group have reduced by 4%.

5. *Obesity* is a risk factor for coronary heart disease and stroke. It is defined as a Body Mass Index (BMI) of over 30 (BMI = weight in kg divided by square of height in metres). Data on obesity are derived from studies which measure weights and heights of a representative sample of the population. In this country, the Health Survey for England established in 1991, provides the national estimates for monitoring the Health of the Nation target. The latest available data for 1994 show that, for the target population aged 16–64, the percentages of men and women classified as obese were 13% and 16% respectively. These percentages have increased significantly since the mid-1980s.

6. Comparisons with other countries are difficult, due to differences in definitions of obesity, different ages studied and different time frames over which the prevalence of obesity was followed. Estimates are not available for all EU countries. However, for those where studies have been carried out, many showed an increasing prevalence of obesity in recent years.

7. Chart A3 was produced by the WHO and presents such data as are available for EU countries—though not strictly comparable for the reasons explained above. It appears to show that the UK has one of the highest percentages of the adult population classified as obese, though lower than those in Germany and Ireland.

8. Another risk factor for CHD and Stroke is excessive *alcohol consumption*. While comparable data on excess consumption are not available, data on average consumption, shown in Chart A4, suggest that the UK has a relatively low level of alcohol consumption, with only Finland and Sweden having lower average levels, and Luxembourg and France having the highest levels. However, these figures do not indicate the distribution of drinkers in the population, nor the proportion of drinkers consuming more than sensible levels of alcohol.

B. Cancer Key Area

9. The UK has a relatively high rate of *death from breast cancer* among women aged under 65. Figures from the WHO HFA database shown in Chart B1 suggest that, around 1992, the UK's rate was the fourth highest in the EU. Luxembourg had the highest rate, and Greece the lowest. The Health of the Nation target relates to a narrower age group, i.e. women aged 50–69, the age group which would most directly benefit from breast screening. The rate in *England* for this age group has fallen by 6% between 1992 and 1995 (adjusted for the effect of ONS coding changes) and is expected to fall further as the effects of the national breast screening programme become apparent.

10. *Incidence of cervical cancer* appears to be higher in the UK than in any other EU country except Denmark—see chart B2. However, the available data may not be strictly comparable since:

(i) these data are based on cancer registration systems which vary in quality between countries;

(ii) in a limited number of countries (including Denmark and England and Wales), data are derived from national schemes—in most others, data are derived from local schemes;

(iii) there is variation between countries in the proportion of cases assigned to "cervical cancer" and to the less specific "cancer of the uterus, not otherwise specified" category.

11. Cancer incidence data are less timely than those for deaths, and the available data here relate to 1990. Hence they are restricted to the 12 member states of the former European Community. Since 1990, there has been an impressive reduction in the cervical cancer incidence rate in England, which can at least in part be attributed to the success of the cervical cancer screening programme. Between 1990 and 1993, the cervical cancer incidence rate in *England* fell by 27%.

12. *Incidence of malignant melanoma* in both men and women in the UK appears to be low compared with our EU neighbours—see charts B3 and B4. Again, the data relate to 1990, and may not be strictly comparable across countries. Denmark has the highest rates for both men and women, and Greece the lowest. In *England*, melanoma incidence has shown a rising trend over recent years.

13. Charts B5 and B6 show the *death rates from Lung Cancer* for men and women respectively. EU data used are for the age group under 65 (the Health of the Nation targets relate to the age group under 75). Among men, the UK rates are in the lower half of the distribution—with Belgium having the highest rates and Sweden the lowest. The picture is different for women, with the UK having the second highest mortality rate in the EU after Denmark. In the Health of the Nation target age groups, the latest figures for England (1995) show a drop of 11% in the death rate among men and 2% among women since 1992.

14. The major risk factor for lung cancer is *smoking*. Charts B7 and B8 show the estimated proportions of the adult and adolescent populations respectively who are smokers. The figures are taken from two studies, and are reproduced from the forthcoming WHO "Highlights on Health" publication. The patterns seem similar. Among adult men, the UK has the second lowest proportion of the population being smokers, while

among adult women, the UK is fourth highest among those EU countries studied. Similarly among adolescents, the males have a relatively low proportion of daily smokers, and the females are second highest (data are for GB rather than UK).

C. Mental Illness Key Area

15. The only routinely available indicator for comparison in this area is *suicide mortality*, and it should be noted that data for EU countries are *not* directly comparable since there are different procedures and conventions relating to coroners' courts and the recording of deaths as from suicide. For this reason, comparisons should be treated with particular caution. Chart C1 shows such information as is available. It suggests that the UK death rates for the category "suicide and self-inflicted injury" are among the lowest in the EU.

16. Death rates from a broader grouping of "all external causes of injury and poisoning", which includes deaths from suicide, accidents and adverse effects, homicides and undetermined injury, should be more directly comparable across countries since they are less susceptible to the coding differences mentioned above. Chart C2 shows that the UK has the lowest rate in the EU from these combined causes of death.

D. AIDS/HIV and Sexual Health Key Area

17. As yet there is no specific Health of the Nation target for AIDS or HIV, though these are under consideration for the future. Gonorrhoea incidence was used as a proxy for HIV, and the trends in the rates have been compared with those for other EU countries in response to an earlier question.

18. *Incidence rates from AIDS* are referred to in the answer to an earlier question on AIDS and HIV trends. Chart D1 shows that the UK rate in 1995 was around the middle of the EU distribution, but low relative to the rates in Spain, Italy and France.

19. Another target within this key area is to reduce the rate of *conceptions to females under the age of 16*. Data on this precise definition are not available across the EU. The nearest available figures are for birth rates to teenage mothers (aged 15–19), which showed the UK with a higher rate than any other EU country in 1990, with the Netherlands having the lowest rate—see chart D2. Since 1990, the conception rate among under 16 year-olds in *England* has reduced substantially, by 17%.

E. Accidents Key Area

20. Data on *deaths from accidents and adverse effects* suggest that the UK has among the lowest rates in the EU. It is in the bottom three ranking countries for death rates in each of the Health of the Nation target age groups (under 15s, 15–24 year olds, and those aged 65 and over), and actually has the lowest rate for the 65 + age group—see charts E1 and E3. Only Sweden has lower rates for both of the younger age groups. Luxembourg has the highest rates for the younger age groups, and France has the highest rate for the elderly age group.

21. A major component of accidental deaths for the younger age groups is deaths from motor vehicle traffic accidents—see chart E4. As may be expected from the results described above, the UK comes out with the third lowest rate in the EU, with Netherlands and Sweden below, and with Portugal having the highest death rate from this cause. The figures in this chart relate to motor vehicle accidents for all ages. (Among the older age group, deaths from falls form the major components of accidental deaths, but comparable data on this cause are not available across the EU).

22. Since 1992, deaths from accidents have fallen further in *England*, by 19% for the under 15s and by 8% for the 15–24 year olds. For the 65 + age group, the rates have remained static, though the comparison may be affected by coding changes.

Department of Health

November 1996

QUESTION 146

The Committee also requested additional socio-economic information on household food purchasing, and its relevance to the setting of future health targets. (Q 146)

1. The Committee asks if the proportion of household income spent on food can be reasonably calculated. I attach a graph from the National Food Survey, carried out on an annual basis by the Ministry of Agriculture, Fisheries and Food which shows, in both numerical and graphical forms, changes over the last 45 years of household food expenditure (see table and figure attached). In theory such data could be used in the process of setting health targets but the lack of an established causal relationship between this measure and health outcomes makes it difficult to identify a meaningful target.

The Targeting of Health Promotion on Groups Who Need it Most

2. There are variations in health between different groups within the population: men and women, people in different geographical areas, different socio-economic groups, and different ethnic groups. The Department of Health has published a report which looks at what we know about variations in health between different population groups, in each of the Health of the Nation key areas[1], and information on the particular difficulties of different population groups is drawn on to inform health promotion activities.

3. Several national health promotion activities specifically target those groups who have poorer than average health status, or who face particular problems. Additionally, a considerable amount of even more closely targeted work goes on at a local level within the NHS, often working in partnership with local authorities, the voluntary sector and local communities themselves. Often this work is targeted on poorer communities who have particularly high rates of ill-health and premature death.

4. A range of national activities are described below:

Coronary Heart Disease (CHD) and Stroke

5. South Asians living in the UK have particularly high rates of CHD while people of Caribbean descent have a greater than average risk of stroke. The Department has funded a range of targeted resources for ethnic minorities on CHD and stroke, including materials on diet and exercise. It is also working with the Conference of Indian Organisations on a major physical activity programme.

6. The next phase of the physical activity campaign will target older people, who lead a more sedentary life than their younger counterparts.

Smoking

7. The adult smoking campaign is targeted on socio-economic groups C2, D and E. The Department is also funding a project working with smokers in lower socio-economic groups which involves training for professionals in helping people quit, and involving people in peer-education.

Nutrition

8. The diet and nutrition targets are applicable to the whole population, but specific initiatives are also developed for priority groups, eg. through the work of a Nutrition Task Force Low Income Project Team. Initiatives are specifically tested for their relevance to social groups C2, D and E, eg. focus groups tested designs for 'The Balance of Good Health', a pictorial representation of the components of a healthy diet. Each of the Nutrition Task Force's Project Teams was asked to consider how its work could be applied to ethnic minority groups and older people. Reviews of interventions' effectiveness help target policy to where most can be achieved, and plans are currently being developed for evaluating the Nutrition Task Force programme.

HIV/AIDS

9. As well as work directed at raising and maintaining awareness in the general population, work is targeted on those particularly at risk: gay men, drug misusers, and people from countries with a high prevalence of HIV.

[1] Variations in Health: What Can the Department of Health and the NHS Do?. Department of Health; London 1995. Copies available in the Libraries of the House.

CANCERS

10. Work has been carried out to raise awareness of cancer screening among Asian women and to encourage women to attend for screening. The Department has provided funding for a screening programme for the homeless through shelters, hostels and day centres.

MENTAL ILLNESS

11. Evidence provided at the hearing mentioned work with farmers, who have particularly high rates of suicide. There is currently a research project underway looking at deliberate self-harm—including suicide—among young Asian women, to help guide the design of interventions to reduce deliberate self-harm in this group.

ACCIDENTS

12. A joint project with the Royal Society for the Prevention of Accidents has looked at whether messages on accidents are received and understood by ethnic minority groups, and how best to reach those groups.

Consumers' expenditure in the United Kingdom

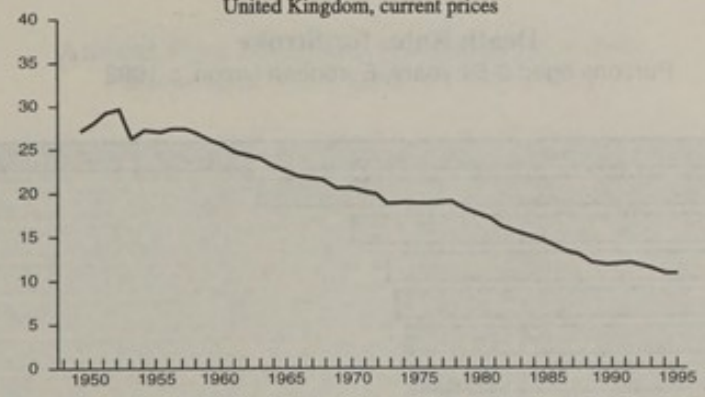
	1985		1990		1995	
	£b	%	£b	%	£b	%
Total consumers' expenditure	217.5	100	347.5	100	447.2	100
Expenditure on household food	30.7	14.1	41.8	12.0	48.9	10.9
Expenditure on alcoholic drink	15.7	7.2	21.4	6.1	26.4	5.9
Expenditure on catering (meals and accommodation)	13.9	6.4	29.8	8.6	38.2	8.5

Source: Office for National Statistics

Figure 1.2

Household food expenditure as a percentage of total consumers' expenditure

United Kingdom, current prices

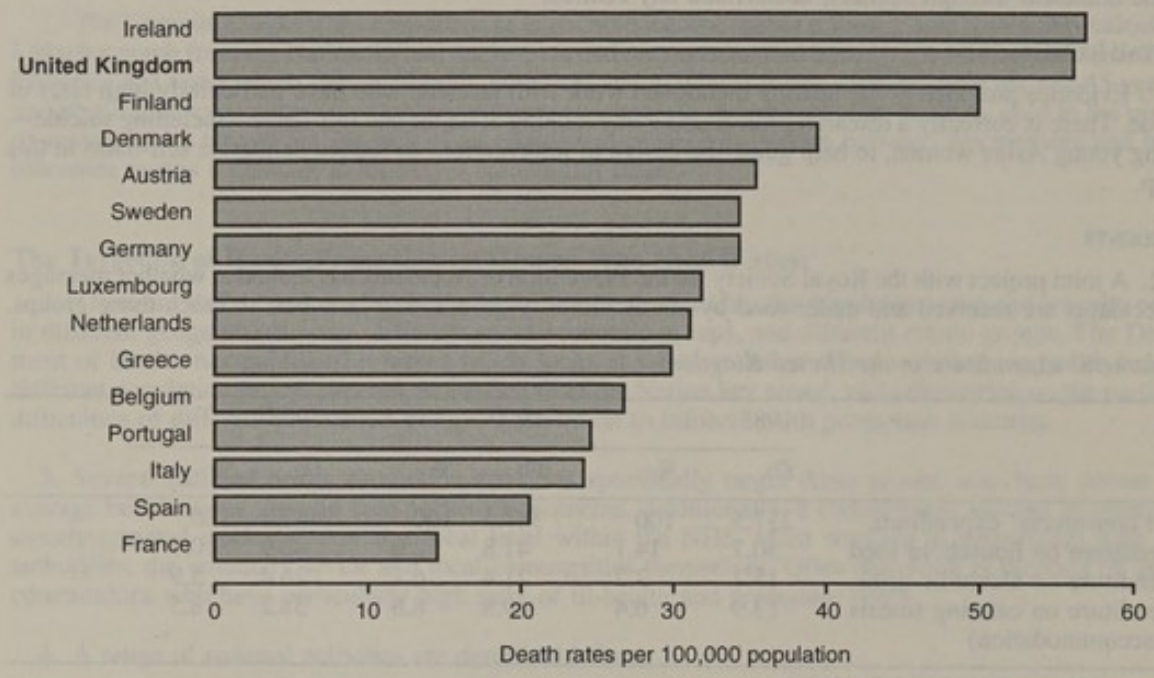


Source: Office for National Statistics, Economic Trends

CHART A1

Death Rates for Coronary Heart Disease

Persons aged 0-64 years, European Union, c 1992



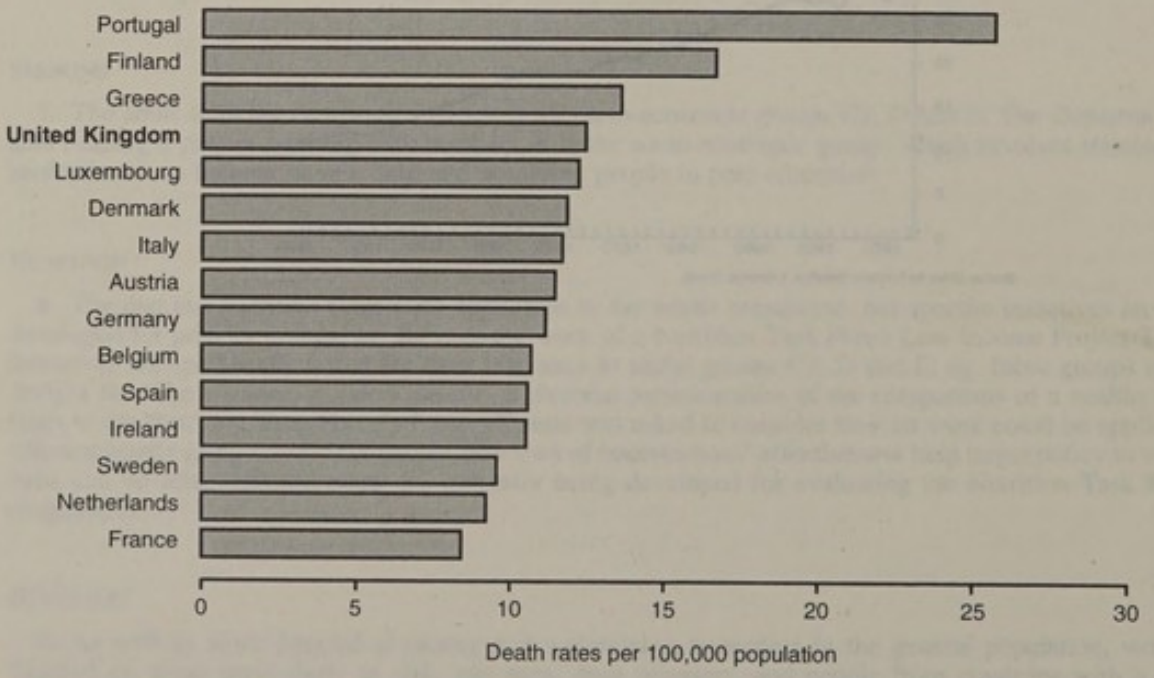
Data are for latest available year (circa 1992).
Definitions may not be strictly comparable across countries.

Source: WHO HFA indicators

CHART A2

Death Rates for Stroke

Persons aged 0-64 years, European Union, c 1992

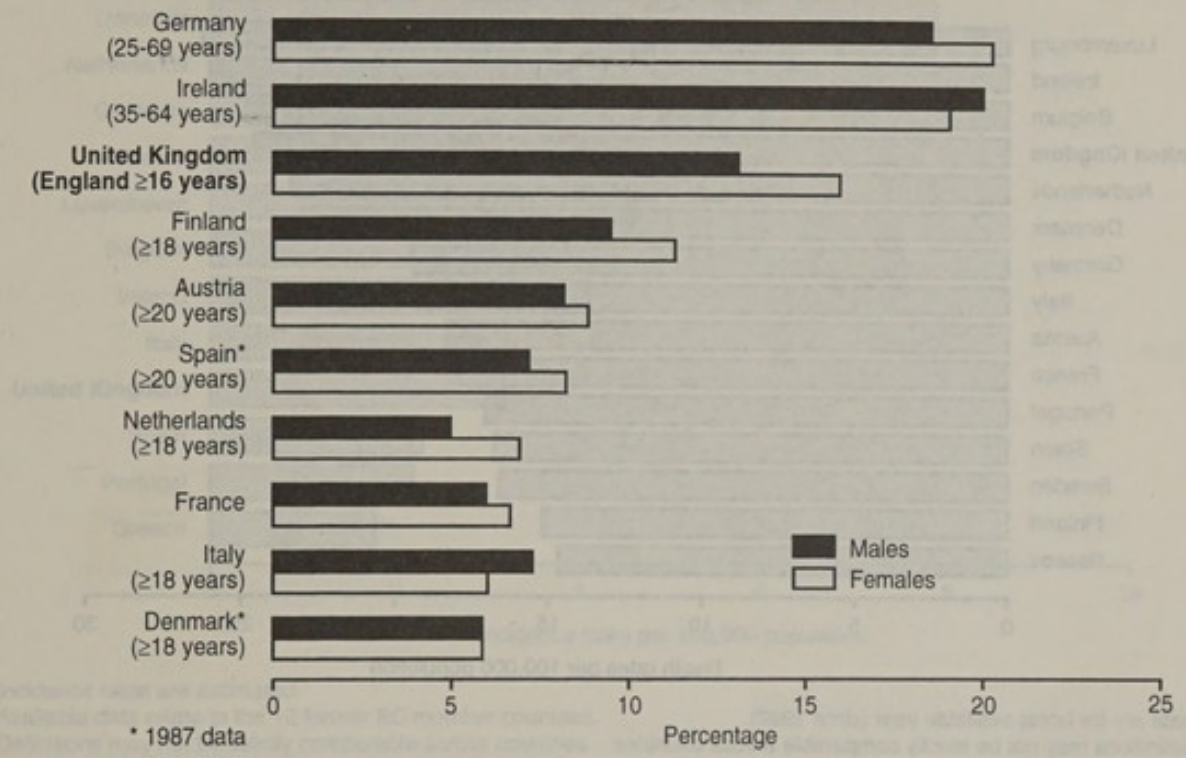


Data are for latest available year (circa 1992).
Definitions may not be strictly comparable across countries.

Source: WHO HFA indicators

CHART A3

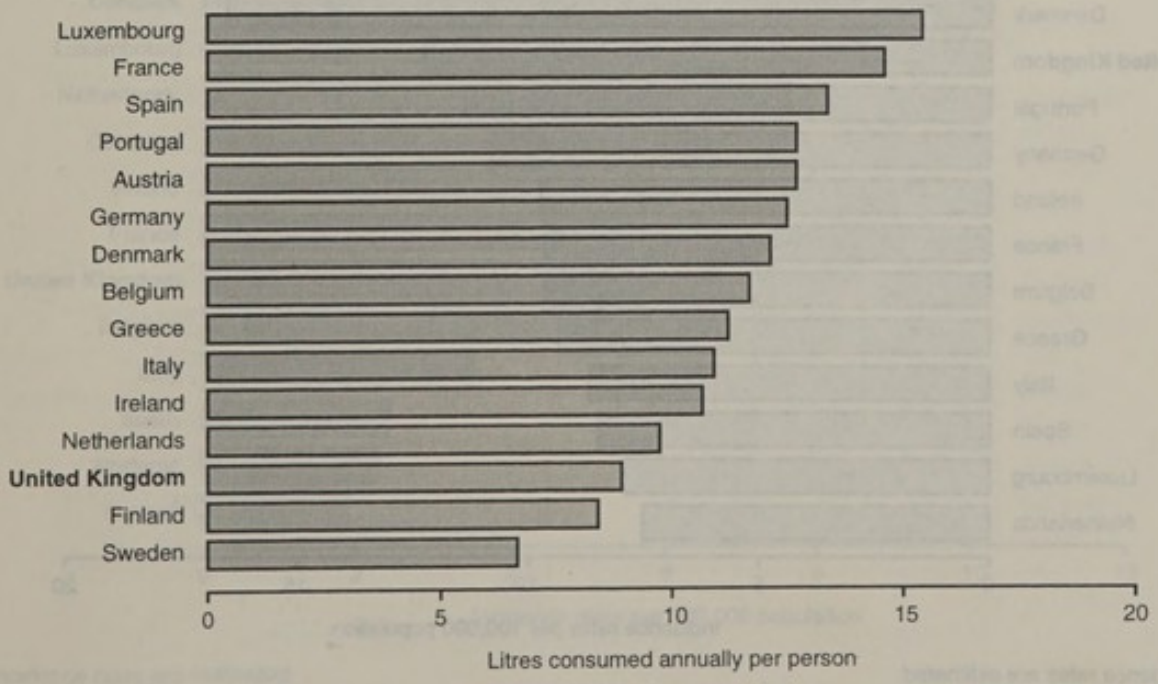
Percentage of population that is obese
(BMI ≥30), 1990/1993



Source: WHO Highlights on Health (unpublished)

CHART A4

Annual Pure Alcohol Consumption in Litres
Persons aged 15+, European Union, c 1992



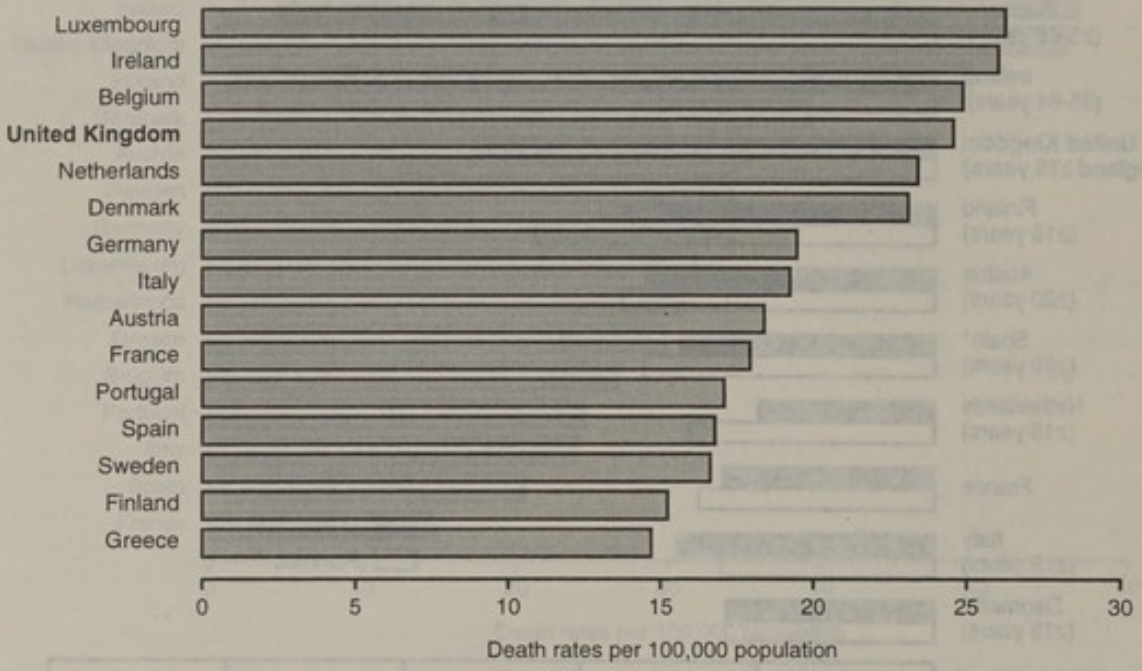
Data are for latest available year (circa 1992).

Source: WHO HFA Indicators

CHART B1

Death Rates for Cancer of the Breast

Females aged 0-64 years, European Union, c 1992



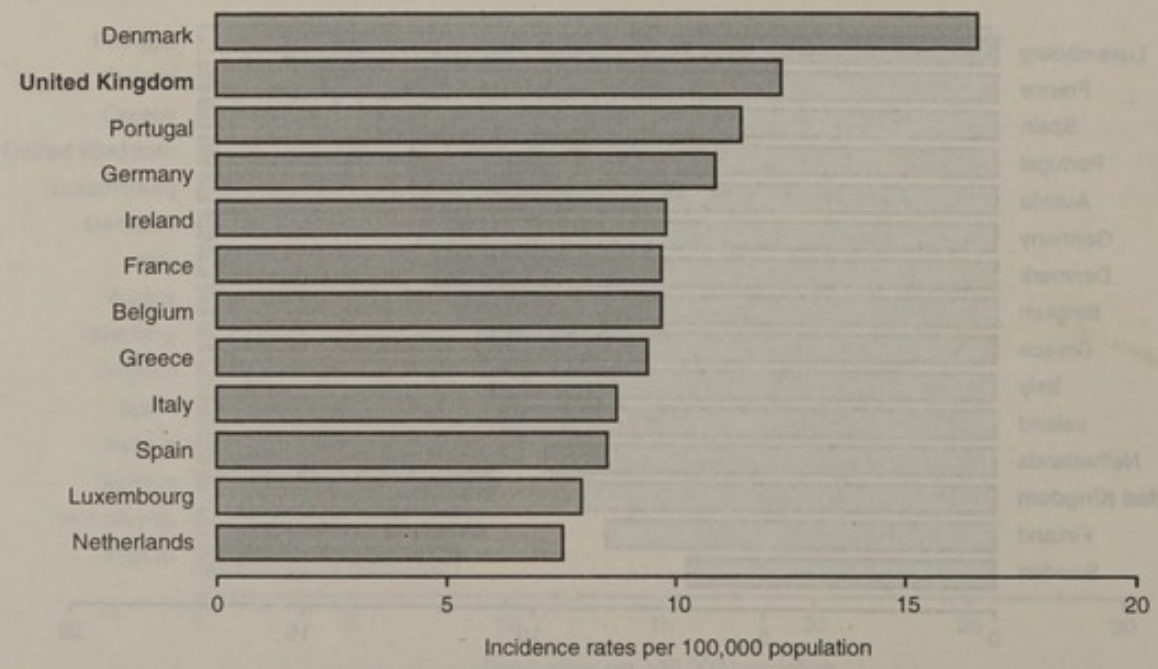
Data are for latest available year (circa 1992).
Definitions may not be strictly comparable across countries.

Source: WHO HFA Indicators

CHART B2

Incidence Rates for Cancer of the Cervix

Females all ages, former European Community, c1990



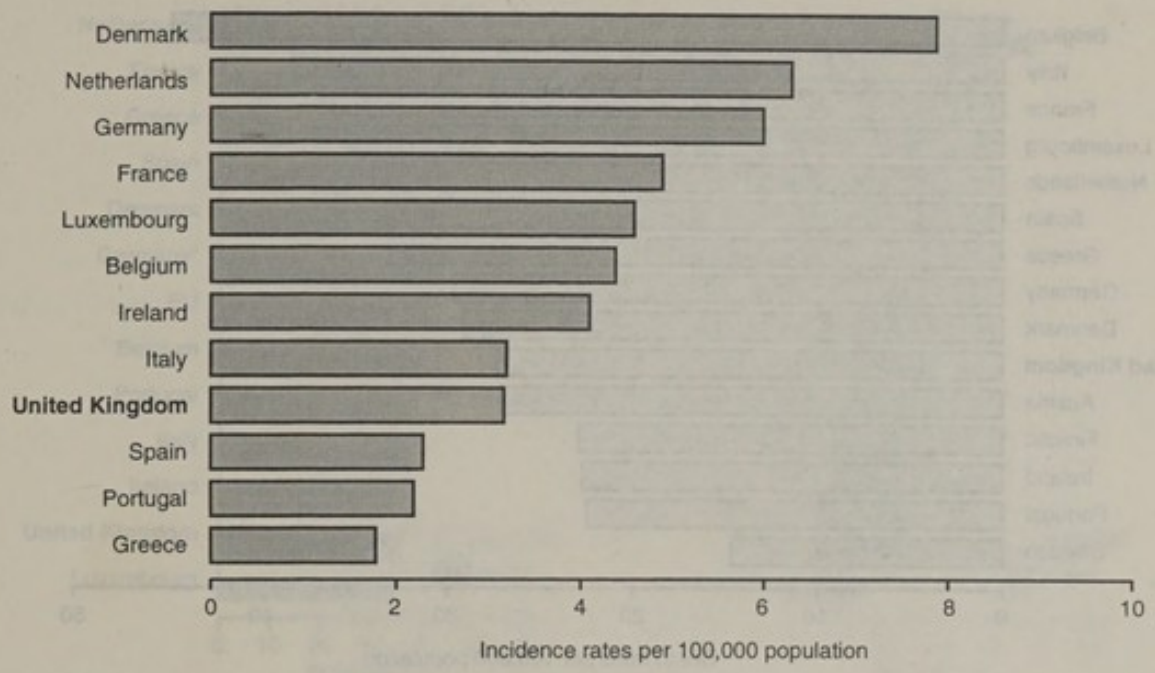
Incidence rates are *estimated.*
Available data relate to the 12 former EC member countries.
Data are not directly comparable across countries as definitions may vary.

Source: Facts & Figures of Cancer in the European Community (IARC 1993)

B3

Incidence Rates for Malignant Melanoma

Males all ages, Former European Community, 1990



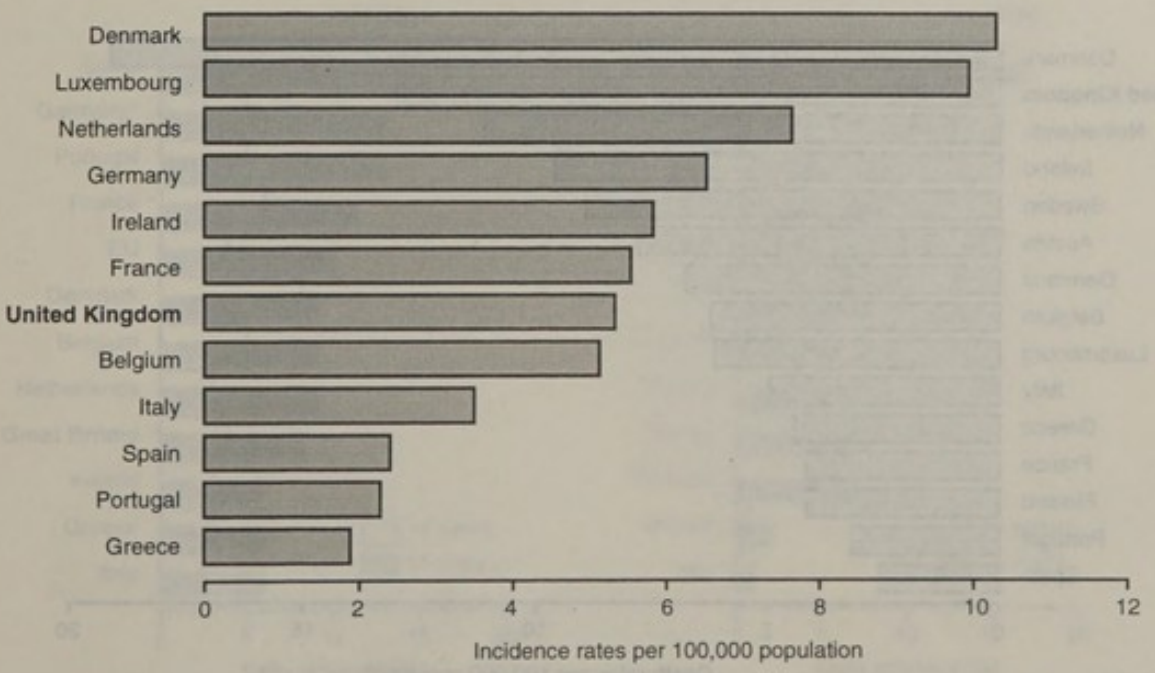
Incidence rates are *estimated.*
Available data relate to the 12 former EC member countries.
Definitions may not be strictly comparable across countries .

Source: Facts & Figures of Cancer in the European Community **(IARC 1993)**

CHART B4

Incidence Rates for Malignant Melanoma

Females all ages, former European Community, 1990



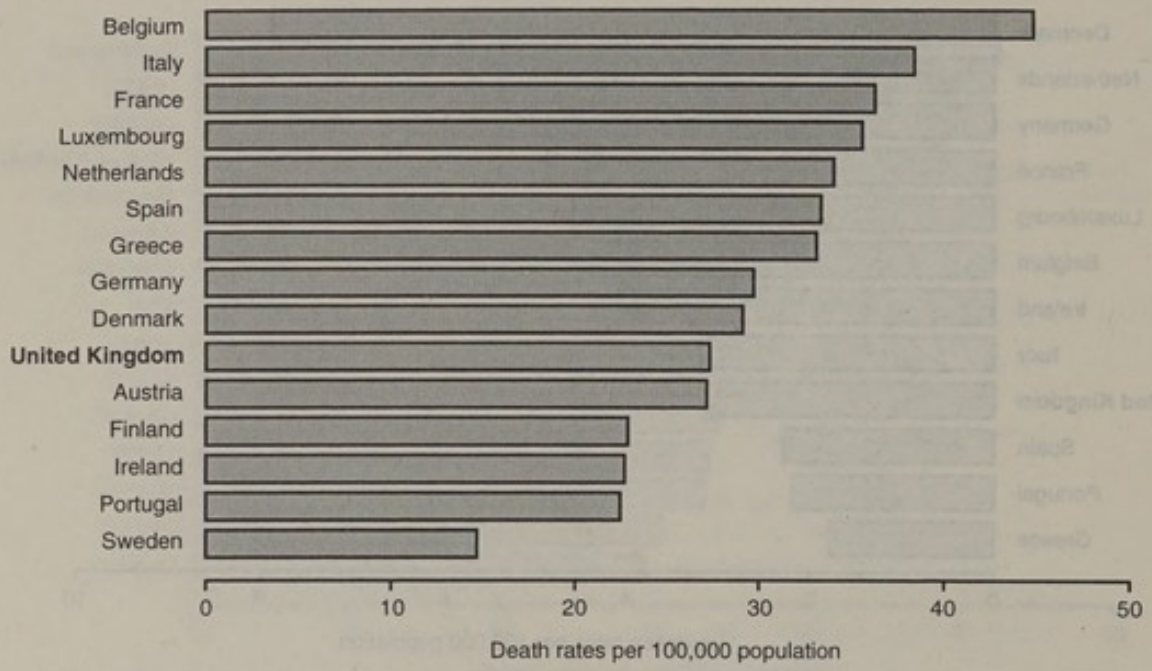
Incidence rates are *estimated.*
Available data relate to the 12 former EC member countries.
Definitions may not be strictly comparable across countries .

Source: Facts & Figures of Cancer in the European Community **(IARC 1993)**

CHART B5

Death Rates for Lung Cancer

Males aged 0-64 years, European Union, c 1992



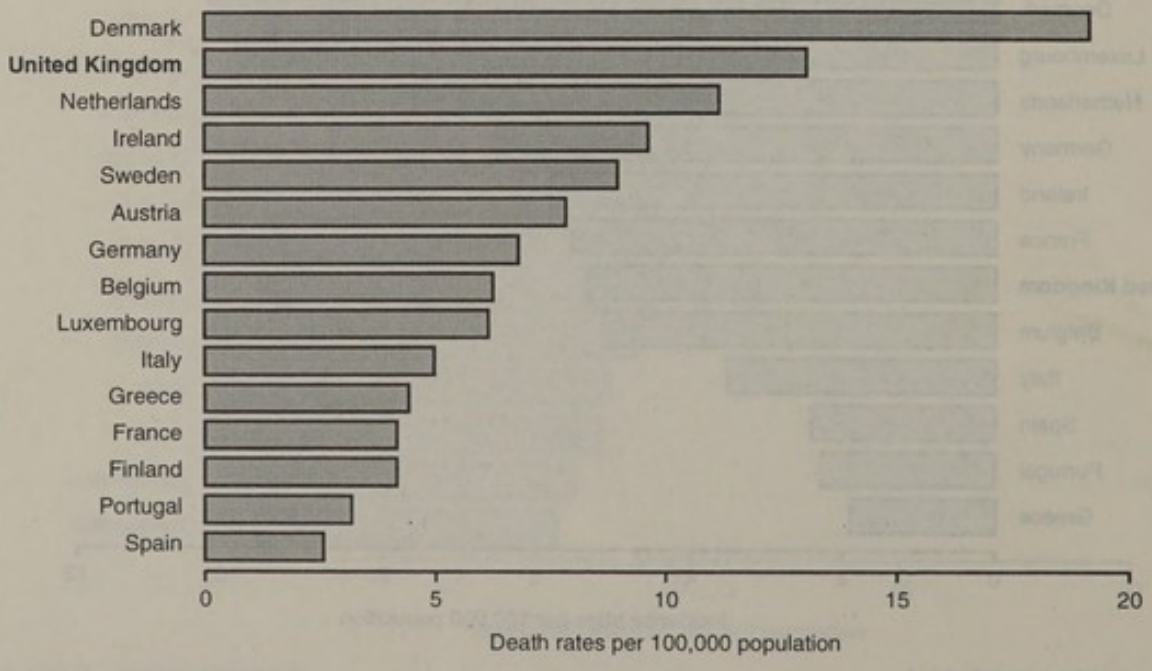
Data are for latest available year (circa 1992).
Definitions may not be strictly comparable across countries.

Source: WHO HFA Indicators

CHART B6

Death Rates for Lung Cancer

Females aged 0-64 years, European Union, c 1992

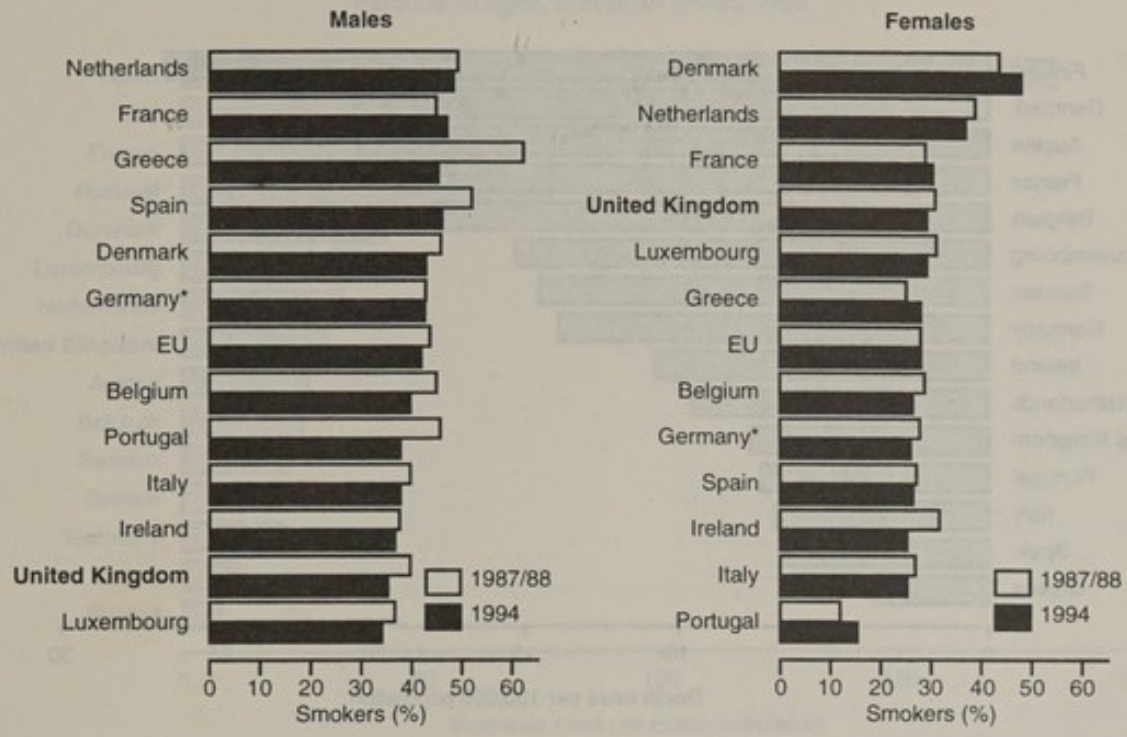


Data are for latest available year (circa 1992).
Definitions may not be strictly comparable across countries.

Source: WHO HFA Indicators

CHART B7

Percentage of smokers among adult population aged 15+



* 1987/88 Federal Republic of Germany only

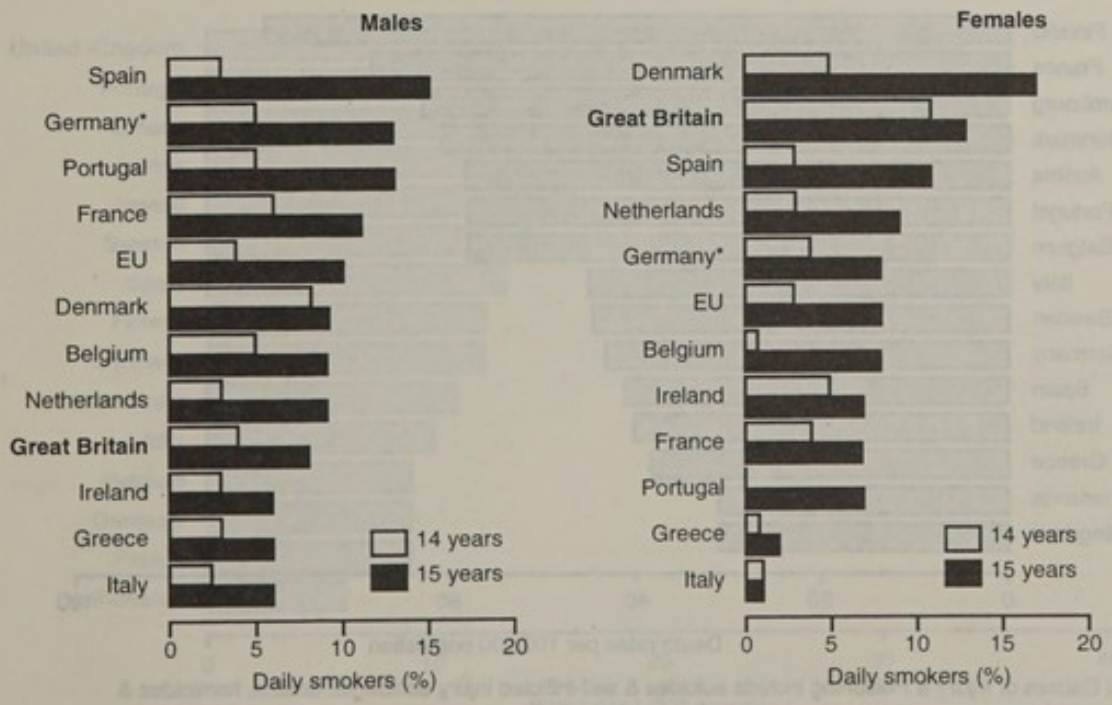
Source: Commission of the European Communities (BASP 1994)

Reprinted from Highlights on Health in the United Kingdom (WHO) (unpublished)

CHART B8

Percentage of daily smokers among adolescents by sex and age, 1990

(N=4,538)



* Federal Republic of Germany

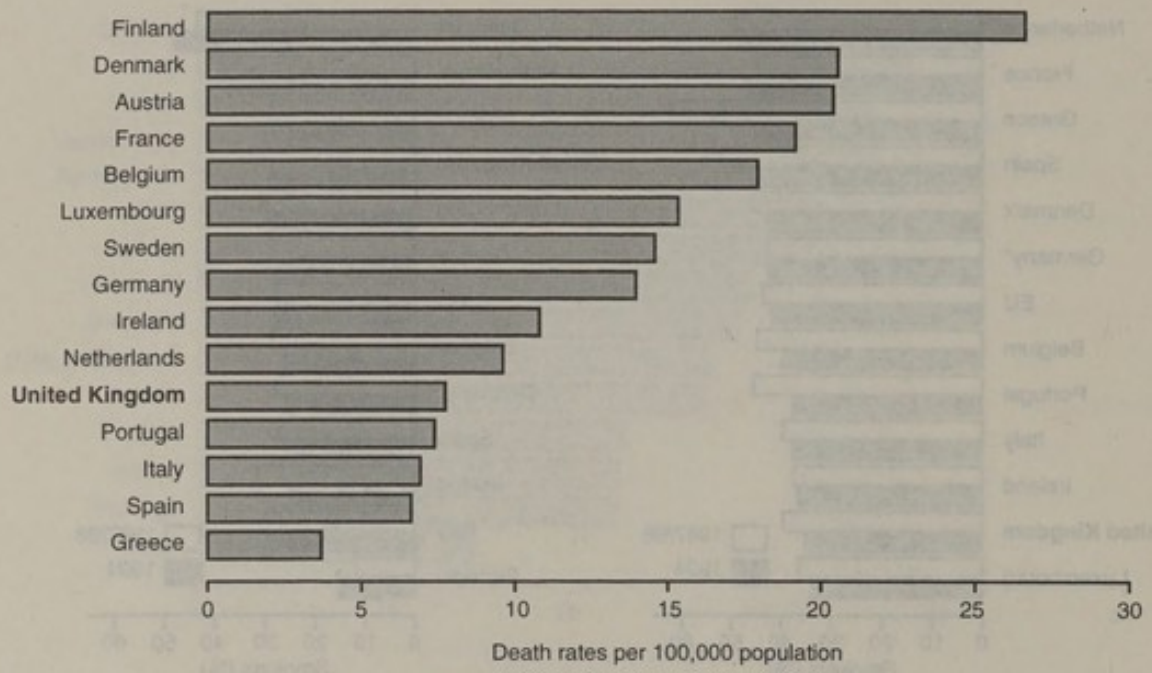
Source: Commission of the European Communities (Van Reek / Adriaanse 1

Reprinted from Highlights on Health in the UK (WHO) (unpublished)

CHART C1

Death Rates for Suicide & Self Inflicted injury

Persons all ages, European Union, c 1992



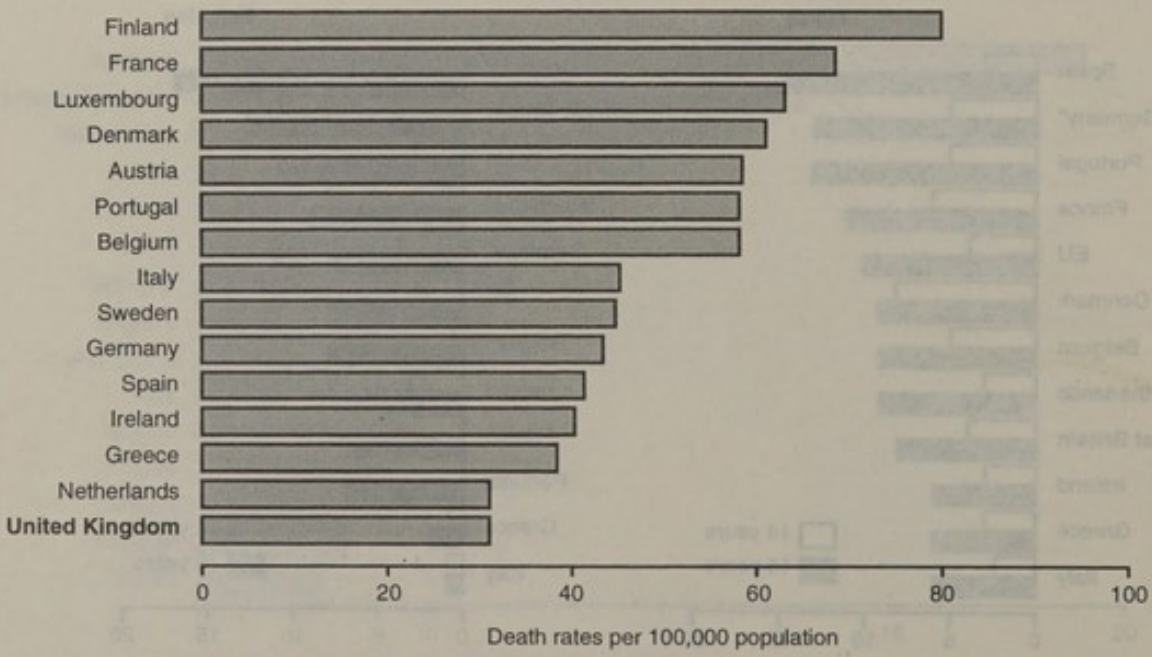
Data are for latest available year (circa 1992).
Definitions may not be strictly comparable across countries.

Source: WHO HFA Indicators

CHART C2

Death Rates for External Causes of Injury and Poisoning*

Persons all ages, European Union, c 1992



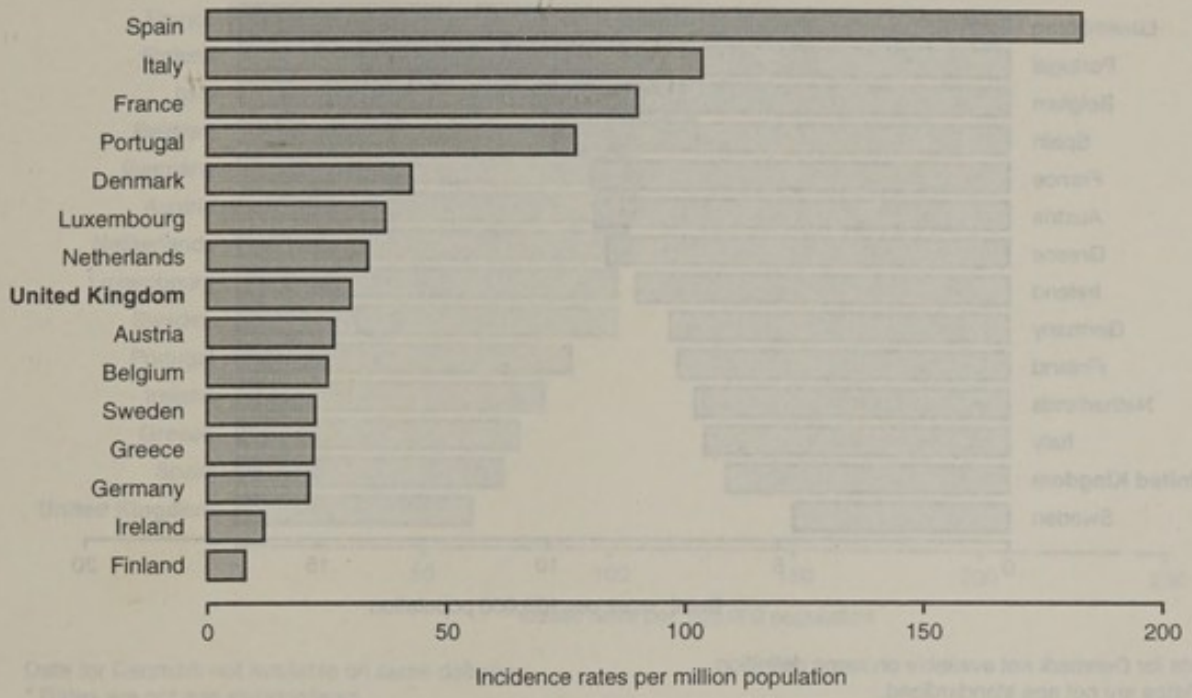
*** External Causes of Injury & Poisoning include suicides & self-inflicted injury, accidental deaths, homicides & undetermined injury.**
Data are for latest available year (circa 1992).
Definitions may not be strictly comparable across countries.

Source: WHO HFA Indicators

CHART D1

Incidence Rates for clinically diagnosed AIDS

Persons all ages, European Union, 1995



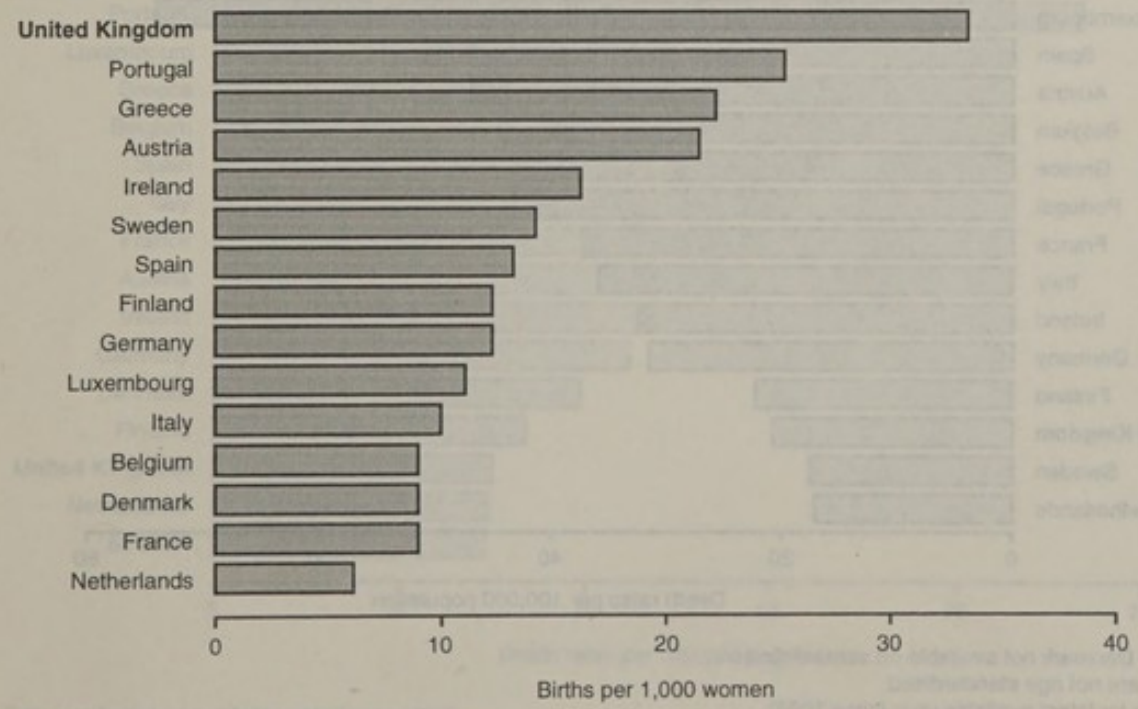
Definitions may not be strictly comparable across countries.

Source: PHLS AIDS/HIV Quarterly Surveillance Tables (to 31 March 1996)

CHART D2

Live Births per 1,000 women

Aged 15-19, European Union, c 1990

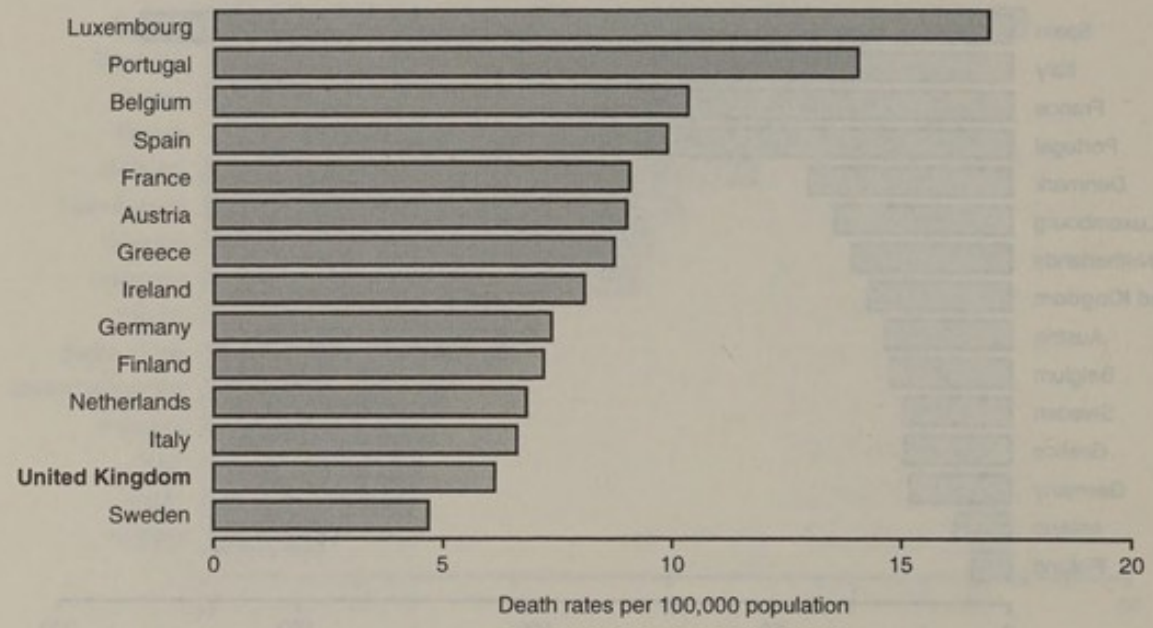


Source: OPCS Population Trends no. 74 Winter 1993

CHART E1

Death Rates* for Accident and Adverse Effects

Persons aged under 15, European Union, c 1992



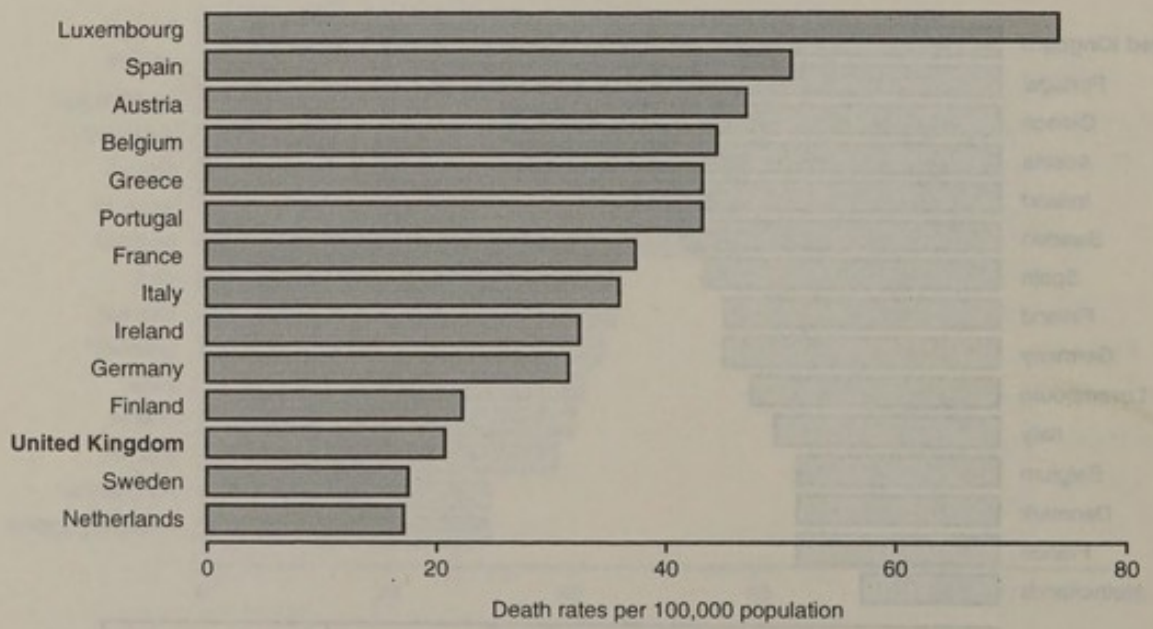
Data for Denmark not available on same definition.
* Rates are not age standardised.
Data are for latest available year (circa 1992).
Definitions may not be strictly comparable across countries.

Source: World Health Statistics Annuals 1993, 1994 (ICD9 E800-E949)

CHART E2

Death Rates* for Accident and Adverse Effects

Persons aged 15-24, European Union, c 1992



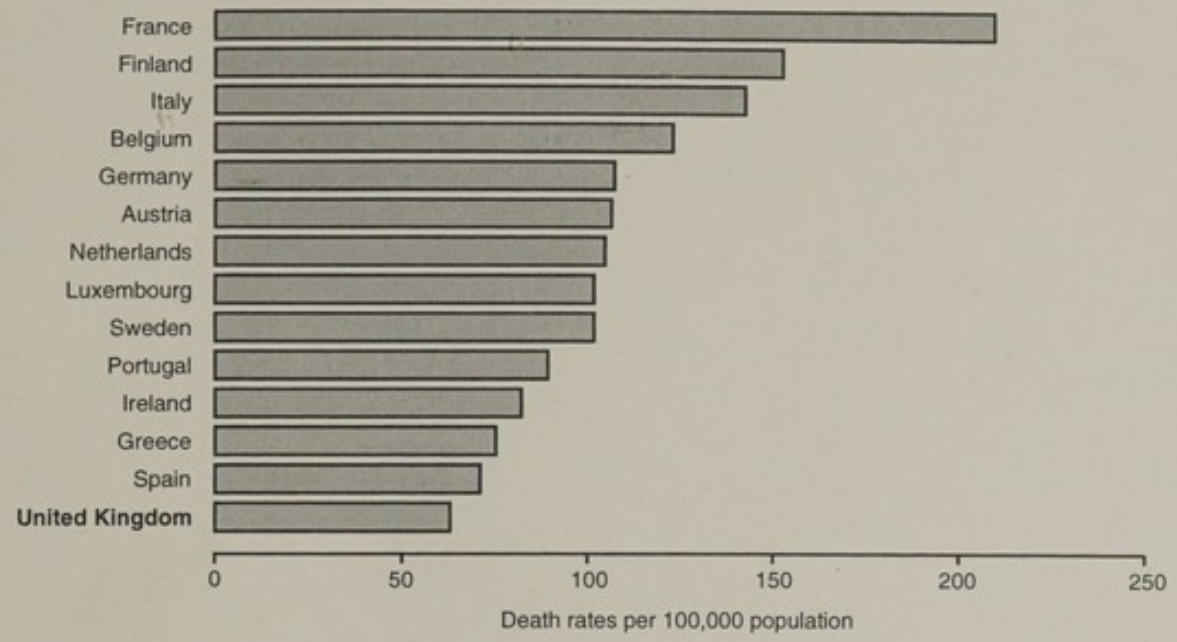
Data for Denmark not available on same definition.
* Rates are not age standardised.
Data are for latest available year (circa 1992).
Definitions may not be strictly comparable across countries.

Source: World Health Statistics Annuals 1993, 1994 (ICD9 E800-E949)

E3

Death Rates* for Accident and Adverse Effects

Persons aged 65+, European Union, c 1992



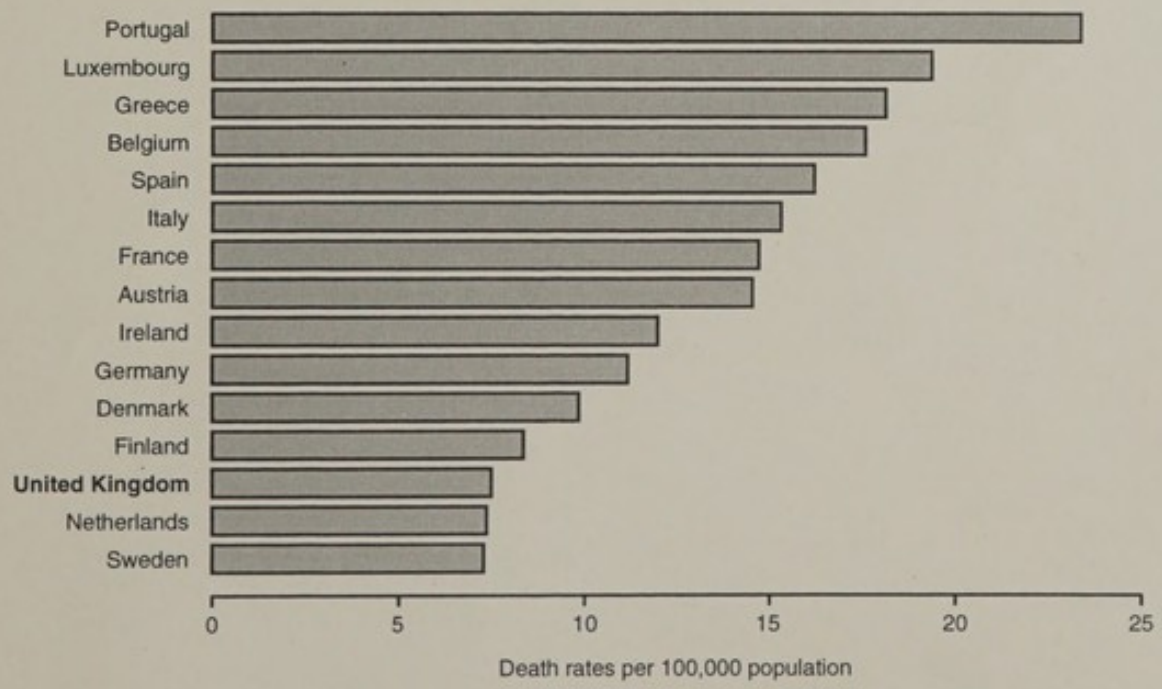
Data for Denmark not available on same definition.
* Rates are not age standardised.
Data are for latest available year (circa 1992).
Definitions may not be strictly comparable across countries.

Source: World Health Statistics Annuals 1993, 1994 (ICD9 E800-E949)

CHART E4

Death Rates for Motor Vehicle Traffic Accidents

Persons all ages, European Union, c 1992



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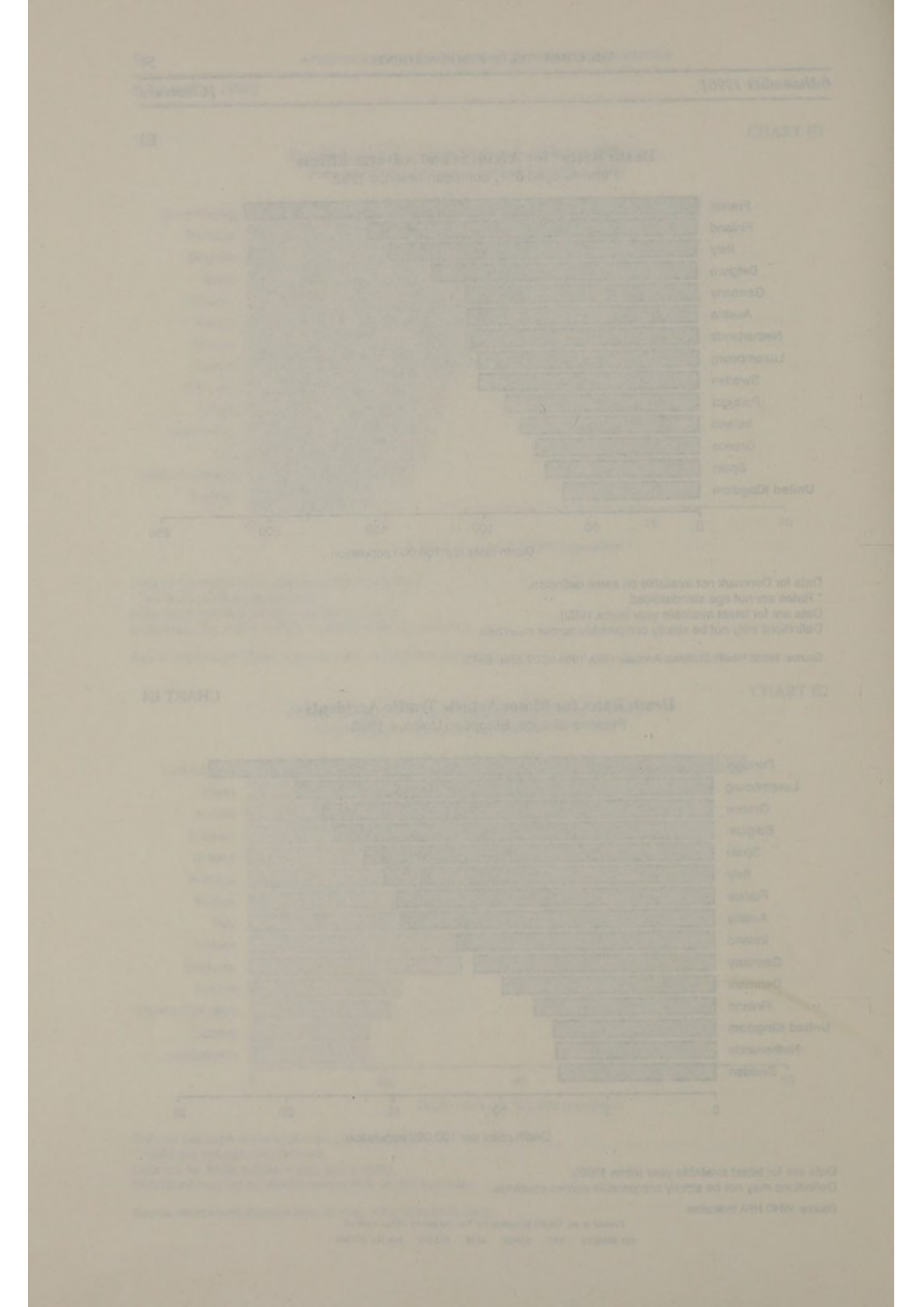

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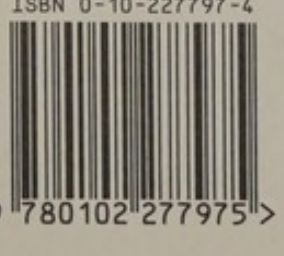

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