



**HEALTH
MATTERS**
in
Argyll and Clyde

1989

**ANNUAL REPORT
OF THE
DIRECTOR OF PUBLIC HEALTH**



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INTRODUCTION



Until 1974, when Health Boards were established, the main responsibility for public health lay with local authorities. In the Argyll and Clyde area these consisted of the counties of Renfrew, Dunbarton, Bute and Argyll and the large burghs of Paisley, Greenock and Dumbarton. Each of these local health authorities had a Public Health Department headed by the authority's Medical Officer of Health and each Medical Officer of Health was required to produce an annual report on the health of the population served by the authority. Some of these reports were more informative than others, but all contained statistical information about the health of the population, and over the years this information allowed the public to follow trends in the improvement (or decline) of health.

When Health Boards were set up in 1974 they took over many of the functions of the Medical Officers of Health, although Environmental Health remained the responsibility of the local (district) authorities. With this change in organisation, in most areas the publication of annual reports on public health matters lapsed, although many Health Boards, including Argyll and Clyde, continued to publish annual statistical reports. Whilst these reports are useful records of activity levels, they do not highlight health issues, nor do they allow trends in health, as opposed to health service activity, to be monitored. However, in the past few years there has been increasing public debate about a number of important health issues, some relating to communicable disease and infection and others to environmental matters, and this increase in public awareness had led to central government to institute reviews of the arrangements for safeguarding the health of the public. In turn, Health Boards have been reminded of their responsibility for making satisfactory arrangements to ensure that medical aspects of the health of the public are properly dealt with.

Resulting from this review of public health responsibilities, the requirement for an annual report on the health of the public in each Board area has been re-introduced. This is the first "new style" annual report for the Argyll and Clyde area. The report is not about the health services provided by the Board, although inevitably reference to health service provision is made here and there; details of the Board's services are available from other sources (1).

Nor is it a report on health service activity since a great deal of detailed information on this is given in the Board's Annual Statistical Report (2). It has a number of purposes:

- * **To highlight health problems in sections of the population indicating, where possible, what needs to be done to alleviate these problems.**
- * **To put national and international public health issues into a local context.**
- * **To record particular local incidents affecting public health during the year, and the action taken to deal with them.**
- * **In future years, to demonstrate trends in the improvement (or decline) in measurable aspects of the health of the population served by the Board. Unfortunately, because of boundary changes, direct comparisons cannot be made with the statistics in the Medical Officers of Health reports of the previous local authorities in the area.**

The report also contains, as appendices, some statistical tables, not all of which are referred to in the text. These statistics are included in the Public Health reports of all Health Boards to allow Scottish comparisons to be drawn.

Production of this report has been a corporate effort by the Board's Department of Public Health and I am indebted to my consultant colleagues in the Department for their enthusiastic help in its preparation, and especially to Dr. Lesley Wilkie, senior registrar in the Department, who undertook the main editorial task. Thanks are also due to the Board's Information Services Officer, Dr. James Shimmins and to the Press and Publicity Officer, Mr. Norman MacPhee, for the considerable assistance given. It is hoped that those who read the report will find it an informative and useful focus on the health of the public of this part of Scotland. Any comments on the content or format of the report will be very welcome.

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June 1990.



THE HEALTH BOARD AND ITS POPULATION: VITAL STATISTICS

The Argyll and Clyde Health Board area is made up of many communities, both urban and rural. The Board has a remit to promote the health of, and to provide services to, the population of the four local government districts of Renfrew, Inverclyde, Dunbarton and Argyll & Bute. These include the towns of Paisley, Greenock, Port Glasgow and Dumbarton with their heritage of heavy industrialisation and its consequent health effects; as well as the more sparsely populated areas of Argyll and the islands with their problems of isolation and access to health facilities.

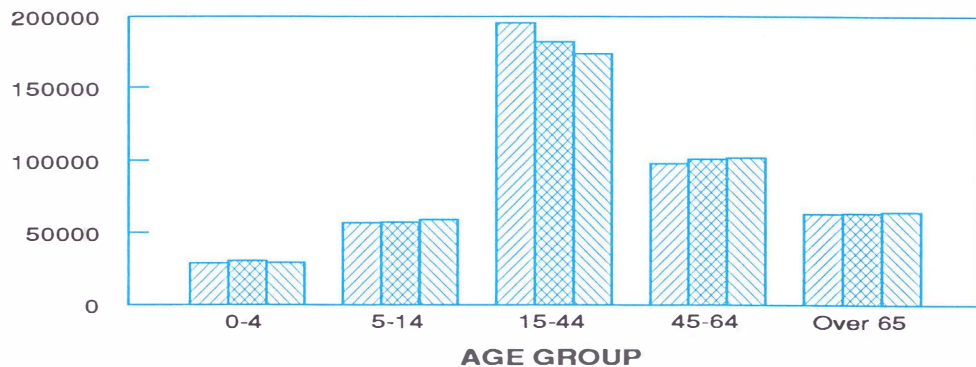
In 1988 there were an estimated 441,966 people living within the Board area, projected to fall to 428,457 by the year 2000. These figures conceal differences among both the age groups and the geographical areas as shown here.

ARGYLL & CLYDE HB



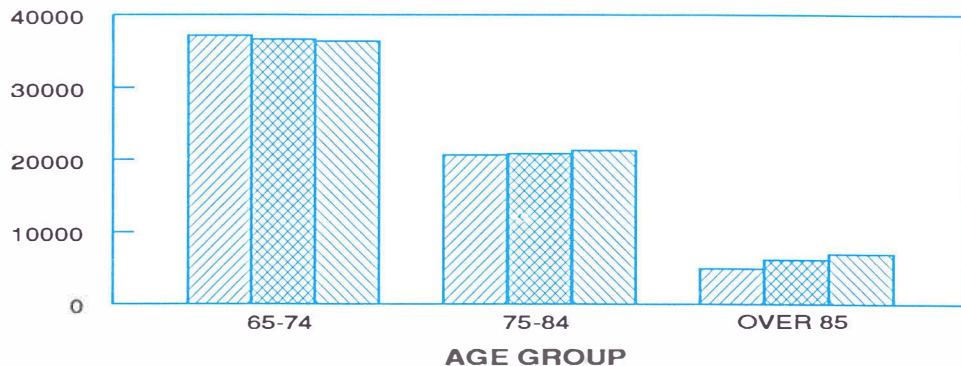
POPULATION STRUCTURE - ALL AGES

NO OF PERSONS



POPULATION STRUCTURE - ELDERLY

NO OF PERSONS

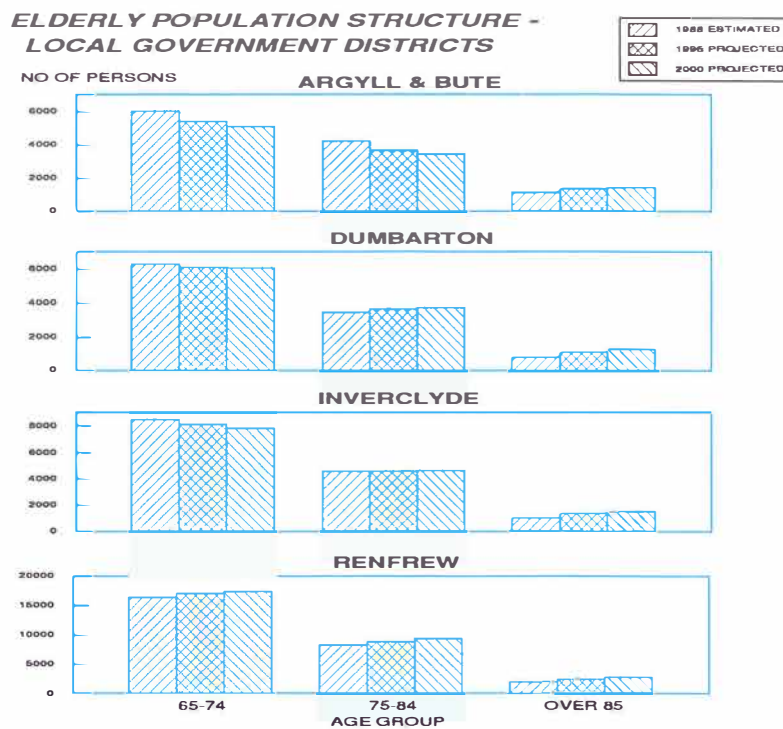
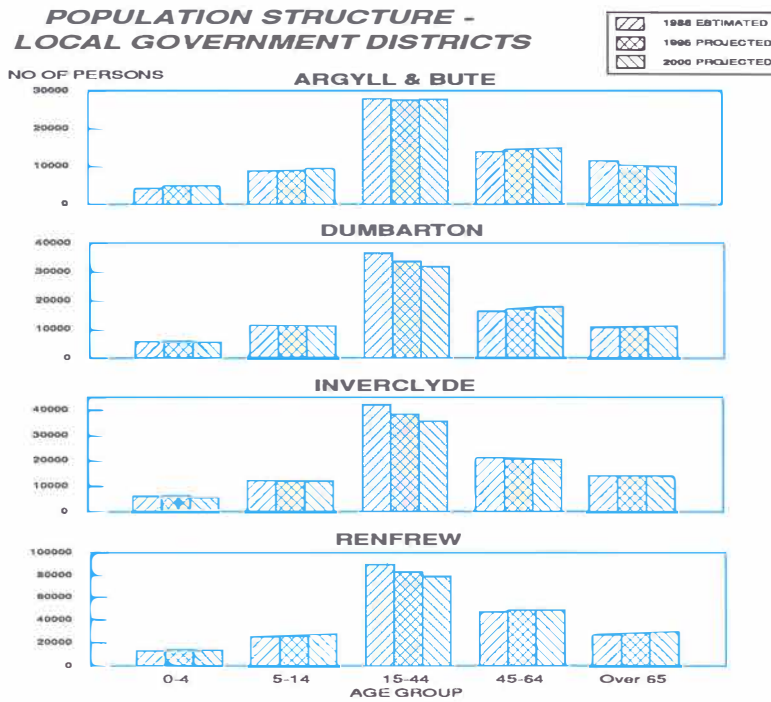


THE HEALTH BOARD AND ITS POPULATION: VITAL STATISTICS



Rise in the over 85's - and a fall in the young

Consistently shown is the rise in both the number and percentage of very elderly people in the population (over the age of 85 years). Elderly people are major users of health services both in hospital and in the community. In addition, with increasing age, they may receive care from family and friends as well as from health, local authority and voluntary services. Significantly, the figures also show a reduction in the number of young and middle aged people who are the potential carers of this elderly population.





THE HEALTH BOARD AND ITS POPULATION: VITAL STATISTICS

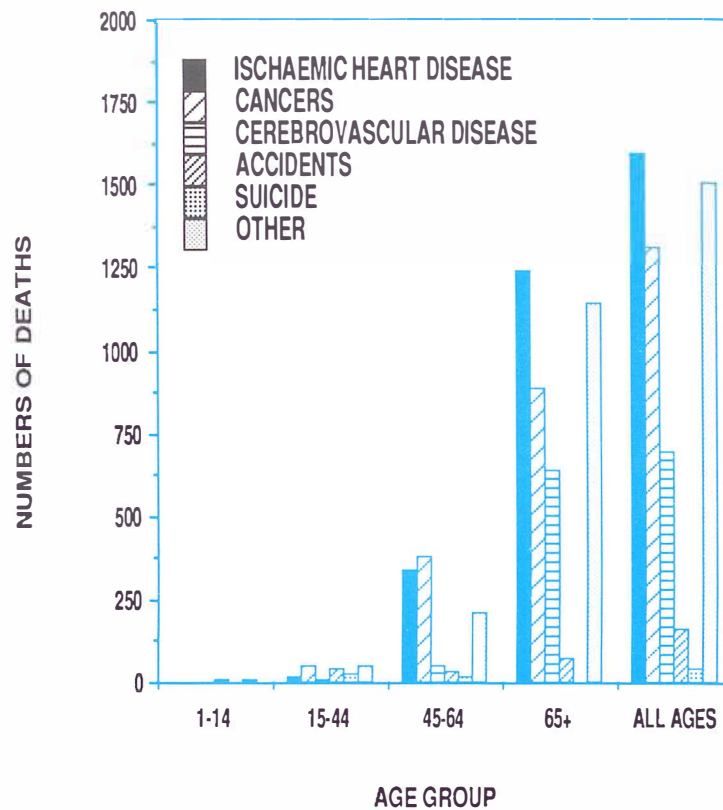
The health of any population is related to social and economic factors as much as, if not more than, the provision of health services. Deprivation - implying a mix of poverty, poor housing, poor environment and possible lack of family support - is a major influence on health. The Board area contains many areas of urban dereliction and social disadvantage, some of which have been designated by the Regional Council as areas of priority treatment (APTs). Recent work from Edinburgh University (3) confirms the link between deprivation and higher than average death rates and it is hoped to use this work in the Board area to examine ways of improving the health of people living in deprived areas.

The expected lifespan at birth in Argyll and Clyde was recently estimated as 68.3 years

for men and 74.9 years for women (5). Although this represents a considerable improvement since the early years of the century, the Board is the third worst (behind Greater Glasgow and Lanarkshire) of all the Health Boards in Scotland. The corresponding figures for Scotland as a whole are 69.3 and 75.4.

The main causes of death in each age group for the Board in 1988 are shown below. Appendix 2 also gives the information in tabular form. The most important single cause of death is ischaemic heart disease (heart attacks). This resulted in 816 deaths in men (30% under 65 years) and 776 deaths in women (13% under 65).

NUMBER OF DEATHS BY AGE FOR MAJOR CAUSES OF DEATH - 1988



THE HEALTH BOARD AND ITS POPULATION: VITAL STATISTICS



A further indication of the relative importance of different causes of death is shown in this table which shows “years of life lost before age 65” and thus looks at “premature deaths”. Using this method it can be seen that the greatest cause of years of life lost prematurely is malignant disease, ahead of ischaemic heart disease and accidents. However, in Inverclyde premature loss of life through accidents exceeds that due to ischaemic heart disease.

NUMBER OF YEARS LOST/100,000 POPULATION

CAUSE	A&B	Dum	Inv	Ren	BOARD
All causes	4733	4710	5601	4933	5006
All cancers	1214	949	1338	1340	1249
of lung	168	244	266	292	259
of breast	68	140	120	199	152
of cervix	88	106	56	55	70
Ischaemic HD	817	651	914	824	810
Cerebrovasc. dis.	256	80	208	135	158
All accidents	641	496	1021	522	641

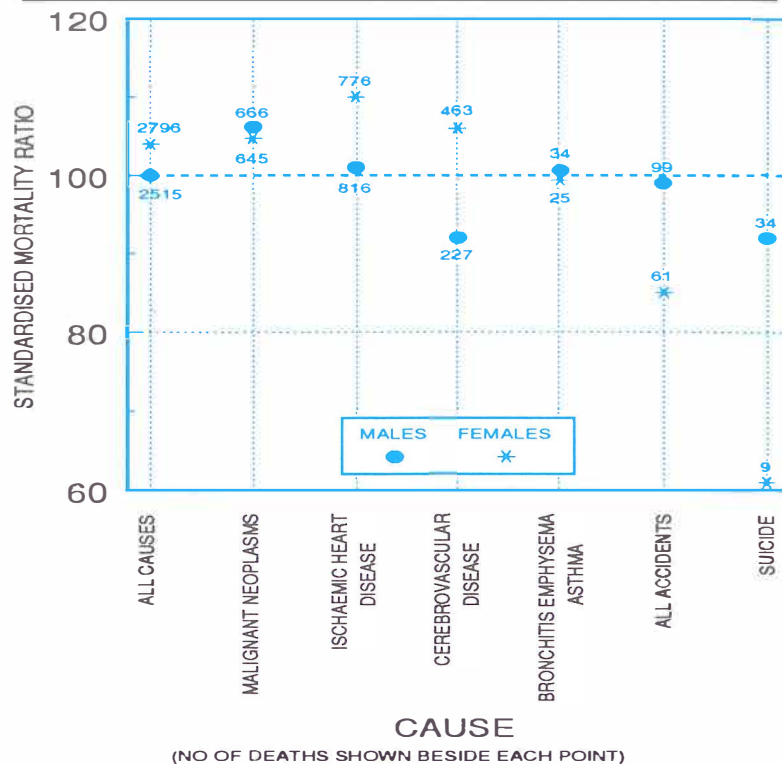


THE HEALTH BOARD AND ITS POPULATION: VITAL STATISTICS

The following series of Graphs show how the Board and its districts compare with Scotland using standardised mortality ratios. Here Scotland is the standard with a value of 100. Any figure above 100 means that there are higher than expected death rates from that cause, taking into account the age structure of the population. Scotland itself is higher than average for most causes of death when compared to the United Kingdom, which in turn compares badly with many other developed countries. The Board's overall position is 102 (100 for men and 104 for women) - above the average for both Scotland and the UK. Of the districts, Inverclyde is highest above the Scotland average, followed by Argyll & Bute, Renfrew and Dumbarton. Women fare worse than men. The smoking related diseases of lung cancer and ischaemic heart disease show particularly high rates for the Board

as a whole, with women being 10% above the average for ischaemic heart disease (higher in Renfrew and Inverclyde) compared to Scotland. Small numbers for some diseases and areas (eg female lung cancer in Dumbarton and deaths in Argyll and Bute) mean that the figures there require careful interpretation. As noted earlier, social deprivation is a major factor leading to higher than average death rates, and any policy to improve the public health must tackle social and economic factors too. The toll of premature death can be reduced. It is now well established that smoking, a high fat diet and lack of exercise contribute to the development of heart disease. This "West of Scotland" way of life is an aspect which health education programmes in the Board have emphasised and a later chapter will explore further the importance of smoking as a cause of ill-health.

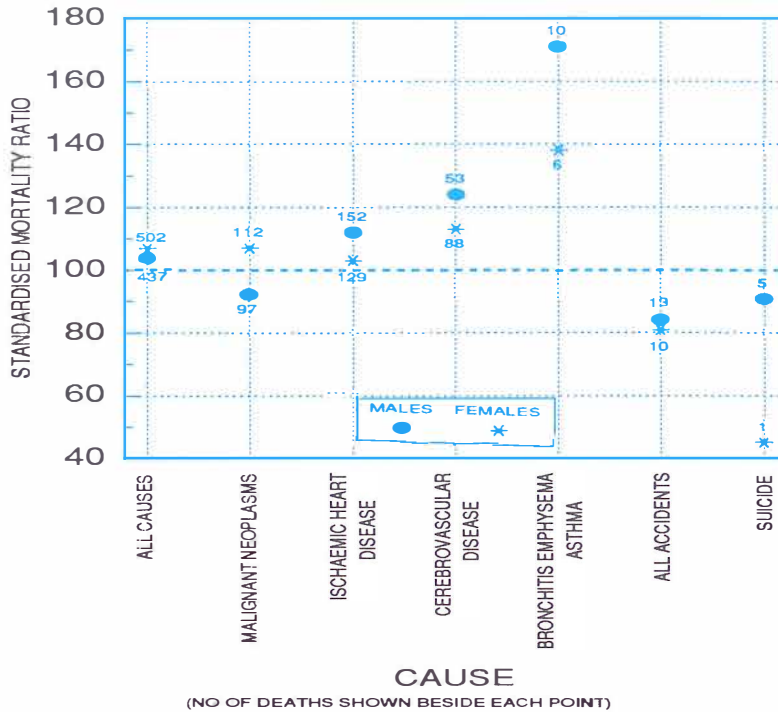
ARGYLL & CLYDE HB RESIDENTS 1988 DEATHS
STANDARDISED MORTALITY RATIOS
(ALL DEATHS & 6 MAIN CAUSES, SCOTLAND = 100)



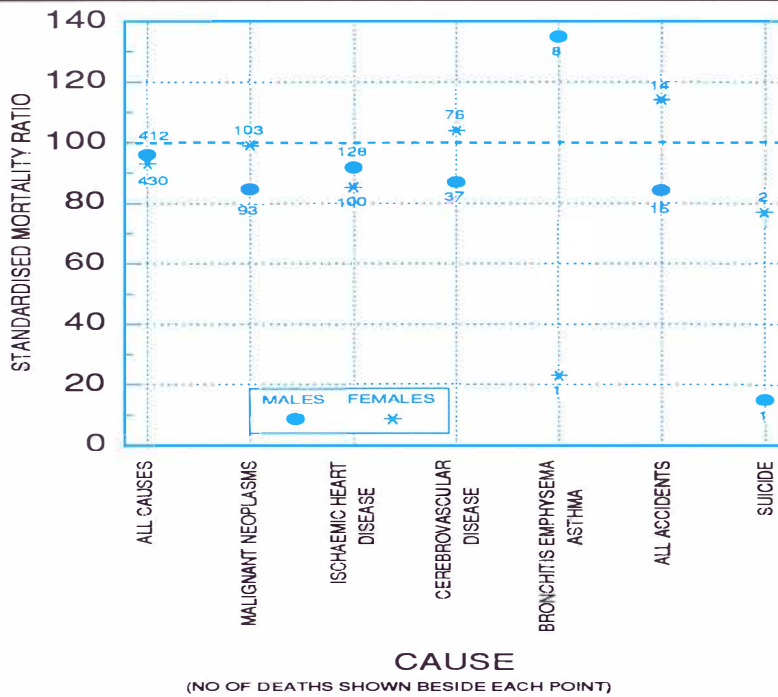
THE HEALTH BOARD AND ITS POPULATION: VITAL STATISTICS



ARGYLL & BUTE LGD RESIDENTS 1988 DEATHS
STANDARDISED MORTALITY RATIOS
(ALL DEATHS & 6 MAIN CAUSES, SCOTLAND = 100)



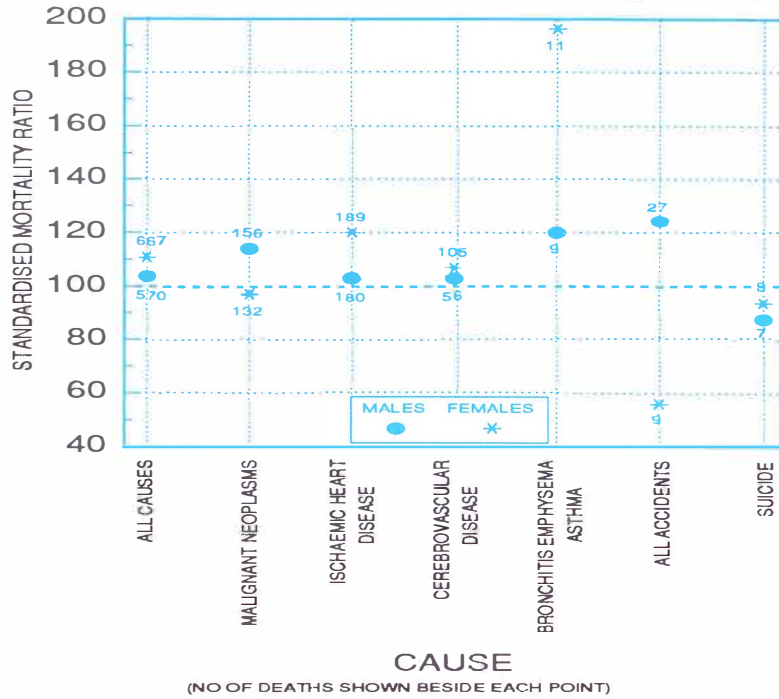
DUMBARTON LGD RESIDENTS 1988 DEATHS
STANDARDISED MORTALITY RATIOS
(ALL DEATHS & 6 MAIN CAUSES, SCOTLAND = 100)



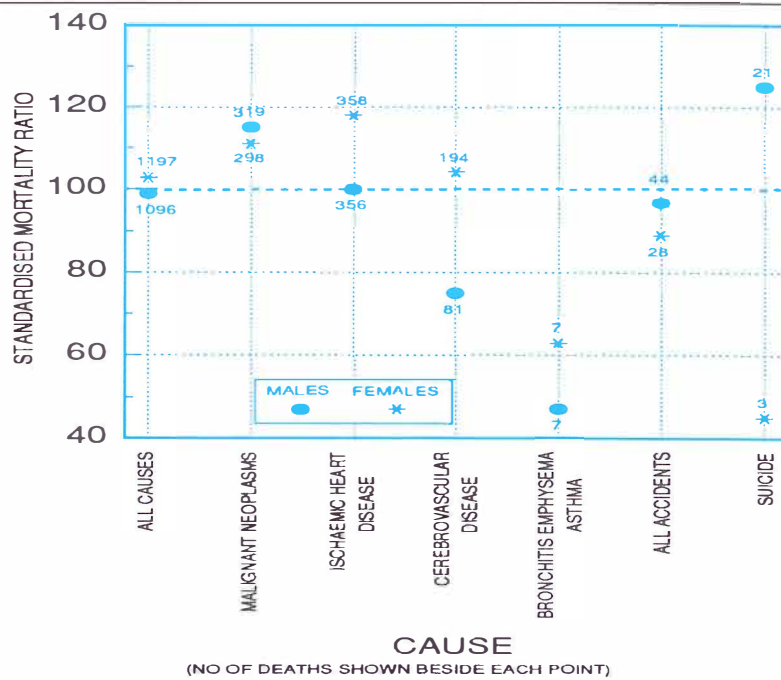


THE HEALTH BOARD AND ITS POPULATION: VITAL STATISTICS

INVERCLYDE LGD RESIDENTS 1988 DEATHS
STANDARDISED MORTALITY RATIOS
(ALL DEATHS & 6 MAIN CAUSES, SCOTLAND = 100)



RENFREW LGD RESIDENTS 1988 DEATHS
STANDARDISED MORTALITY RATIOS
(ALL DEATHS & 6 MAIN CAUSES, SCOTLAND = 100)



THE HEALTH OF WOMEN AND CHILDREN



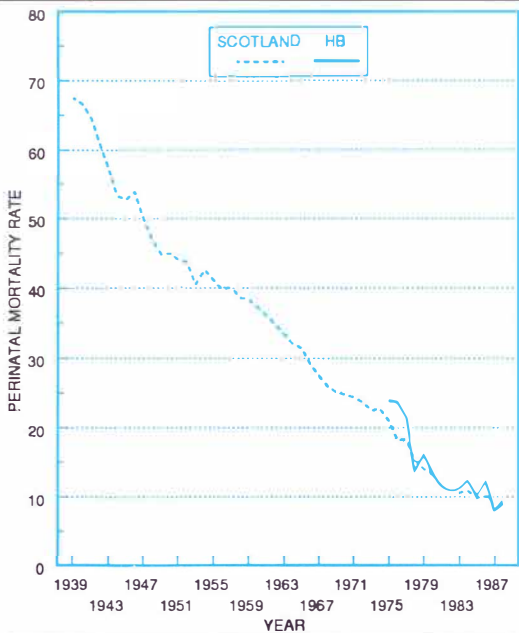
In 1988, there were 5873 births to Board residents. Of these, 5295 (90%) occurred in Argyll and Clyde hospitals. Most of the remainder took place in hospitals in other Health Boards, mainly in Greater Glasgow. This use of other Board's facilities is due to a number of factors such as the provision of regional specialised services and continuation of long established associations. Only 20 births took place at home in 1988.

From 1975 to 1988, the Argyll and Clyde birth rate is slightly higher than the Scottish rate. In particular, the Dumbarton district is higher. This principally reflects the age structure of the population. The rates are shown in Appendix 2.

One of the factors influencing the successful outcome of pregnancy has been the development of specialised intensive care techniques for looking after babies. There

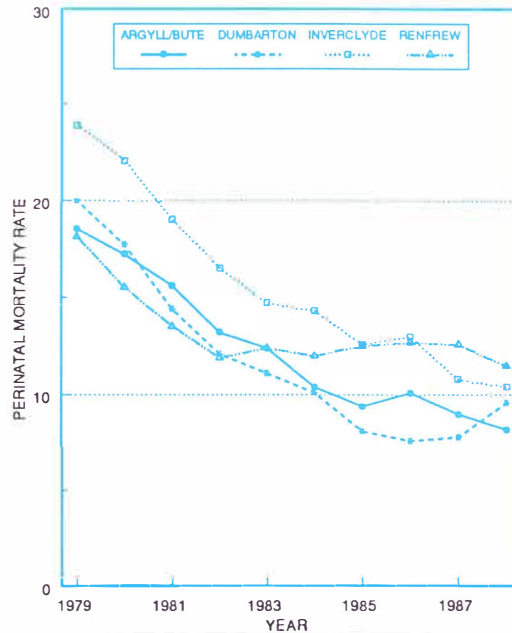
are Special Care Baby Unit facilities in each of the Board's three main obstetric units. Facilities in Glasgow are used for more specialised areas, such as paediatric surgery. The majority of pregnancies have a successful outcome but a number of babies may be stillborn or die in the first week of life. These are known as perinatal deaths and, in 1988, there were 56 such instances giving a perinatal mortality rate of 9.5 per 1000 total births. Deaths of babies within the first month of life are known as neonatal deaths. In 1988, there were 33 such instances giving a neonatal mortality rate of 5.6 per 1000 live births. These events have become much less frequent during this century and the numbers are still declining. However, this remains an important area of interest. The trend in the perinatal mortality rates over the past 50 years is shown for Scotland and (since 1974) for Argyll and Clyde.

PERINATAL MORTALITY RATES 1939/1988
ARGYLL & CLYDE HEALTH BOARD AND SCOTLAND



Perinatal mortality defined as stillbirths and deaths in the 1st week of life per 1000 births (including stillbirths).
SOURCE: Scottish Health Statistics & HB Annual Statistical Reports

PERINATAL MORTALITY RATES
4 LOCAL GOVERNMENT DISTRICTS OF HEALTH BOARD
5 YEAR MOVING AVERAGES 1975/1988



Each point is the average of the rates for 5 years - the year plotted against and the 4 previous years.



THE HEALTH OF WOMEN AND CHILDREN

Now that numbers are small, fluctuations from year to year need to be interpreted with care. Careful examination of the circumstances of each stillbirth or death is long established in this area of work. The medical and nursing staff in each of the maternity hospitals in Argyll and Clyde meet on a regular basis to examine and discuss all deaths in their units and to act on any factors which might improve the services provided. This is also done at a national level in the form of a confidential survey. As a result, the numbers of stillbirths and deaths in the first weeks of life have declined substantially. Most of the causes of these events are related to multiple pregnancies, prematurity and to very low birth weights.

These rates provide indicators of the success in reducing deaths but they do not describe the quality of life of the babies who do survive. This is an important issue which is currently under examination. Argyll and Clyde are participating in a Scotland wide research study which is following the progress of babies who were born in 1984. It is hoped that this and similar studies will help provide services which improve both rates of live births and the quality of life of these babies.

By tackling known risk factors, such as low birthweight, we hope to play a part in helping parents to produce live and healthy babies.

Planning for Pregnancy

Just as the aim is towards live, healthy mothers and babies, there is also a need to provide a wide range of services to help couples to have children when they want to have them. Infertility is a not uncommon

problem and this is an area where knowledge and ability to help is increasing. Specialised services for this are being steadily developed in the Board's hospitals.

Conversely, legislation exists to permit terminations of pregnancy under certain circumstances. While this is an emotive area, it is important that services are provided which offer high levels of technical expertise but which also include professional counselling and other forms of support in what can be a very difficult period in a woman's life. The number of terminations for Argyll and Clyde residents under the Abortion Act 1967 are shown in Appendix 2. It can be seen that the rate for Argyll and Clyde in 1988 was 7.5 per 1000 women aged 15-44yrs compared to the Scottish rate of 9.7.

Family planning advice to help make informed choices is also available both in Health Board clinics and from general practitioners.

The health of children

The health of babies aged less than 4 weeks is described above. Patterns of health and illness are, in the main, influenced by different factors before and after the first month of life.

Survival in the first month of life is more closely related to health in pregnancy and to the birth process. After the first month social and environmental influences play an increasingly greater part. During the ten years from 1979 to 1988, there were 901 deaths in children aged under 16 years. This number does not include stillbirths which comprised an additional 368 over this same period. Approximately 15% of liveborn babies died within the first 24 hours, 38% by



the end of the first week of life, 45% by the end of the first month of life and 70% of the deaths had occurred by the end of the first year. The remaining 30% of deaths are spread fairly evenly over the ages 1 to 15 years. The distribution of age at death has remained in this pattern over the ten years but actual numbers have declined in all age groups in recent years. A number of deaths in later childhood may have been avoidable, such as accidents on the roads, in the home or elsewhere.

One of the ways to try to improve the health of children is by child health surveillance. Immunisation against a number of infections is discussed elsewhere. The purpose of child health surveillance is to offer each child a number of screening procedures aimed at detecting problems or potential problems at the earliest time so that effective and, it is hoped curative, treatment can be provided. There are, of course, a number of other benefits including the opportunity to promote health and healthy lifestyles. The way that this service is provided has changed recently to recognise the increasing involvement of general medical practitioners in this preventive work.

The health of women

As with children, the causes of death of women residents can provide an indication of some of the factors which can affect health and wellbeing. Until 1984, deaths from cancer of the breast were more common than those from cancer of the lung. Since then lung cancer has been the greater problem. However, ischaemic heart disease is the biggest single cause of death and accounts for more deaths than all cancers together. Ischaemic heart disease and cancer of the lung are well recognised to be strongly

associated with cigarette smoking. As has already been highlighted stopping smoking points a way to reducing premature death and a considerable amount of ill health. This topic is considered further on page 16. There are other areas where premature deaths and avoidable ill health can be influenced. Two major screening programmes are aimed specifically at preventing illness in women;

Screening with the Cervical Smear Test

Programmes of screening using the cervical smear test are long established and the test detects conditions which if left untreated could develop into cancer of the cervix (the neck) of the womb. Treatment using colposcopy, a special microscopic examination of the neck of the womb, is available in each of our main hospitals for women who are found to have one of these conditions. This is a straightforward procedure done at an outpatient clinic.

While cervical cancer is not very common by comparison with other conditions it was the cause of death for 204 Argyll and Clyde women in the ten years from 1979 to 1988. Nearly twice this number of women (372) were found to have a cancer of the cervix. More than half of these women are aged under 55 years. Evidence from elsewhere suggests that nearly 9 out of every 10 women who now die from cancer of the cervix have never had a routine cervical smear test. Similarly, there is evidence that intensive screening programmes, as were begun in Grampian and Tayside regions during the 1960s, can prevent much of this cancer occurring by detecting the precursor conditions which are curable. To illustrate this point, the figure below demonstrates the changes in cervical cancer mortality in



THE HEALTH OF WOMEN AND CHILDREN

four Scottish cities from 1965 to 1985. The Board has begun a major programme to offer an invitation to attend for a cervical smear test to all of the eligible women in Argyll and Clyde who are aged between 20 and 60 years and also to invite them to attend for further tests at regular intervals. Included with the invitation is a leaflet designed in this Board which answers questions which women have identified as important in this condition.

The aim is to provide an accessible and acceptable service to residents to reduce the illness, death and distress caused by cancer of the cervix. Further details are included in Appendix 2.

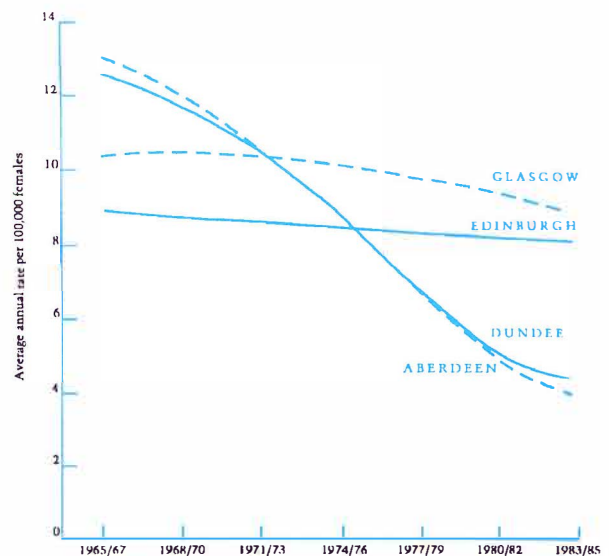
Screening for Breast Cancer

Breast cancer is a distressing condition which is now second only to cancer of the lung as the cause of death from cancer in Argyll and Clyde women. Experts throughout the world are trying to find the best ways of tackling this disease which was the cause of death of 115 women residents in 1988.

UK wide screening programme is being set up to offer 3 yearly mammography screening to women aged between 50 and 64 years. Current evidence suggests that the available methods of detecting breast cancer offer a good chance of effective therapy for women of this age range. This policy is under continuing review. Argyll and Clyde will be using mobile mammography screening units which will travel to the different parts of the Board on a three yearly programme.

Invitations will be sent to all of the women in the target age range according to this programme. General practitioners and a number of specialists will be involved in this.

There have been doubts, over the years, on the best ways to deal with breast cancer. These doubts have not yet been resolved but the design of this national programme should, in time, help to provide some of the answers. Further details are provided in Appendix 2.



Cervical cancer mortality in four Scottish cities, 1965-85.



INFECTION

The public awareness of infectious diseases, especially the environmentally related ones has increased in recent times. This is partly attributable to media and political interest in certain illnesses; AIDS, Legionnaire's disease, listeriosis and salmonellosis being prime examples. However there is a wider range of infections causing human illness, most of which are preventable by public health measures.

There were 30 infectious diseases which medical practitioners were required by statute to notify to the Chief Administrative Medical Officer during 1989. While it has been shown in many studies that many notifications do not occur (10) and the annual totals under-estimate the true problem, examining trends over time are of value. To determine the true scale of these diseases requires accurate diagnosis and rapid notification by all doctors.

In 1989, 4046 notifications were received from doctors within Argyll and Clyde Health Board. These ranged in frequency from 1 case of puerperal fever to 3039 of chickenpox. This Table shows the annual numbers of notifications of the more common infections during the period 1980-89.

**ANNUAL NUMBERS OF NOTIFICATIONS OF
INFECTIOUS DISEASES 1980-89**

Year	'80	'81	'82	'83	'84	'85	'86	'87	'88	'89
Measles	426	137	998	97	496	449	406	123	244	192
Mumps										134
Rubella										137
Chickenpox										3039
Whooping Cough	89	135	290	110	16	110	146	49	37	39
Food Poisoning	105	179	235	206	197	216	309	184	256	277
Dysentery	36	40	4	2	111	74	21	6	16	7
Viral Hepatitis	19	11	18	53	68	31	17	7	14	23
Meningococcal	10	2	7	4	5	18	27	13	10	9
Resp TB.	58	68	63	48	40	55	58	39	27	32

Mumps, rubella and chickenpox became notifiable as of 1st October 1988.



The numbers of cases of measles have shown a welcome reduction in the last 3 years but in 1989 it was disturbing to note that 17 (9%) occurred in adults and 84 (44%) in school age children. There may now be a case to be made for the immunisation of susceptible contacts of measles. The scale of chickenpox in our community is demonstrated for the first time by these figures. It was disappointing that there were 14 cases of rubella notified in women of childbearing age during 1989. Of the mumps cases, 109 (83%) were in the under 15 year age group where it is the commonest cause of viral meningitis. The introduction of mumps, measles and rubella vaccine should contribute to the eradication of these conditions.

"The numbers of cases of measles have shown a welcome reduction in the last three years."

No adult cases of whooping cough were notified in 1989 but 7(18%) were in children under 1 year of age. There is some evidence that the peaks of the 4 yearly cycles of this illness are declining (11). Cases of respiratory tuberculosis occurred predominantly in males (75%), of whom 9 (38%) were aged 65 or over. Annual notifications of food poisoning remained relatively constant over the 10 year period. These rates vary within the Board (ranging from 71 per 100,000 in Argyll & Bute to 39 in Dumbarton in 1989).

From 1st January 1989 a schedule of Reportable Infections was introduced. The concept is still being refined but the aim is to improve the surveillance of non-notifiable diseases of public health importance.

This Table demonstrates the numbers of the commoner diseases reported.

REPORTABLE INFECTIONS 1989

Campylobacter	217
Cryptosporidiosis	118
Giardiasis	14
Listeriosis	3
Rotavirus	95
Salmonellosis	203
Yersiniosis	8

All these conditions are based on laboratory diagnosis so the numbers of cases reported do not match those statutorily notified which are mainly based on clinical diagnoses. While there were no major outbreaks of communicable disease during 1989, several episodes of probable food-related illnesses were investigated in collaboration with our Environmental Health colleagues. An overgrowth of a toxic algae necessitated the interruption of the public water supply in the Uplawmoor area for a week but no evidence of persistent health-related effects were detected. An ongoing investigation has been mounted in collaboration with Lothian and Lanarkshire Health Boards into the apparent increase in cases of cryptosporidiosis and their cause.



IMMUNISATION

The aim of immunisation is to prevent certain infectious diseases in both the individual and the community at large. On 1st October 1988 the combined Measles/Mumps/Rubella vaccine was introduced with the objective of eliminating these three diseases and thereby the effects of rubella (German measles) on unborn children.

Childhood immunisation uptake rates are calculated as the percentage of those born in a year immunised by the end of the next year (the next two years for measles)

IMMUNISATION ACCEPTANCE RATES (percentage uptake)

Year	'80	'81	'82	'83	'84	'85	'86	'87	'88	'89
Diphtheria	80	61	74	73	79	84	86	84	87	88
Tetanus	80	61	74	73	79	84	86	84	87	88
Polio	80	61	74	73	79	84	86	84	87	88
Pertussis	49	40	56	55	64	70	72	73	76	78
Measles	42	44	54	57	69	72	75	74	79	
Rubella	87	86	88	86	80	89	92	93	93	

It is gratifying to see the continuing increase in immunisation rates, the result of much hard work by many different health care workers. These must be sustained and indeed improved upon if our aim of the elimination of these preventable diseases by the year 2000 is to be achieved. In 1989 immunisation rates of the local government Districts comprising the Board varied by up to 5%. This variation is being studied further.

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

The emergence of AIDS poses one of the greatest potential threats to the health of our community. By the end of December 1989, 1729 persons in Scotland have had a positive Human Immunodeficiency Virus (HIV) test. There have been 132 reported cases of AIDS of whom 64 (48%) have died. The numbers of HIV positive tests and cases of AIDS in Argyll and Clyde residents are still very small, so much so that their publication could compromise the affected persons' anonymity.

The main areas to be considered at present in the AIDS field are health promotion, testing and treatment, and continuing care. As well as the national media campaigns, local initiatives have been mounted with drug users and school teachers. A specific training for NHS staff is about to commence. The education of school leavers who may be sexually active is another priority. Laboratory testing for HIV infection is undertaken within the Board but Argyll and Clyde residents also present for testing in others centres, predominantly in Glasgow. The collection of accurate statistics on HIV infection is therefore difficult though means of improving these are now in place.



Smoking is the greatest preventable risk to life and health in Argyll and Clyde

Smoking is the greatest preventable risk to life and health in Argyll and Clyde. It cost an estimated 766 lives from heart disease, lung cancer and bronchitis in 1988 - compared with 38 deaths on the roads - causing approximately half a million working days to be lost and at least 2013 admissions to hospital. Hospital care for smoking related diseases cost over £2 million.

Despite awareness of the risks, the recent 'Smokecheck' survey, commissioned in part of the Health Board (6) has shown that smoking is more prevalent than in Great Britain as a whole. 38% of the population are cigarette smokers compared with the British figure of 33%.

Scotland has an unenviable record as the country with the highest death rates from lung cancer and heart disease, although recent trends suggest that the death toll is falling, and this may continue if more smokers stop and fewer young people take up the habit. Already fewer adult men are smoking, but women continue in greater numbers. Young people, even in primary school, are still taking up cigarette smoking.

Learning to smoke usually occurs in childhood and adolescence, and the 'Smokecheck' survey showed that about half the smokers had started before the age of 16, 90% before the age of 20.

There are many possible causes of smoking-related death, ranging from heart and lung

diseases, strokes and gangrene, to lip, tongue, throat and even bladder cancers. But smokers do not just affect their own health; smoking mothers endanger the health and survival of their babies and young children suffer more from chest complaints than the children of non-smokers as a result of their parents' cigarette smoke.

Passive smoking, which is the exposure to other people's tobacco smoke, has now been shown to be a risk factor resulting in lung cancer as well as other smoke-related illnesses(7).

Many residents of Argyll and Clyde grew up in an age when tobacco was seen as a harmless social habit, popular as a stimulant and for these people, giving up the addiction of smoking can seem irrelevant and unnecessary. However we now know that, even after years of smoking, success in stopping offers a much better chance of good health and a longer life.

In addition to health damage, there is now growing agreement that smoking is an unpleasant minority habit. Many young people no longer see it as smart, sociable behaviour, and increasingly both public and work places are making smoke-free environments available for the non-smoking majority. Even cigarette makers agree that cigarettes harm non-smokers(8).

In Europe, where approximately 1,000,000 people die of smoking-related disease every year, the European Commission proposes



The tobacco companies need to enlist new customers to replace the 766 who die every year in Argyll and Clyde

tough new restrictions on tobacco company advertising. In addition to adopting these, the U.K. government's most important contribution would be to continue to raise taxes on cigarettes and tobacco, as price is a key factor in lessening their attractions.

The Department of Public Health for Argyll and Clyde is working to promote a healthier environment for all its residents, and to encourage smokers to stop and young people not to start. However, this task relies on the goodwill and efforts of many people and organisations, both local and national. The department has several projects in this field, and encourages and collaborates with many more local initiatives. In Inverclyde, where a higher percentage of residents continue to smoke than the Scottish average, the special 'Smoke Check' project began in 1989 to encourage smokers to stop.

Local Authorities, especially their Environmental Health Departments, are progressing with policies for their own premises and public places, such as the awards system for caterers in Renfrew District run jointly with the Council and Health Board. More factories and offices now implement smoke-free areas for their employees and prevent smoking at meetings and the Health Board is currently reviewing its own policy for staff, patients and visitors.

In the Health Service, doctors and nurses, with the help and support of many other

health care professionals, offer patients advice on the hazards of smoking. The Health Education Department have developed information materials to assist in this work including the 'No Puffin' campaign which has been widely adopted by other Health Boards and organisations. Special clinics are being run to give encouragement to individuals who want to give up smoking and the 'Look After Yourself' groups provide a complete health and fitness programme for all ages. Through the joint efforts of the Department and the many agencies working in this field, all districts support anti-smoking initiatives, including participation in National No Smoking Day, but the message to women and youngsters especially requires continuing emphasis.

The tobacco companies need to enlist new customers to replace the 766 smokers who die as a result of their products every year in Argyll and Clyde, and those who give up smoking.

There is a responsibility to ensure that they do not.



TARGETS FOR THE IMPROVEMENT OF HEALTH

In 1977 the World Health Organisation (the health arm of the United Nations) published ‘Health for All by the Year 2000’⁽⁴⁾ which set targets for improving health for all member states. In the European Region 38 specific targets were set and these are shown in Appendix 3.

These targets rest on 6 main principles for achieving health:

- 1. Equity in health**
- 2. Empowerment of the people**
- 3. Participation of the people**
- 4. Co-operation**
- 5. Local health care**
- 6. International co-operation**

In 1989 these targets were re-examined in Scotland (5) and goals were set which each Health Board should work towards to improve the health of their population. These are recorded in Appendix 4. They concentrate on those causes of death and disease which are preventable and they all require an increased emphasis on health promotion and on primary care. Most of the targets set require a reduction in number of deaths from key diseases such as ischaemic heart disease, cerebrovascular disease and lung cancer. Since the Board has a record similar to, if not worse than Scotland as a whole the target reductions for the Board should be the same as for Scotland.

To achieve these reductions requires the action not of one department of the Board or even of the whole Board alone; it requires a joint effort by the Board, local and central government and by individuals themselves. This department will monitor the local health experience and help devise means by which this can be improved.

APPENDIX 1



ARGYLL AND CLYDE HEALTH BOARD

DEPARTMENT OF PUBLIC HEALTH - 1989.

DIRECTOR AND CHIEF ADMINISTRATIVE MEDICAL OFFICER.
Dr. Andrew A. Reid.

CONSULTANTS IN PUBLIC HEALTH MEDICINE.

Dr. Donald M. Campbell
Dr. Stella E. Gibson
Dr. Norman H. Logan
Dr. A. Christina Marr
Dr. Lewis M. Reay
Dr. David S. Ross
Dr. L. Michael St.G. Wertheim
Dr. James G. Young

SENIOR REGISTRARS

Dr. Margaret Watts
(On secondment from Common Services Agency)
Dr. Lesley M. Wilkie

REGISTRAR

Dr. Andrew K. Fraser.

ADMINISTRATIVE STAFF

Mrs. Dorothy Cafferty Senior Administrative Assistant.
Miss Adrienne Hannah AIDS Outreach Worker.
Miss Morag McFadyen Staff Protection Officer.

SECRETARIAL AND CLERICAL STAFF

Mr. Paul Bowie
Mrs. Eileen Farmer
Mrs. Doreen Gibson
Mrs. Jessie Goudie
Mrs. Lorna MacIntyre
Mrs. Janine Muir
Miss Ellen Saunders.

APPENDIX 2

Number of Sudden Infant Deaths

Year.	Numbers.
1979	6
1980	6
1981	12
1982	11
1983	16
1984	12
1985	14
1986	8
1987	10
1988	12

Therapeutic abortions

Residents of Argyll and Clyde by area in which treatment took place, 1988.

Area of Treatment	Number
TOTAL	727
Argyll and Clyde	474
Greater Glasgow	80
Lothian	17
Forth Valley	5
Highland	1
Lanarkshire	1
England and Wales	149

20

Cervical Cytology Acceptance Rates.

	Age Bands								
	15-19:	20-24:	25-29:	30-34:	35-39:	40-44:	45-49:	50-54:	55-59yrs.
%	12%	52%	63%	65%	68%	63%	59%	57%	47%

NB Refers to therapeutic abortions notified in accordance with the Abortions Act 1967

SOURCE: Scottish Health Statistics, Information and Statistics Division, Common Services Agency.

- N.B. 1. As recorded at April 1990.
 2. Full data collection commenced 1 January 1987. Data prior to that date is not complete.

ESTIMATED POPULATION

Health Board and Scotland by age and sex

At 30 June 1988

APPENDIX 2

Age Bands	Health Board						Scotland					
	Persons	%	Males	%	Females	%	Persons	%	Males	%	Females	%
ALL AGES	441,966	100.0	213,588	100.0	228,378	100.0	5,094,001	100.0	2,462,270	100.0	2,631,731	100.0
Less than 1	5,858	1.3	3,009	1.4	2,849	1.2	66,359	1.3	34,230	1.4	32,129	1.2
1 to 4	23,080	5.2	11,852	5.5	11,228	4.9	256,630	5.0	131,232	5.3	125,398	4.8
5 to 14	56,753	12.8	29,102	13.6	27,651	12.1	633,404	12.4	324,961	13.2	308,443	11.7
15 to 24	70,616	16.0	36,022	16.9	34,594	15.1	829,404	16.3	423,567	17.2	405,837	15.4
25 to 34	66,790	15.1	33,810	15.8	32,980	14.4	765,567	15.0	388,464	15.8	377,103	14.3
35 to 44	58,324	13.2	29,165	13.7	29,159	12.8	675,153	13.3	337,684	13.7	337,469	12.8
45 to 54	50,975	11.5	24,897	11.7	26,078	11.4	570,124	11.2	277,779	11.3	292,345	11.1
55 to 64	46,711	10.6	22,050	10.3	24,661	10.8	542,678	10.7	255,392	10.4	287,286	10.9
65 to 74	37,193	8.4	15,596	7.3	21,597	9.5	434,545	8.5	185,356	7.5	249,189	9.5
75 to 84	20,697	4.7	6,938	3.2	13,759	6.0	257,951	5.1	89,446	3.6	168,505	6.4
85 and over	4,969	1.1	1,147	.5	3,822	1.7	62,186	1.2	14,159	.6	48,027	1.8

Note : Individual percentages have not been adjusted to sum to 100%

Source: Registrar General's mid year estimates for 1988.

ESTIMATED POPULATION
Local authority districts by age and sex
At 30 June 1988

APPENDIX 2

	Argyll & Bute Local Authority District						Dumbarton Local Authority District					
	Persons	%	Males	%	Females	%	Persons	%	Males	%	Females	%
ALL AGES	65,993	100.0	32,107	100.0	33,886	100.0	80,372	100.0	39,018	100.0	41,354	100.0
Less than 1	843	1.3	420	1.3	423	1.2	1,158	1.4	605	1.6	553	1.3
1 to 4	3,383	5.1	1,752	5.5	1,631	4.8	4,578	5.7	2,332	6.0	2,246	5.4
5 to 14	8,715	13.2	4,537	14.1	4,178	12.3	11,170	13.9	5,767	14.8	5,403	13.1
15 to 24	9,257	14.0	4,698	14.6	4,559	13.5	12,565	15.6	6,362	16.3	6,203	15.0
25 to 34	10,044	15.2	5,440	16.9	4,604	13.6	12,885	16.0	6,488	16.6	6,397	15.5
35 to 44	8,643	13.1	4,423	13.8	4,220	12.5	11,128	13.8	5,629	14.4	5,499	13.3
45 to 54	7,158	10.8	3,545	11.0	3,613	10.7	8,602	10.7	4,180	10.7	4,422	10.7
55 to 64	6,574	10.0	3,084	9.6	3,490	10.3	7,699	9.6	3,598	9.2	4,101	9.9
65 to 74	6,020	9.1	2,495	7.8	3,525	10.4	6,312	7.9	2,681	6.9	3,631	8.8
75 to 84	4,268	6.5	1,445	4.5	2,823	8.3	3,476	4.3	1,178	3.0	2,298	5.6
85 and over	1,088	1.6	268	.8	820	2.4	799	1.0	198	.5	601	1.5

Note : Individual percentages have not been adjusted to sum to 100%

Source: Registrar General's mid year estimates for 1988.

ESTIMATED POPULATION
Local authority districts by age and sex
At 30 June 1988

APPENDIX 2

	Inverclyde Local Authority District						Renfrew Local Authority District					
	Persons	%	Males	%	Females	%	Persons	%	Males	%	Females	%
ALL AGES	95,192	100.0	45,795	100.0	49,397	100.0	200,409	100.0	96,668	100.0	103,741	100.0
Less than 1	1,226	1.3	629	1.4	597	1.2	2,631	1.3	1,355	1.4	1,276	1.2
1 to 4	4,845	5.1	2,487	5.4	2,358	4.8	10,274	5.1	5,281	5.5	4,993	4.8
5 to 14	11,965	12.6	6,036	13.2	5,929	12.0	24,903	12.4	12,762	13.2	12,141	11.7
15 to 24	15,597	16.4	7,997	17.5	7,600	15.4	33,197	16.6	16,965	17.5	16,232	15.6
25 to 34	14,744	15.5	7,380	16.1	7,364	14.9	29,117	14.5	14,502	15.0	14,615	14.1
35 to 44	11,642	12.2	5,936	13.0	5,706	11.6	26,911	13.4	13,177	13.6	13,734	13.2
45 to 54	10,581	11.1	5,188	11.3	5,393	10.9	24,634	12.3	11,984	12.4	12,650	12.2
55 to 64	10,467	11.0	4,906	10.7	5,561	11.3	21,971	11.0	10,462	10.8	11,509	11.1
65 to 74	8,488	8.9	3,496	7.6	4,992	10.1	16,373	8.2	6,924	7.2	9,449	9.1
75 to 84	4,600	4.8	1,534	3.3	3,066	6.2	8,353	4.2	2,781	2.9	5,572	5.4
85 and over	1,037	1.1	206	.4	831	1.7	2,045	1.0	475	.5	1,570	1.5

Note : Individual percentages have not been adjusted to sum to 100%

Source: Registrar General's mid year estimates for 1988.

PROJECTED POPULATIONS

Health Board and Scotland by age and sex
1987 based

APPENDIX 2

	Health Board						Scotland					
	All ages	0 - 14	15 - 44	45 - 64	65 - 74	Over 74	All ages	0 - 14	15 - 44	45 - 64	65 - 74	Over 74
1990 Persons	439,788	85,879	193,381	97,738	36,355	26,435	5,090,643	957,758	2,263,766	1,110,004	430,890	328,225
Males	212,870	44,157	97,823	47,110	15,491	8,289	2,464,742	491,041	1,147,845	533,543	185,988	106,325
Females	226,918	41,722	95,558	50,628	20,864	18,146	2,625,901	466,717	1,115,921	576,461	244,902	221,900
1995 Persons	434,968	88,201	182,155	100,860	36,680	27,072	5,068,880	984,914	2,156,531	1,156,642	440,625	330,168
Males	211,010	45,264	92,044	49,047	16,053	8,602	2,462,129	504,709	1,095,217	560,772	193,670	107,761
Females	223,958	42,937	90,111	51,813	20,627	18,470	2,606,751	480,205	1,061,314	595,870	246,955	222,407
2000 Persons	428,457	88,366	173,788	101,670	36,386	28,247	5,038,198	992,220	2,080,459	1,188,913	427,703	348,903
Males	208,155	45,502	87,536	49,571	16,175	9,371	2,453,882	508,859	1,058,499	577,427	190,148	118,949
Females	220,302	42,864	86,252	52,099	20,211	18,876	2,584,316	483,361	1,021,960	611,486	237,555	229,954
2005 Persons	418,583	84,200	163,123	105,624	36,618	29,018	4,977,074	960,572	1,981,876	1,251,934	423,746	358,946
Males	203,555	43,370	82,023	51,667	16,448	10,047	2,429,964	492,845	1,011,218	609,488	189,904	126,509
Females	215,028	40,830	81,100	53,957	20,170	18,971	2,547,110	467,727	970,658	642,446	233,842	232,437

Note : Projections are based on assumptions about the future mortality, fertility and migration which are summarised in Table N 2.4 of the Annual Report, Registrar General for Scotland. The assumptions are subject to revision in the light of changing trends.

Source: Registrar General's projections for 1987

PROJECTED POPULATIONS

Local authority districts by age and sex

1987 based

APPENDIX 2

	Argyll & Bute Local Authority District						Dumbarton Local Authority District					
	All ages	0 - 14	15 - 44	45 - 64	65 - 74	Over 74	All Ages	0 - 14	15 - 44	45 - 64	65 - 74	Over 74
1990 Persons	65,639	12,975	27,870	13,775	5,687	5,332	79,469	16,779	35,657	16,421	6,105	4,507
Males	32,017	6,760	14,464	6,730	2,394	1,669	38,641	8,658	18,039	7,854	2,596	1,494
Females	33,622	6,215	13,406	7,045	3,293	3,663	40,828	8,121	17,618	8,567	3,509	3,013
1995 Persons	66,002	13,661	27,471	14,415	5,412	5,043	78,781	16,927	33,561	17,411	6,109	4,773
Males	32,348	7,114	14,202	7,139	2,321	1,572	38,386	8,652	17,046	8,439	2,666	1,583
Females	33,654	6,547	13,269	7,276	3,091	3,471	40,395	8,275	16,515	8,972	3,443	3,190
2000 Persons	66,704	14,230	27,635	14,846	5,103	4,890	77,525	16,495	31,921	18,033	6,048	5,028
Males	32,841	7,348	14,250	7,386	2,295	1,562	37,826	8,469	16,115	8,832	2,667	1,743
Females	33,863	6,882	13,385	7,460	2,808	3,328	39,699	8,026	15,806	9,201	3,381	3,285

Note : Projections are based on assumptions about the future mortality, fertility and migration which are summarised in Table N 2.4 of the Annual Report, Registrar General for Scotland. The assumptions are subject to revision in the light of changing trends.

Source: Registrar General's projections for 1987

PROJECTED POPULATIONS

Local authority districts by age and sex
1987 based

APPENDIX 2

	Inverclyde Local Authority District						Renfrew Local Authority District					
	All ages	0 - 14	15 - 44	45 - 64	65 - 74	Over 74	All Ages	0 - 14	15 - 44	45 - 64	65 - 74	Over 74
1990 Persons	94,334	18,052	41,406	20,755	8,304	5,817	200,346	38,073	88,448	46,787	16,259	10,779
Males	45,414	9,189	21,004	9,962	3,495	1,764	96,798	19,550	44,316	22,564	7,006	3,362
Females	48,920	8,863	20,402	10,793	4,809	4,053	103,548	18,523	44,132	24,223	9,253	7,417
1995 Persons	90,966	17,977	38,315	20,560	8,158	5,956	199,219	39,636	82,808	48,474	17,001	11,300
Males	43,803	9,165	19,311	10,049	3,503	1,775	96,473	20,333	41,485	23,420	7,563	3,672
Females	47,163	8,812	19,004	10,511	4,655	4,181	102,746	19,303	41,323	25,054	9,438	7,628
2000 Persons	86,993	17,296	35,348	20,329	7,841	6,179	197,235	40,345	78,884	48,462	17,394	12,150
Males	41,887	8,892	17,704	9,991	3,392	1,908	95,601	20,793	39,467	23,362	7,821	4,158
Females	45,106	8,404	17,644	10,338	4,449	4,271	101,634	19,552	39,417	25,100	9,573	7,992

Note : Projections are based on assumptions about the future mortality, fertility and migration which are summarised in Table N 2.4 of the Annual Report, Registrar General for Scotland. The assumptions are subject to revision in the light of changing trends.

Source: Registrar General's projections for 1987

APPENDIX 2

BIRTHS, DEATHS, INFANT DEATHS, NEONATAL DEATHS AND PERINATAL DEATHS

Numbers (4)

At 30 June 1985 to 1988

	Births				Deaths				(1) Infant Deaths				(2) Neonatal Deaths				(3) Perinatal Deaths							
	Live		Still																					
	1985	1986	1987	1988	'85	'86	'87	'88	1985	1986	1987	1988	'85	'86	'87	'88	'85	'86	'87	'88				
Scotland	66676	65812	66241	66212	366	385	339	357	63967	63467	62014	61957	627	579	563	543	367	342	311	298	656	673	594	594
Health Board	6016	6059	5843	5843	40	39	27	30	5556	5646	5399	5311	50	57	46	55	30	40	27	33	61	75	47	56
Argyll & Bute	824	871	846	875	5	4	2	1	964	1023	994	939	6	11	10	7	2	8	5	4	7	11	5	5
Dumbarton	1147	1120	1143	1129	3	8	8	9	904	872	841	842	8	9	5	17	2	4	3	12	3	11	10	18
Inverclyde	1316	1297	1222	1172	9	11	1	7	1272	1316	1208	1237	10	10	5	6	5	9	4	3	13	20	4	9
Renfrew	2729	2771	2632	2667	23	16	16	13	2416	2435	2356	2293	26	27	26	25	21	19	15	14	38	33	28	24

Notes : (1) Deaths in the first year of life.

(2) Deaths in the first four weeks of life.

(3) Stillbirths and deaths in the first week of life.

(4) The numbers of births in this table are corrected for area of mother's residence.

This table is not equivalent to table 3.1 or 3.1(a).

Source: Registrar General's Annual Reports, 1985 TO 1988.

APPENDIX 2

BIRTHS, DEATHS, INFANT DEATHS, NEONATAL DEATHS AND PERINATAL DEATHS

Rates (6)

at 30 JUNE 1985 TO 1988

	Births				Crude Death Rate				(3) Infant Deaths				(4) Neonatal Deaths				(5) Perinatal Deaths							
	Live (1)		Still (2)																					
	1985	1986	1987	1988	1985	1986	1987	1988	1985	1986	1987	1988	1985	1986	1987	1988	1985	1986	1987	1988				
Scotland	13.0	12.9	13.0	13.0	5.5	5.8	5.1	5.4	12.5	12.4	12.1	12.2	9.4	8.8	8.5	8.2	5.5	5.2	4.7	4.5	9.8	10.2	8.9	8.9
Health Board	13.5	13.6	13.2	13.2	6.6	6.4	4.6	5.1	12.4	12.7	12.2	12.0	8.3	9.4	7.9	9.4	5.0	6.6	4.6	5.6	10.1	12.3	8.0	9.5
Argyll & Bute	12.5	13.3	12.9	13.3	6.0	4.6	2.4	1.1	14.6	15.6	15.1	14.2	7.3	12.6	11.8	8.0	2.4	9.2	5.9	4.6	8.4	12.6	5.9	5.7
Dumbarton	14.4	14.1	14.3	14.0	2.6	7.1	7.0	7.9	11.4	11.0	10.6	10.5	7.0	8.0	4.4	15.1	1.7	3.6	2.6	10.6	2.6	9.8	8.7	15.8
Inverclyde	13.4	13.3	12.7	12.3	6.8	8.4	.8	5.9	13.0	13.5	12.5	13.0	7.6	7.7	4.1	5.1	3.8	6.9	3.3	2.6	9.8	15.3	3.3	7.6
Renfrew	13.4	13.6	13.1	13.3	8.4	5.7	6.0	4.9	11.9	12.0	11.7	11.4	9.5	9.7	9.9	9.4	7.7	6.9	5.7	5.2	13.8	11.8	10.6	9.0

Notes : (1) Live births per 1,000 total population.

(2) Per 1,000 births (including stillbirths).

(3) Deaths in the first year of life per 1,000 live births.

(4) Deaths in the first four weeks of life per 1,000 live births.

(5) Stillbirths and deaths in the first week of life per 1,000 births (including stillbirths).

(6) The number of births in the table are corrected for area of mother's residence. This table is not equivalent to table 3.1 or 3.1(a).

Source: Registrar General's Annual Reports, 1985 TO 1988

APPENDIX 2

ICD B List (1)	Cause of Death	All Ages		Age Band															
		Male	Female	<1		1-4		5-14		15-34		35-44		45-64		65-74		75+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	ALL CAUSES	2515	2796	31	24	3	4	9	1	57	25	65	48	618	403	748	612	984	1679
	Main Causes	1990	2162	6	8	1	3	5	2	49	17	45	39	525	333	630	509	729	1251
02	Tuberculosis	2	1	-	-	-	-	-	-	-	-	-	-	1	1	-	-	1	-
020-021	Respiratory	2	1	-	-	-	-	-	-	-	-	-	-	1	1	-	-	1	-
08-14	Malignant Neoplasms	665	646	-	1	-	-	2	1	2	9	16	25	201	174	219	185	225	251
091	Stomach	53	30	-	-	-	-	-	-	-	-	1	1	20	5	15	11	17	13
101	Lung	268	125	-	-	-	-	-	-	-	-	1	1	87	40	96	45	84	39
113	Breast	.	115	.	.	.	.	.	.	2	.	7	.	39	.	27	.	.	40
120	Cervix	.	27	.	.	.	.	.	.	1	.	6	.	8	.	5	.	.	7
181	Diabetes	16	36	-	-	-	-	-	-	-	-	1	5	8	3	8	8	19	
26-28	Heart Diseases	885	904	-	-	-	-	-	1	-	15	4	250	106	301	228	318	566	
27	Ischaemic	816	776	-	-	-	-	-	1	-	12	4	237	98	286	205	280	469	
29	Cerebrovascular Diseases	227	463	-	-	-	-	-	1	1	1	4	27	20	67	73	131	365	
323	Bronchitis,Emphysema,Asthma	34	25	-	-	-	-	-	1	-	-	-	3	6	11	7	19	12	
341	Ulcer of Stomach & Duodenum	21	10	-	-	-	-	-	-	-	1	-	5	1	8	1	7	8	
44	Congenital Anomalies	7	7	6	7	-	-	-	1	-	-	-	-	-	-	-	-	-	
E47-E53	Accidents & Adverse Effects	99	61	-	-	1	3	3	1	29	3	7	3	21	15	19	6	19	30
E471	Motor Vehicle	31	12	-	-	-	1	2	1	12	2	3	1	6	3	4	2	4	2
E50-E52	Home Accidents	19	26	-	-	1	1	-	-	3	-	-	2	6	7	4	2	5	14
E54	Suicide	34	9	-	-	-	-	-	-	14	4	5	2	12	2	2	1	1	-

Note : (1) All data is from B List, table C2.15 (Health Board)

Source: Registrar General for Scotland

APPENDIX 2

ICD B List (1)	Cause of Death	All Ages		Age Group															
		Health Board	Scot- land	<1		1-4		5-14		15-34		35-44		45-64		65-74		75+	
				HB	S	HB	S	HB	S	HB	S	HB	S	HB	S	HB	S	HB	S
	ALL CAUSES	1202	1216	939	818	30	38	18	20	60	76	194	189	1045	1013	3657	3600	10376	9927
	Main Causes	939	938	239	237	17	23	12	16	48	56	144	146	878	848	3062	2965	7714	7273
02	Tuberculosis	1	1	-	-	-	-	-	-	-	-	-	-	2	2	-	2	4	7
020-021	Respiratory	1	1	-	-	-	-	-	-	-	-	-	-	2	1	-	2	4	6
08-14	Malignant Neoplasms	297	289	17	3	-	4	5	4	8	9	70	56	384	354	1086	1071	1855	1743
091	Stomach	19	19	-	-	-	-	-	-	0	0	3	2	26	20	70	65	117	132
101	Lung	89	81	-	-	-	-	-	0	-	0	3	7	130	112	379	362	479	400
113	Breast (2)	50	44	-	-	-	-	-	-	3	2	24	23	77	72	125	130	228	153
120	Cervix (2)	12	7	-	-	-	-	-	-	1	1	21	9	16	12	23	22	40	13
181	Diabetes	12	10	-	-	-	-	-	0	-	0	2	2	13	9	30	31	105	76
26-28	Heart Diseases	405	401	-	-	-	-	-	0	1	2	33	32	364	351	1422	1341	3444	3266
27	Ischaemic	360	353	-	-	-	-	-	-	1	1	27	28	343	325	1320	1235	2918	2739
29	Cerebrovascular Diseases	156	160	-	-	-	-	-	-	1	1	9	10	48	70	376	379	1933	1761
323	Bronchitis,Emphysema,Asthma	13	14	-	-	-	1	-	0	1	1	-	2	9	12	48	51	121	100
341	Ulcer of Stomach & Duodenum	7	7	-	-	-	-	-	-	-	-	2	1	6	5	24	21	58	65
44	Congenital Anomalies	3	5	222	220	-	6	-	1	1	2	-	1	-	2	-	2	-	2
E47-E53	Accidents & Adverse Effects	36	40	-	14	17	12	7	9	23	26	17	26	37	29	67	53	191	241
E471	Motor Vehicle	10	11	-	5	4	4	5	5	10	15	7	8	9	10	16	12	23	20
E50-E52	Home Accidents	10	11	-	6	9	6	-	1	2	2	3	5	13	8	16	18	74	94
E54	Suicide	10	12	-	-	-	-	-	0	13	14	12	16	14	15	8	12	4	12

Notes : (1) All data from B List Table C2.15 (Health Board) & Table C2.14(Scotland)
(2) Rate per 100,000 female population

Source: Registrar General for Scotland

APPENDIX 3



THE 38 TARGETS FROM W.H.O. EUROPEAN REGION

- 1 By the year 2000, the actual differences in health status that exist between countries and between groups within countries should be reduced by at least 25% by improving the levels of health of disadvantaged nations and groups.
- 2 By the year 2000, people should have the basic opportunity to develop and use their health potential to live socially and economically fulfilling lives.
- 3 By the year 2000, disabled persons should have the physical, social and economic opportunities that allow at least for a socially and economically fulfilling and mentally creative life.
- 4 By the year 2000, the average number of years that people live free from major disease and disability should be increased by at least 10%.
- 5 By the year 2000, there should be no indigenous measles, poliomyelitis, neonatal tetanus, congenital rubella, diphtheria, congenital syphilis and indigenous malaria in the Region.
- 6 By the year 2000, life expectancy at birth in the Region should be at least 75 years.
- 7 By the year 2000, infant mortality in the Region should be less than 20 per 1000 live births.
- 8 By the year 2000, maternal mortality in the Region should be less than 15 per 100,000 live births.
- 9 By the year 2000, mortality in the Region from diseases of the circulatory system in people under 65 should be reduced by at least 15%.
- 10 By the year 2000, mortality in the Region from cancer in people under 65 should be reduced by at least 15%.
- 11 By the year 2000, deaths from accidents in the Region should be reduced by at least 25% through an intensified effort to reduce traffic, home and occupational accidents.
- 12 By the year 2000, the current rising trend in suicides and attempted suicides in the Region should be reversed.
- 13 By 1990, national policies in all member states should ensure that legislative, administrative and economic mechanisms provide broad intersectoral support and resources for the promotion of healthy lifestyles and ensure effective participation of the people at all levels of such policy making.
- 14 By 1990, all member states should have specific programmes which enhance the major roles of the family and other social groups in developing and supporting healthy lifestyles.
- 15 By 1990, educational programmes in all member states should enhance the knowledge, motivation and skills of people to acquire and maintain health.
- 16 By 1995, in all member states, there should be significant increases in positive health behaviour, such as balanced nutrition, non-smoking,



APPENDIX 3

appropriate physical activity and good stress management.

- 17 By 1995, in all member states, there should be significant decreases in health-damaging behaviour, such as overuse of alcohol and pharmaceutical products, use of illicit drugs, dangerous chemical substances, dangerous driving and violent social behaviour.
 - 18 By 1990, member states should have multisectoral policies that effectively protect the human environment from health hazards, ensure community awareness and involvement, and effectively support international efforts to curb such hazards affecting more than one country.
 - 19 By 1990, all member states should have adequate machinery for the monitoring, assessment and control of environmental hazards which pose a threat to human health, including potentially toxic chemicals, radiation, harmful consumer goods and biological agents.
 - 20 By 1990, all people of the Region should have adequate supplies of safe drinking water, and by the year 1995 pollution of rivers, lakes and seas should no longer hold a threat to human health.
 - 21 By 1995, all people of the Region should be effectively protected against recognised health risks from air pollution.
 - 22 By 1990, all member states should have significantly reduced health risks from food contamination and implemented measures to protect consumers from harmful additives.
 - 23 By 1995, all member states should have eliminated major known health risks associated with the disposal of hazardous wastes.
 - 24 By the year 2000, all people of the Region should have the opportunity of living in houses and settlements which provide a healthy and safe environment.
 - 25 By 1995, people of the Region should be effectively protected against work-related health risks.
 - 26 By 1990, all member states, through effective community representation, should have developed health care systems that are based on primary health care and supported by secondary and tertiary care as outlined at the Alma-Ata Conference.
 - 27 By 1990, in all member states, the infrastructures of the delivery systems should be organised so that resources are distributed according to need, and that services ensure physical and economic accessibility and cultural acceptability to the population.
 - 28 By 1990, the primary health care system of all member states should provide a wide range of health-promotive, curative, rehabilitative and support services to meet the basic health needs of the population and give special attention to high-risk, vulnerable and underserved individuals and groups.
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- 29** By 1990, in all member states, primary health care systems should be based on cooperation and teamwork between health care personnel, individuals, families and community groups.
- 30** By 1990, all member states should have mechanisms by which the services provided by all sectors relating to health are coordinated at the community level in the primary health care system.
- 31** By 1990, all member states should have built effective mechanisms for ensuring quality of patient care within their health care systems.
- 32** Before 1990, all member states should have formulated a research strategy to stimulate investigations which improve the application and expansion of knowledge needed to support their national 'Health for All' developments.
- 33** Before 1990, all member states should ensure that their health policies and strategies are in line with 'Health for All' principles and that national legislation and regulations make their implementation effective in all sectors of society.
- 34** Before 1990, member states should have a managerial process for health development geared to the attainment of 'Health for All', actively involving communities and all sectors relevant to health and, accordingly, ensuring preferential allocation of resources to health development priorities.
- 35** Before 1990, member states should have health information systems capable of supporting their national strategies for 'Health for All'.
- 36** Before 1990, in all member states, the planning, training and use of health personnel should be in accordance with 'Health for All' policies with emphasis on the primary health care approach.
- 37** Before 1990, in all member states, education should provide personnel in sectors related to health with adequate information on national 'Health for All' policies and programmes and their practical application to their own sectors.
- 38** Before 1990, all member states should have established a formal mechanism for the systematic assessment of the appropriate use of health technologies and of their effectiveness, efficiency, safety and acceptability, as well as reflecting national health policy and economic restraints.



APPENDIX 4

HEALTH FOR ALL BY THE YEAR 2000 - TARGETS FOR SCOTLAND

1 Life expectancy.

The Scottish target should be to maintain the current level of increasing expectation of life in women and to reduce the differences between the sexes.

2 Maternal mortality.

The Scottish aim should be to keep the rate at its current low level.

3 Infant mortality.

The Scottish target should be to reduce the current mortality rates by 15% by the year 2000 and to reduce the inequalities in rates by improving the highest ones.

4 Ischaemic heart disease (IHD).

The Scottish target should be a reduction of 30% in the mortality from IHD in the under 65 age group, with a 25% reduction in the total mortality at all ages.

5 Cerebrovascular disease (CVD).

The Scottish target is to reduce by one quarter the premature deaths from CVD.

6 All cancers.

The Scottish target is a reduction in cancer deaths of 15%, both in the under 65s and at all ages.

7 Lung cancer.

The target for reduction in deaths from lung cancer is 30% in those aged under 65 and 15% overall.

8 Breast cancer.

The target for reduction in breast cancer deaths in Scottish women aged under 65 is 20%.

9 Cervical cancer.

The target for reduction in cervical cancer deaths in all Scottish women is 50% reduction by the year 2000.

10 The target for the reduction in deaths from accidents is 25%.

11 The Scottish target is to stop the current rising trend in suicides and attempted suicides.

12 The Scottish targets for infectious disease are to reduce the current increase in food poisoning and to eradicate the infectious diseases of childhood.

13 The Scottish target should be to reduce the percentage of heavier and moderate drinkers by 30% by 2000.

14 The Scottish target should be to halve the percentage of smokers by the year 2000.

15 The Scottish target should be to increase all immunisation uptake rates to 95% by the year 2000.

REFERENCES



- 1 *Argyll and Clyde Health Board Annual Review 1988-89*
- 2 *Argyll and Clyde Health Board Annual Statistical Report Information Services Division, Argyll and Clyde Health Board.*
- 3 *Carstairs V, Morris R. Deprivation and mortality: an alternative to social class? Community Medicine 1989;11:210-19.*
- 4 *World Health Organisation. Health for All 2000. W.H.O, European Office,1985.*
- 5 *Watts M. Health for all by the year 2000-targets for Scotland. Information & Statistics Division of the Common Services Agency for Scotland 1989.*
- 6 *System 3 Scotland. Survey on smoking and health issues in Inverclyde District. 1989.*
- 7 *Wald NJ, Nanchahal K Thompson SG, Cuckle HS. Does breathing other people's tobacco smoke cause lung cancer? British Medical Journal1986;293:1217-22.*
- 8 *Froggatt P. Determinants of policy on smoking and health. International Journal of Epidemiology1989;18:1-9.*

