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THE ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH

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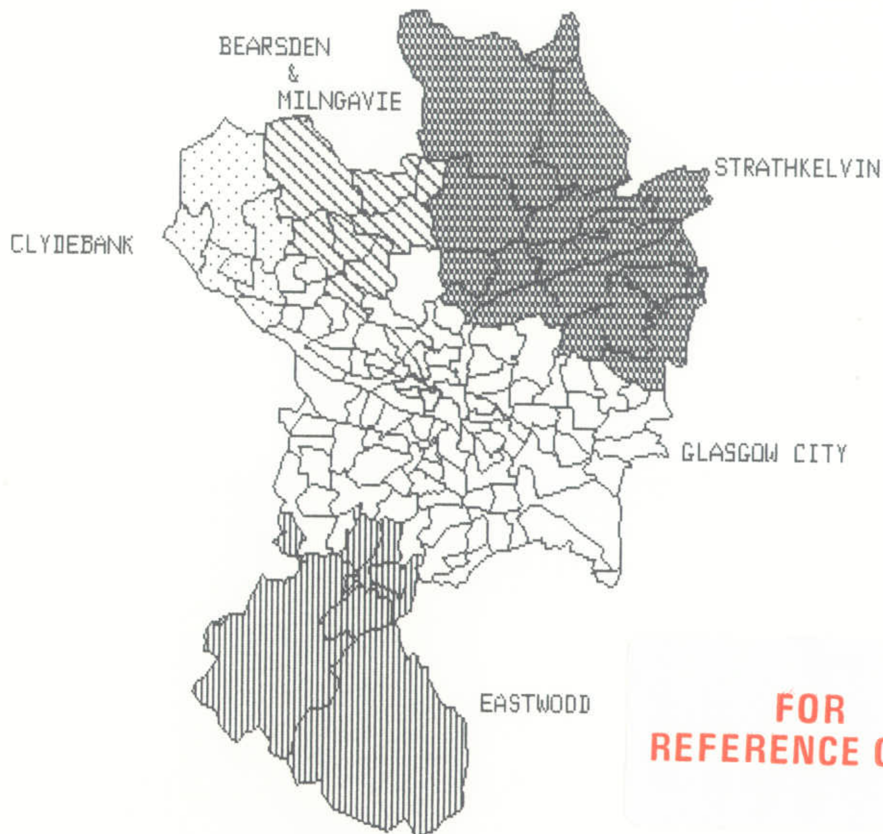


FOR
REFERENCE ONLY

GREATER GLASGOW HEALTH BOARD

For each financial year, Greater Glasgow Health Board publishes an Annual Report and Statement of Accounts. In addition it is now a responsibility of Directors of Public Health of Health Boards to provide regular reports on the health of the population for which their Boards are responsible*. These reports are intended to be "commentaries on the health of the population, drawing attention to changes which are taking place, to factors influencing these changes and to the implications for public services".

Annual reports of this nature were produced by Medical Officers of Health for Glasgow from the 1890s until 1973, before local government and health services were re-organised. Since 1974, annual statistical reports have been produced for the maternity and child health services of Greater Glasgow Health Board and there have been occasional reports on a variety of other topics, including a 'ten-year report' which provided an assessment of selected major changes in health and in the provision of health and related services over the period 1974-83.

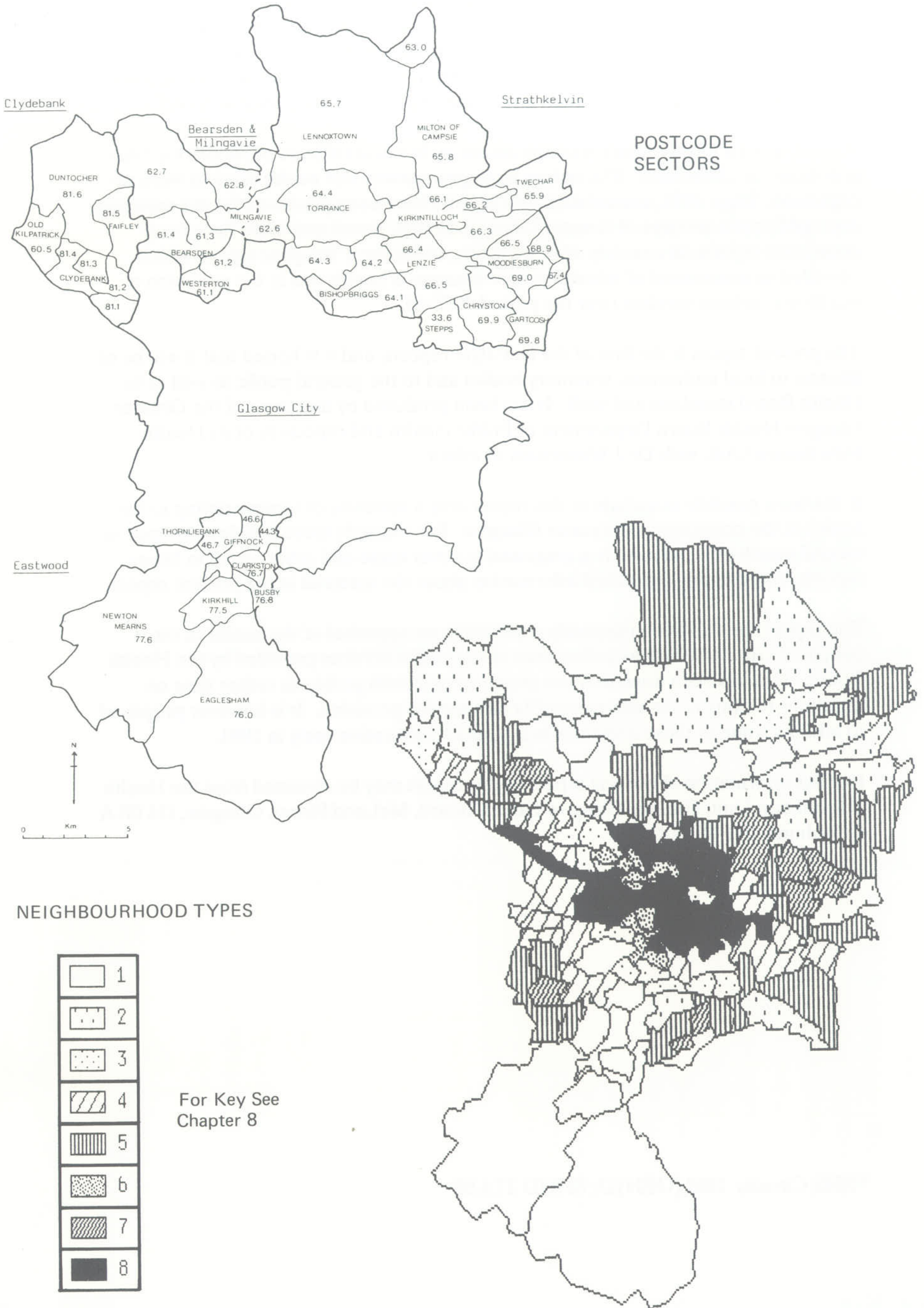
The present report is the first of the new style reports, and it is hoped that it will be of interest to local authorities, voluntary bodies and to the general public as well as to Health Board members and staff. It has been produced by members of the Greater Glasgow Health Board Department of Public Health and especially of its Health Information Unit, with Dr J Womersley as editor.

It has been possible to include in this report only a selection of topics relating to the health of the population of Greater Glasgow. For example there is little reference to mental health or accidents. It is proposed to cover these and other topics in future reports, together with up-dated information about the material in the present report.

The report has also been purposely confined to an appraisal of the health of the people of Greater Glasgow rather than of the health services provided by the Health Board. This has been done to focus attention on health problems rather than on questions relating to the adequacy of health service provision. It is however proposed to address some of these questions in a parallel publication early in 1991.

Further information about any aspect of this report may be obtained from the Health Information Unit, Greater Glasgow Health Board, McLeod Street, Glasgow, G4 0RA (telephone: 041-553 1833).

*NHS Circular 1988 (GEN)15; SHHD 27.4.88


THE GREATER GLASGOW HEALTH BOARD AREA
POSTCODE SECTORS
Clydebank
Bearsden & Milngavie
Strathkelvin
Glasgow City
Eastwood
DUNTOCHER
81.6
OLD KILPATRICK
60.5
81.5
FAIFLEY
81.4
81.3
CLYDEBANK
81.2
81.1
62.7
62.8
61.4
61.3
BEARSDEN
61.2
WESTERTON
61.1
MILNGAVIE
62.6
65.7
LENNOXTOWN
63.0
MILTON OF CAMPSIE
65.8
64.4
TORRANCE
64.3
64.2
BISHOPBRIGGS
64.1
66.1
66.2
KIRKINTILLOCH
66.3
66.4
LENZIE
66.5
TWECHAR
65.9
66.5
68.9
MOODIESBURN
69.0
67.4
CHRYSTON
69.9
GARTCOSH
69.8
33.6
STEPPS
THORNLIEBANK
46.6
44.3
46.7
GIFFNOCK
CLARKSTON
76.7
BUSBY
76.8
KIRKHILL
77.5
NEWTON MEARNS
77.6
EAGLESHAM
76.0
N
0
Km
5
NEIGHBOURHOOD TYPES
1
2
3
4
5
6
7
8
For Key See Chapter 8

THE CITY OF GLASGOW

POSTCODE SECTORS

NEIGHBOURHOOD TYPES

1
2
3
4
5
6
7
8

For Key See Chapter 8

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Introduction

The conventional attitude to health is that ill-health strikes at random and is dealt with, successfully or otherwise, by the health service. However, particularly in Greater Glasgow, it is more instructive to regard health as a stock of capital with which we are all initially endowed, although in varying degrees; this stock then depreciates through time and at an increasing rate in later life. Glasgow's health problem, compared with Scotland as a whole, is that the years of life lost by premature death and disability are excessive. This effect is relatively more striking under age 65 than in later life.

The determinants of health include genetic endowment, standard of living, environment, lifestyle and health services, and, of these, health services are by no means the most important. Greater Glasgow Health Board as its name suggests, should be interested in all these determinants, otherwise it would appropriately have been called Greater Glasgow Health Services Board. However, the Health Board has little direct responsibility for other than health services. Accordingly, it must find means of exerting its influence on the population largely in association with a range of other agencies: community, voluntary or statutory.

700,000 of today's Greater Glasgow population of 935,000 live in the City of Glasgow District and the health of this city population is poorer than that of the other four local Government Districts which together comprise Greater Glasgow. Furthermore, the city is the administrative level which can marshal the resources and has the political mandate and authority to develop and implement intersectoral approaches to health. Accordingly, the 'Healthy Cities' forum is a major vehicle for delivery of the Board's health promotion strategy. The present aims of this strategy, in priority order, are the development of a healthy environment, healthy life styles and the reduction of premature deaths, morbidity and disability. These aims are being promoted by the three pronged approach of health education, preventive medicine and protection of environmental health.

The survival rate around birth of those born in Greater Glasgow is similar to elsewhere in Scotland despite relatively more frequent adverse factors. These adverse factors include a high rate of teenage pregnancies, a lower proportion of terminations of pregnancy, and a high rate of 'illegitimate' births. In considering the significance of the last factor, it has to be taken into account that today a substantial proportion of births is registered in the name of both parents.

Maternal death is now so rare that it is an individual tragedy rather than a statistic. Since 1974, the stillbirth rate and the proportion of live babies dying within the first year of life (infant mortality rate) have fallen by 50%. It is difficult to envisage this rate of improvement being continued, considering the main remaining causes of death are low birthweight, congenital abnormalities and cot deaths.

The diphtheria, tetanus and pertussis immunisation rate has risen to a stable 90% and present early indications of achievement with the new combined Measles, Mumps and Rubella vaccine (MMR) are reasonably favourable.

Of deaths in the 1-14 year old group, 50% are the result of accidents (half of them road

accidents), 40% due to a variety of diseases (mainly cancer) and 10% are associated with congenital abnormalities.

The most striking feature of the 20-24 age group is that its numbers will fall by 35% over the next 10 years, a diminution of 30,000.

At adult ages under 65 the health of the population, especially in the City of Glasgow District, is markedly poorer than in Scotland as a whole. For this District the death rate in men is 26% higher and in women 20% higher than for Scotland. For Greater Glasgow as a whole this differential is reduced to 16% for men and 11% for women. The corresponding proportions for men and women aged 65 and over are only 6% for Glasgow and 2% for Greater Glasgow. Alarmingly, this poor health record for adults is increasing relative to Scotland, especially in men, whereas there is no similar trend for those aged 65 and over. Of the 12,500 or so deaths which occur each year in residents of Greater Glasgow, 3,200 take place under age 65; the principal causes, in order of scale, are heart disease, cancer and accidents. Smoking is the most striking causative factor of these premature deaths. In men it is estimated this is a crucial factor in 90% of deaths from lung cancer, 75% from bronchitis and emphysema and 25% from ischaemic heart disease, the values for women being rather lower; in all some 1,500 men and 550 women in Glasgow die prematurely each year from tobacco induced disease.

The following table gives the populations for the five local government districts within the Greater Glasgow Health Board together with population projections for the year 2000, and - as a measure of socio-economic disadvantage - the proportion of the population in social classes IV and V (1981 census).

DISTRICT	POPULATION 1000s 1988	%CHANGE 2000	SOCIAL CLASS IV + V (%)	STANDARDISED MORTALITY RATIO
Bearsden and Milngavie	40	-1	6	60
Clydebank	48	-6	26	110
Eastwood	59	+11	6	65
Glasgow	703	-11	32	120
Strathkelvin	89	-6	14	90
TOTAL	939	-8	29	108

In socio-economic terms, Glasgow and Clydebank are disadvantaged, Bearsden and Milngavie and Eastwood advantaged, with Strathkelvin holding an intermediate position. There is a clear correlation between standardised death rates (SMR for Scotland = 100) and socio-economic status: the more disadvantaged areas clearly have the higher death rates.

Another means of measuring social disadvantage is to classify neighbourhoods in Greater Glasgow into eight types. The distinction between these neighbourhood types can be demonstrated by comparing the 25% most deprived with the 25% least deprived; there is a two-fold range in perinatal deaths, a 70% difference in low birth weights and a six-fold difference in the proportion of teenage mothers. Between 1983/85 and 1986/88 there was no change in these differences.

The significance of neighbourhood types is also clear from the use by their populations of health services resources. For example, as regards acute hospital bed utilisation by those aged 0-64 years, using the average value for Greater Glasgow as a standard, for men Type 1 neighbourhood utilisation was 60% and Type 8, 140% - more than a two-fold range. For women the corresponding proportions were 70% and 120%. These differentials are not so striking as regards men and women aged 65 and over (Type 1, 75%; Type 8, 125%).

Another important factor to be taken into account is household. In Glasgow, compared with Scotland as a whole, there are higher proportions of children in single parent families, of people living alone, of overcrowded households and of households without their own transport.

A one sentence summary of the health of Glasgow is that 'we are born well and become ill'. This is a statistical fact, the explanation for which is likely to be multi-factorial. However, adverse environmental factors are of paramount importance. It is a striking fact that, within the boundary of the Greater Glasgow Health Board, there are Eastwood, Bearsden and Milngavie Local Government Districts which are among the most healthy District populations in Scotland and parts of Glasgow District which are the least healthy in Scotland. This differential impels the Board to seek to deliver its health services in such a way as to discriminate positively in favour of the deprived populations with poor health standards. In considering this discrimination it has to be kept in mind that apart from the large peripheral post-war housing estates there are many smaller geographical pockets of deprivation.

Enquiries into perinatal and infant deaths were originated some years ago in Glasgow. The perinatal enquiry into stillbirths and neonatal deaths is now organised on a Scottish basis. These studies have made a considerable contribution to the fall in perinatal and infant mortality which has taken place during recent years.

A computer-based health visitor record for preschool children has been operating in Glasgow since 1982, in conjunction with the standard immunisation recall system (SIRS). This has led to the production of a considerable amount of information about health in different communities within the GGHB area, and about variation in the caseloads among different health visitors and general practitioners. An obvious deficiency in this system is that it does not include any information about medical assessments or other clinical detail. The opportunity to bring together medical and nursing information in a single recording system will arise when a national computer-based system is established. At present the major thrust in national computer software developments is towards the design and installation of the immunisation and cervical screening systems.

The publication of the Hall Report on screening procedures in childhood provides an

opportunity, throughout Scotland, to rationalise the hitherto uncoordinated and inefficient 'programme of preschool health surveillance'. The recommendation to implement a simplified programme which maximises the skills of nurses and doctors in an integrated way should be put into effect as soon as possible.

The general practitioner administrative computer software system G-PASS is another national development which it is important to employ to full potential locally. From 1st April 1990, general practitioners are required to have readily available much more information about their individual patients and about their practice population as a whole than they generally have done in the past. For most general practitioners this means that as each patient comes to the surgery it will be necessary to find out from the computer what are the key problems and what interventions (in terms of screening and other preventive measures) are necessary. It is important that the Health Board provides encouragement and assistance for general practitioners who have not previously used computers and who wish to avail themselves of the many facilities which are offered by G-PASS.

It is recognised that 'top down' or professional approaches will be relatively ineffective without 'community development' by local populations. However, this does not mean the statutory and voluntary agencies, in unison, cannot facilitate this local action. The Healthy Cities project provides a vital stimulus for all agencies to collaborate to tackle the problems which underlie the poor health record of parts of Glasgow. It is also important in that it makes explicit the need to involve local people in the planning and management of services, and it has established the very important principle of equity - to strive to narrow the gap between the least healthy and healthiest communities - while promoting 'health for all'.

In terms of ideological politics there is sometimes apparent a difference of perception whether Glasgow's health problems primarily are due to 'deprivation' or 'self-indulgence'. In practice, this difference is only of theoretical significance because both groups of factors apply and they interact with each other. For example, a higher proportion of the populations in socio-economically deprived areas smoke than in less deprived areas. How independent are those two factors? Smoking is the major public health hazard at present. People are beginning to give up smoking, and in Glasgow almost two thirds of adults are willing to try to do so. The Health Board - through the various programmes in the Health Promotion Strategy and otherwise - must make every endeavour to help those people who need assistance to give up the habit.

It is too soon to seek to speculate what may be the impact on health standing of the Government's three major initiatives 'Working for Patients', 'Caring for People' and the new contract for general medical practitioners. What is obvious is that it is likely to be several years before any improvements become evident from statistics. However, the advent of systematic medical audit offers the opportunity for the elaboration of measures of outcome of treatment, including measures for use in subsequent annual Reports.

Dr George Forwell
Director of Public Health and Chief Administrative Medical Officer

The Greater Glasgow Health Board Population

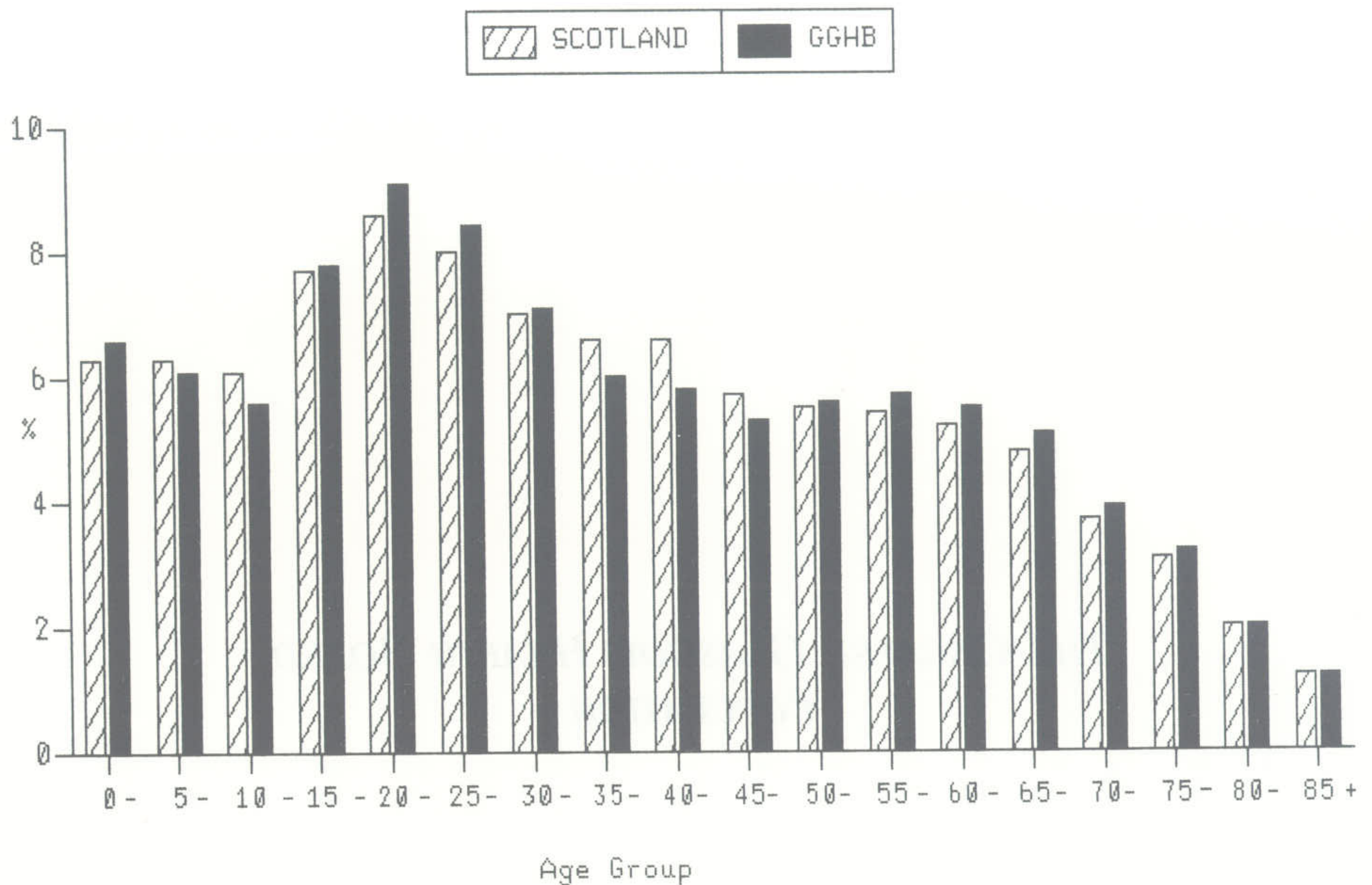
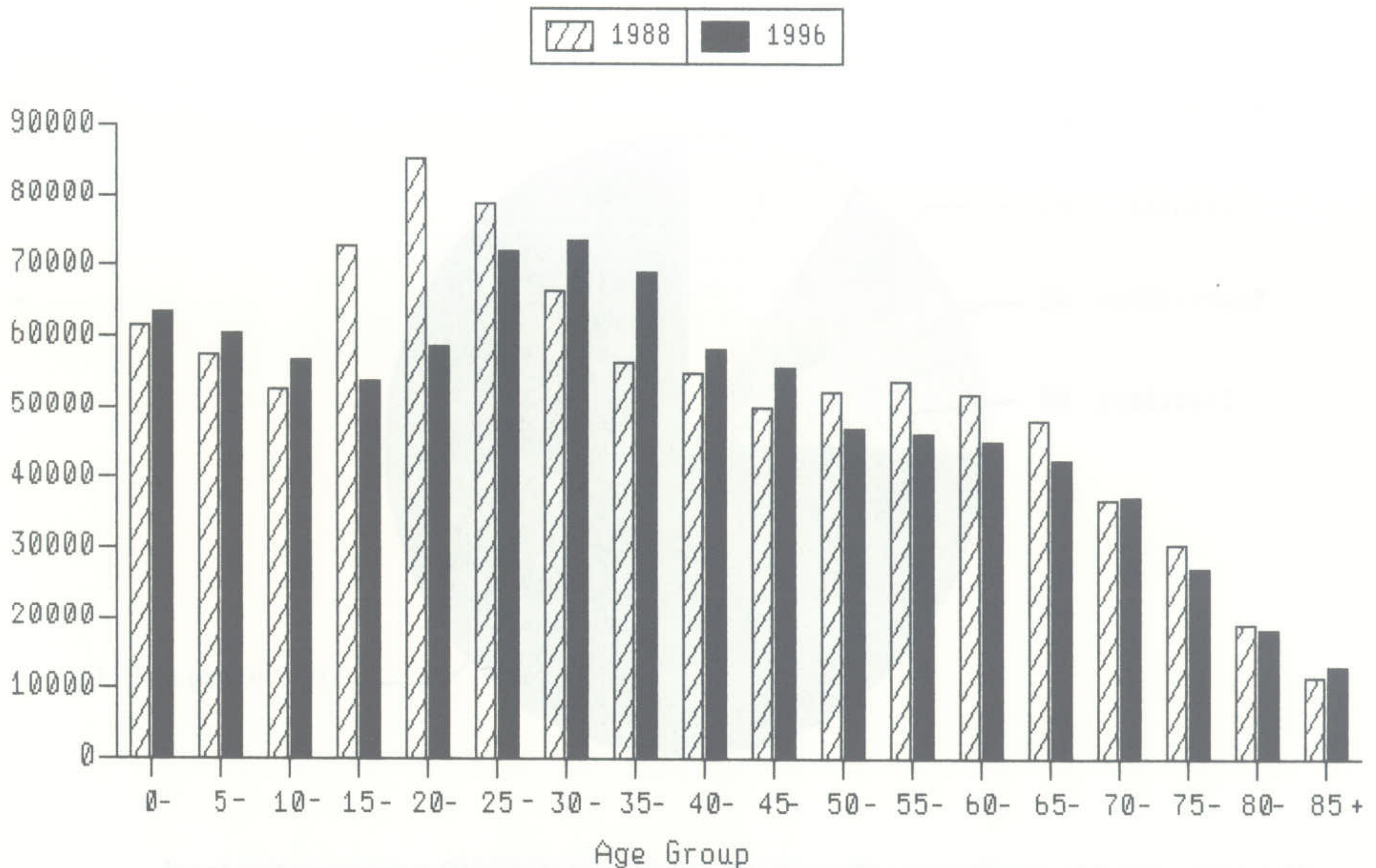


Fig 1 shows the age distribution of the population living within the area served by the Greater Glasgow Health Board and for Scotland.

The peak (20 to 29 years) coincides closely with the age group of women with the highest reproductive rate. It might therefore be expected that the number of births in the GGHB area (and Scotland) will soon begin to fall. However the Registrar General argues that because fertility rates have decreased in the recent past, parents will attempt to 'catch up' and that birth rates may in fact increase.

Source: Registrar General for Scotland, Annual Population Estimates

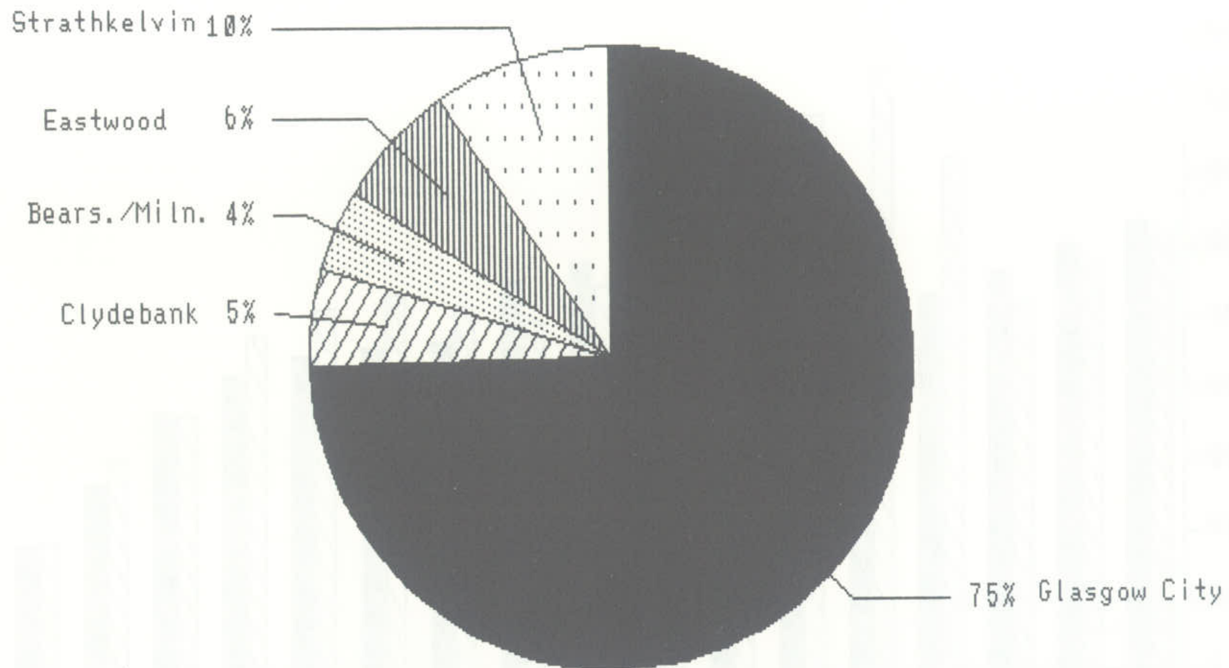


The graph also shows how by 1996 the 'peak' (20 to 29 year age group) will have moved to a less fertile age range. There is an increase (which must be entirely hypothetical) in the numbers of children aged between 0 to 9 years, but between the ages of about 50 and 77 years the numbers decrease - particularly in the immediate pre-retirement age groups. There will however be more very elderly people.

The most striking difference between the two population profiles however is among young adults. There will for example be a fall of over 30,000 (over one third) in the numbers of 20-24 year olds over the next ten years. This means that the number of young people entering the labour market is beginning to decline drastically, and the Health Service in particular is likely to suffer from a dearth of would-be entrants.

These population projections are based on the known age structure of the population in 1987, projected future migration and current age specific death rates (with a correction factor applied to each age group to anticipate likely future reductions).

Source: Registrar General for Scotland, Annual Population Estimates



The area served by the Greater Glasgow Health Board (GGHB) comprises five local government districts with the following populations (mid year estimate for 1989):

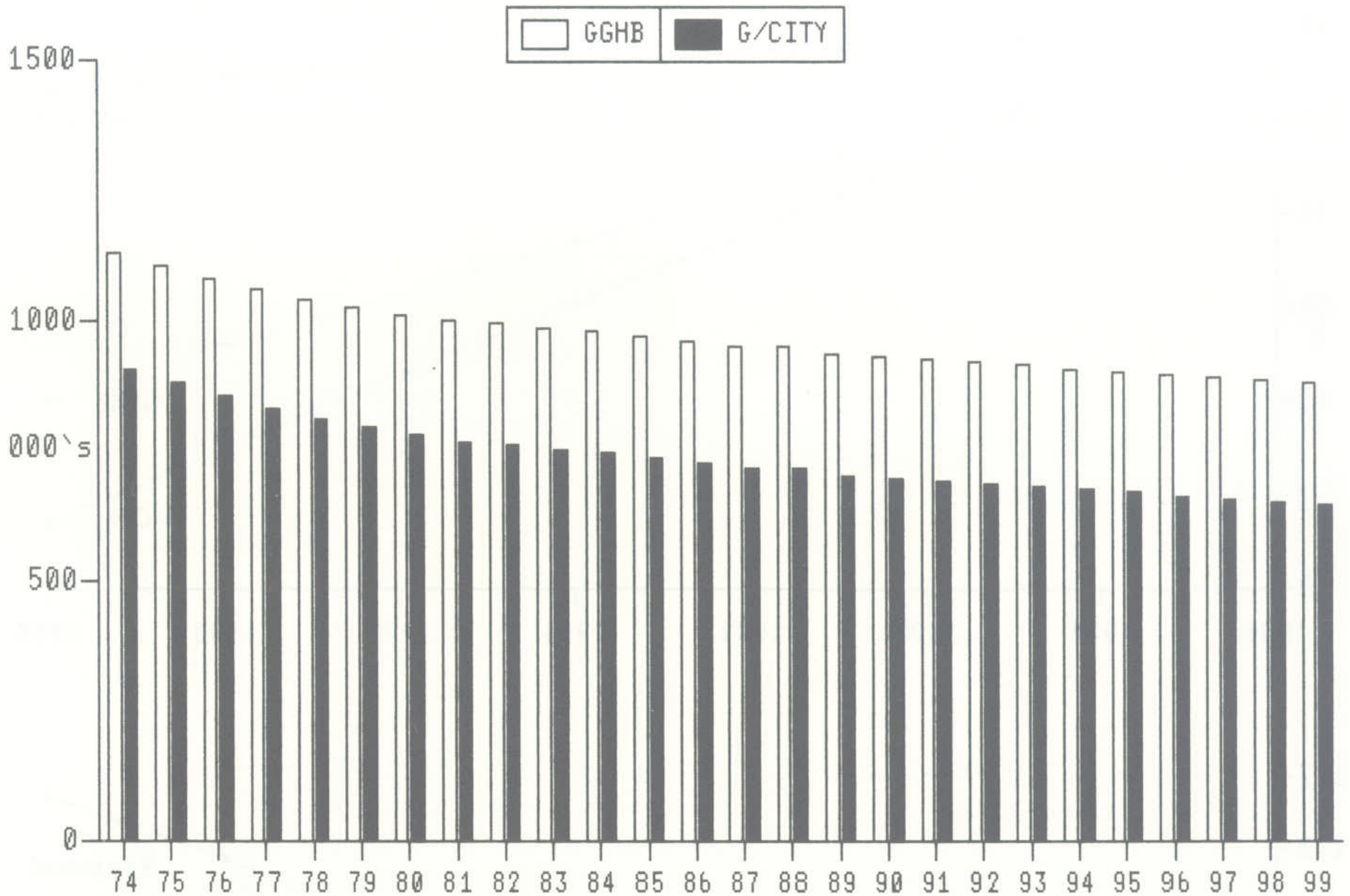
City of Glasgow	695,630	(74.6%)
Clydebank	47,180	(5.1%)
Bearsden & Milngavie	40,270	(4.3%)
Eastwood	60,250	(6.3%)
Strathkelvin	89,420	(9.6%)

TOTAL	932,750	

The 1989 mid year estimate for the population of Scotland as a whole is 5,090,700 and for Great Britain (1988) 55,355,000. GGHB thus comprises some 18.6% of the population of Scotland, although its area is only about 0.71% of that for Scotland.

	Population	Area (hectares)
GGHB	933,200	55,000
Scotland	5,090,700	7,716,690
Great Britain	55,355,000	22,830,400

Source: Registrar General for Scotland, Annual Population Estimates

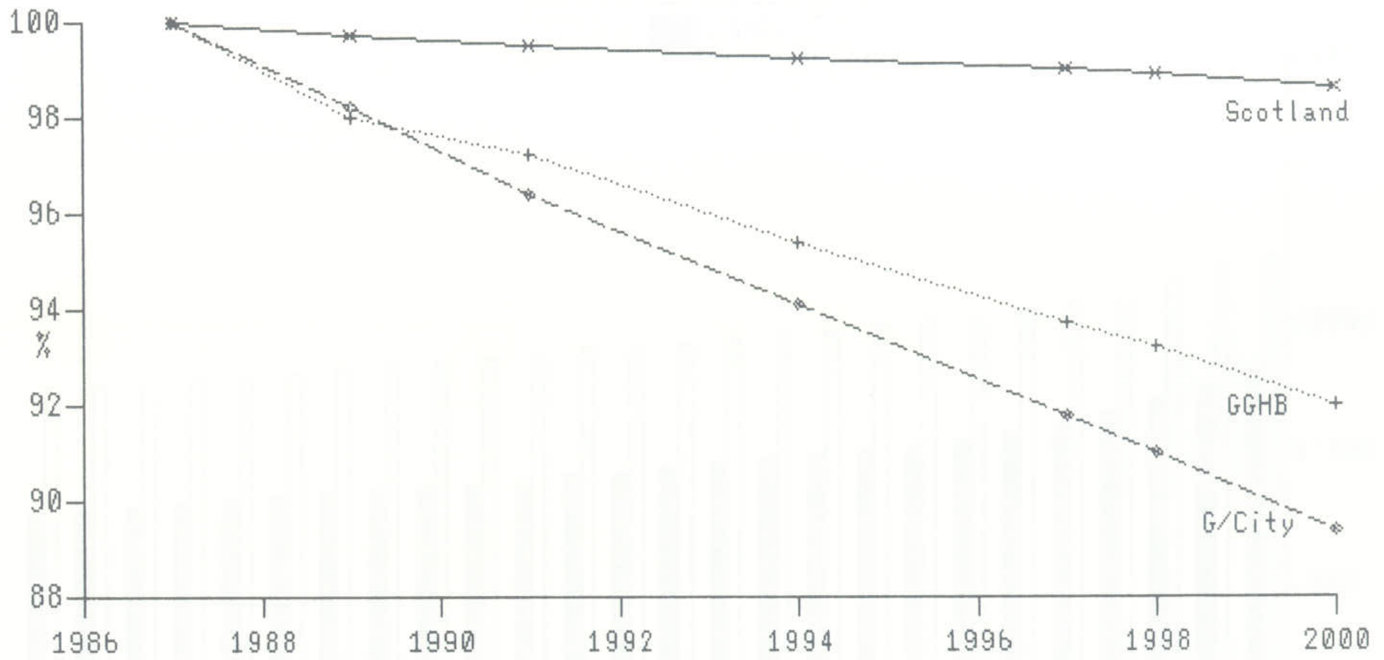


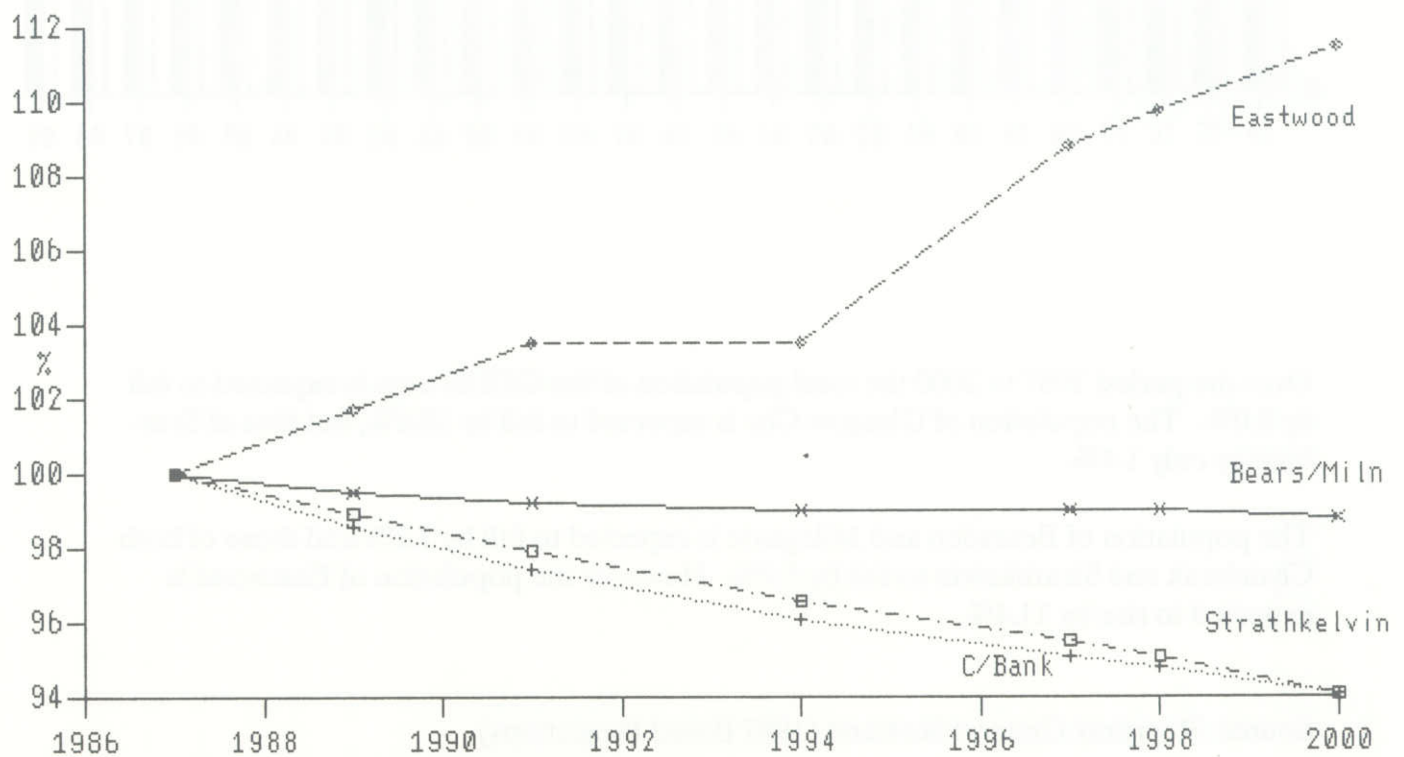
Over the period 1987 to 2000 the total population of the GGHB area is expected to fall by 8.0%. The population of Glasgow City is expected to fall by 10.6%, but that of Scotland by only 1.4%.

The population of Bearsden and Milngavie is expected to fall by 1.2% and those of both Clydebank and Strathkelvin to fall by 5.9%. However the population of Eastwood is expected to rise by 11.4%.

Source: Registrar General Scotland (1987 Based Projections)

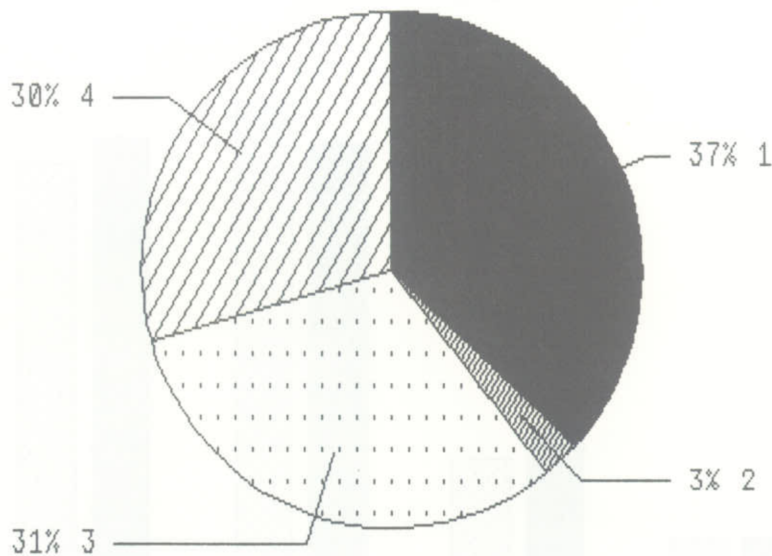
PROJECTED PERCENTAGE CHANGE IN POPULATION TO YEAR 2000
SCOTLAND, GGHB & LOCAL GOVERNMENT DISTRICTS





Source: Registrar General Scotland
1987 Based Population Projections

HOUSEHOLD COMPOSITION FOR THE GGHB AREA
A TYPES OF HOUSEHOLD:- SUMMARY



1 At least one pensioner present

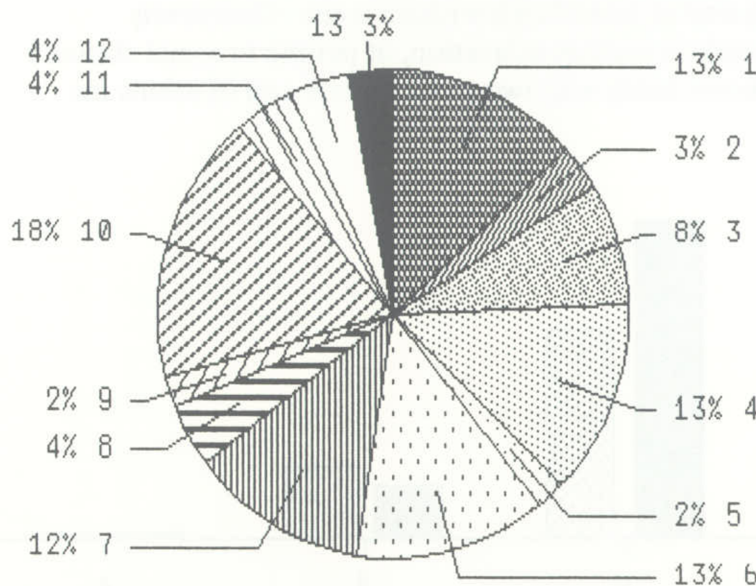
2 Single person >= 16y with child(ren) under 16y

3 Households with 2 or more adults and child(ren) under 16

4 Purely adult (non pensioner) households

Over one third (37%) of households include at least one pensioner, and less than one third (31%) include a child or children under the age of 16 years. Almost one third of households (30%) are adult, non-pensioner, households. About 2.5% of households comprise a single adult living with one child or children.

B TYPES OF HOUSEHOLD:- DETAIL



At least one pensioner present

1 Lone woman

2 Lone man

3 2 or more pensioners together

4 Pensioners with younger persons

5 Single adult with child(ren)

Two or more adults with child(ren)

6 2 children
7 3 children
8 >= 4 children
9 1 child

Adults only

10 >= 2 Adults no child(ren)
11 Lone man 16-64y
12 Lone woman 16-59y
13 Dependent children present 16-24 years

Source: Census Tables 1981