

REGULAR REVIEW

Child health statistical review

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This is the third review of national statistics pertaining to children, earlier reviews having been published in this journal in 1987 and 1988. This review adopts the approach used in the earlier publications, and also includes data relevant to *The Health of the Nation* white paper.¹ Suggested key areas and targets in the

white paper were selected because they are causes of substantial mortality; causes of substantial ill health; factors which contribute to mortality, ill health, and healthy living; areas where there is great potential for harm; and areas where there is clear scope for improvement. It is in the last of these categories that the health of pregnant women, infants, and children is specifically considered, though child health permeates all key areas. Again we invite suggestions from readers as to what additional material could be included in future papers.

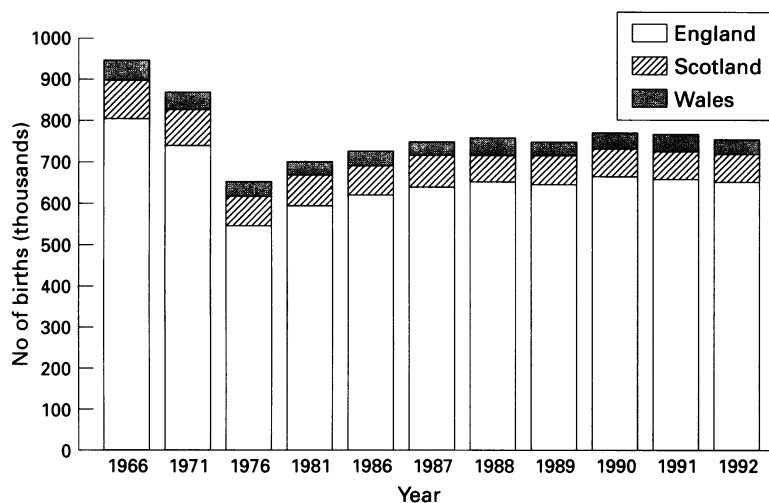


Figure 1 Trend in total number of births for England, Scotland, and Wales. (Source: Population Trends No 75, Spring 1994.)

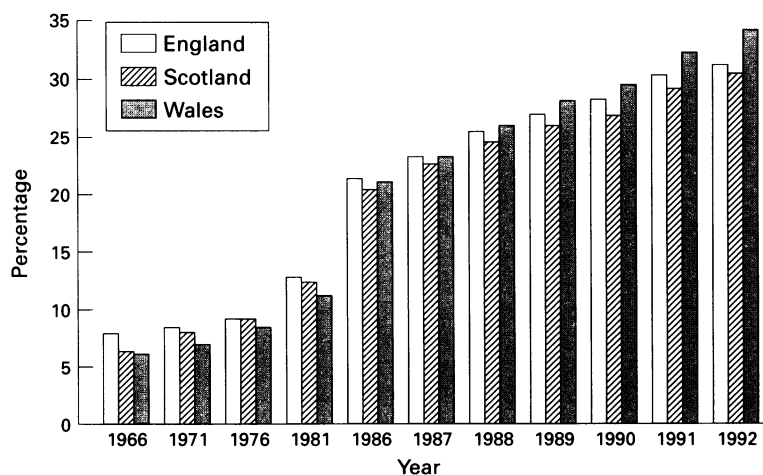


Figure 2 Proportion of children born outside marriage for England, Scotland and Wales. (Source: Population Trends No 75, Spring 1994.)

Demography

NUMBER OF BIRTHS

The number of births for each of the constituent countries of Great Britain has remained stable since the early 1980s (fig 1). However, during this time there has been a steady increase in the number and proportion of children born outside marriage (fig 2). England, Scotland, and Wales all show similar trends with more than 30% of children now born outside marriage. However, these data include children born to couples in unmarried but stable relationships and so do not indicate numbers of children being born into single parent households.

Crude birth rates and numbers of births may conceal trends that are important to child health. There has been a significant trend of women postponing their childbearing as shown by age specific birth rates (table 1). While the birth rate in teenagers has remained unchanged, the birth rate in women aged 20-29 has decreased and there has been a

Table 1 Age specific birth rates in England and Wales

Year	Births/1000 women in each age group						
	All ages	<20	20-24	25-29	30-34	35-39	≥40
1986	61	30	93	124	78	25	5
1987	62	31	93	125	81	26	5
1988	63	32	95	124	83	28	5
1989	62	32	92	120	84	29	5
1990	64	33	92	122	87	31	5
1991	64	33	89	119	87	32	5
1992	64	32	86	117	87	33	6

Source: Population Trends No 75, Spring 1994.

Table 2 Conceptions to women aged under 20 and under 16 (numbers and rates) in England and Wales

Age and year	No of conceptions (000s)				Rate/1000 women*†			
	Total	Leading to a maternity		Leading to an abortion	Total	Leading to a maternity		Leading to an abortion
		Inside marriage	Outside marriage			Inside marriage	Outside marriage	
Under 20								
1971	133.1	44.2	65.6	23.3	81.5	311.7	44.0	14.3
1981	115.2	26.7	51.8	36.7	57.1	287.3	26.9	18.2
1990	115.1	10.7	63.4	41.0	69.0	269.9	38.9	24.6
1991	103.3	9.4	58.4	35.5	65.1	276.1	37.6	22.4
Under 16								
1971	8.8	0.05	5.5	3.3	8.8	0.0	5.5	3.2
1981	8.6	0.05	3.6	4.9	7.3	0.0	3.1	4.1
1990	8.6	0.03	4.2	4.4	10.1	0.0	5.0	5.1
1991	7.8	0.02	3.8	4.0	9.3	0.0	4.5	4.8

Source: *Population Trends* No 74, Winter 1993.

*The rates for women aged under 20 are based on all conceptions in this age group with a denominator population of women aged 15–19 years. The rates for those under 16 are based on all conceptions in this age group with a denominator population of women aged 13–15 years.

†Marital and extramarital fertility rates are based upon provisional estimates by marital status. All rates for 1982–91 may be revised slightly when marital status estimates, which take account of all appropriate census data, have been prepared.

Table 3 International comparison of teenage fertility

Country (ranked by 1990)	Rate/1000 women aged 15–19		
	1970 (rank)	1980 (rank)	1990*
USA	68.2 (1)	53.0 (1)	53.6
England and Wales	49.6 (3)	30.4 (6)	33.3
Scotland	47.6 (4)	32.0 (5)	31.9
Northern Ireland	42.9 (6)†	29.2 (7)	29.3
Portugal	29.8 (12)	41.0 (3)	24.6
Greece	36.9 (7)	52.6 (2)	21.8
Austria	58.2 (2)	34.5 (4)	21.3
Norway	43.7 (5)	25.2 (9)	17.1
Republic of Ireland	16.3 (17)	23.0 (10)	16.2
Sweden	34.0 (9)	15.8 (15)	14.1
Spain	13.8 (19)	25.3 (8)	13.4
Finland	32.2 (11)	18.9 (12)	12.4
West Germany	35.8 (8)	15.2 (16)	11.6
Italy	27.1 (13)	20.6 (11)	9.8
Belgium	23.2 (15)	14.9 (17)	9.3
Denmark	32.4 (10)	16.8 (14)	9.1
France	27.0 (14)	17.8 (13)	8.8
Netherlands	17.0 (16)	6.8 (19)	6.4
Switzerland	16.0 (18)	7.2 (18)	4.6

Source: *Population Trends* No 74, Winter 1993.

*1990 or latest available year; †1971.

Table 4 Trends in infant mortality rates in England, Scotland, and Wales

Country	Year	Infant mortality rate*	Neonatal mortality rate*	Perinatal mortality rate†	Postneonatal mortality rate†
England	1988	9.1	4.9	8.7	4.2
	1989	8.4	4.7	8.3	3.7
	1990	7.9	4.6	8.1	3.3
	1991	7.3	4.3	8.0	3.0
	1992	6.5	4.3	7.6	2.2
Scotland	1988	8.2	4.6	9.0	3.6
	1989	8.7	4.7	8.7	4.0
	1990	7.7	4.4	8.7	3.3
	1991	6.8	4.6	9.0	2.2
	1992	6.8	4.6	8.5	2.2
Wales	1988	7.6	4.7	8.6	2.9
	1989	8.0	4.7	8.3	3.3
	1990	6.9	3.9	7.4	3.0
	1991	6.6	4.1	7.9	2.5
	1992	6.0	3.8	7.0	2.2

Source: *Population Trends* No 76, Summer 1994.

*Based on all live births; †Based on all live births and still birth.

reciprocal increase in births in women in their 30s and a small increase in women aged over 40 years. In 1992 the birth rate for women aged 30–34 was higher than that of the 20–24 age group. These trends have implications for health services as maternal age affects the

frequency of congenital abnormalities (for example, Down's syndrome) and perinatal infant mortality.

TEENAGE PREGNANCY

Teenage births may be associated with a variety of adverse outcomes for both mother and child, including an increased risk of infant mortality and morbidity. Sexual health is one of the key areas in *The Health of the Nation* white paper.¹ A target of reducing the rate of conceptions among the under 16s by at least 50% by the year 2000 has been set (from 9.5 per 1000 girls aged 13–15 in 1989 to no more than 4.8). Although the number of conceptions in those under 16 year olds has shown a slow downward trend over the last 20 years, the conception rates do not show a similar decrease (table 2). About half of all conceptions in the under 16s lead to an abortion.

The conception rate for all teenagers fell from 1971, reaching a minimum of 56 conceptions/1000 women in 1983. Since then there has been an upward trend, although this may have reversed in 1991. During this time the abortion rate also increased until 1990 and then fell slightly in 1991. The overall result was that, among teenagers, the proportion of conceptions leading to abortion almost doubled from 18% in 1971 to 34% in 1991. Achieving *The Health of the Nation* target will, therefore, be difficult as effective intervention will be required to bring about any alteration in current trends.

The UK consistently has higher teenage fertility rates than those of most other developed countries (table 3). In 1990 the constituent countries of the UK had three out of the four highest rates for teenage fertility among developed countries. UK rates between 1980 and 1990 remained stable while many other European countries achieved a marked improvement. There is currently more than a tenfold national difference in teenage fertility rates.

Mortality

INFANT MORTALITY

In England the infant mortality rate has dropped from 9.1 deaths/1000 live births in 1988 to 6.5 deaths/1000 live births in 1992 (table 4). Scotland and Wales are also exhibiting a similar downward trend, although rates fluctuate due to the smaller numbers involved.

The inverse relationship between infant mortality and birth weight is well recognised. The greatest relative risk for low birthweight infants is in the neonatal period. Infants of birth weight <1500 g have almost a 50-fold increased risk of neonatal death compared with all children (table 5). An alternative presentation of this observation is that 1% of all live births weighed <1500 g but they contributed to 46% of all neonatal deaths.

Perinatal and neonatal mortality rates for all low birthweight groups improved between 1986 and 1991 (table 6). The greatest

Table 5 Infant mortality by birth weight, 1991 in England and Wales

Birth weight (g)	Perinatal mortality		Neonatal mortality		Postneonatal mortality	
	Rate	Relative risk	Rate	Relative risk	Rate	Relative risk
All weights	8.0	1.0	4.3	1.0	2.9	1.0
<2500	68.4	8.6	38.4	8.9	12.9	4.5
<1500	272.5	34.1	211.6	49.2	36.8	12.7
1500-1999	68.8	8.6	22.1	5.1	13.9	4.8
2000-2499	20.4	2.6	6.8	1.6	7.5	2.6
2500-2999	6.0	0.8	2.3	0.5	3.3	1.1
3000-3499	2.3	0.3	1.0	0.2	2.1	0.7
≥3500	1.8	0.2	0.9	0.2	1.7	0.6
Not stated	22.9	2.9	19.1	4.4	3.8	1.3

Source: OPCS series DH3, *Mortality Statistics*.

Table 6 Trends in birthweight specific infant mortality in England and Wales

Year		Birth weight (g)		
		<1500	1500-1999	2000-2499
1986	Perinatal	345.5	85.0	27.3
	Neonatal	262.3	40.1	10.7
1987	Perinatal	322.8	86.5	22.4
	Neonatal	257.5	36.1	8.9
1988	Perinatal	319.2	82.7	24.1
	Neonatal	260.5	34.6	9.6
1989	Perinatal	275.6	75.6	22.3
	Neonatal	223.6	29.1	7.4
1990	Perinatal	279.6	75.7	19.5
	Neonatal	217.7	25.0	6.5
1991	Perinatal	272.5	68.8	20.4
	Neonatal	211.6	22.1	6.8

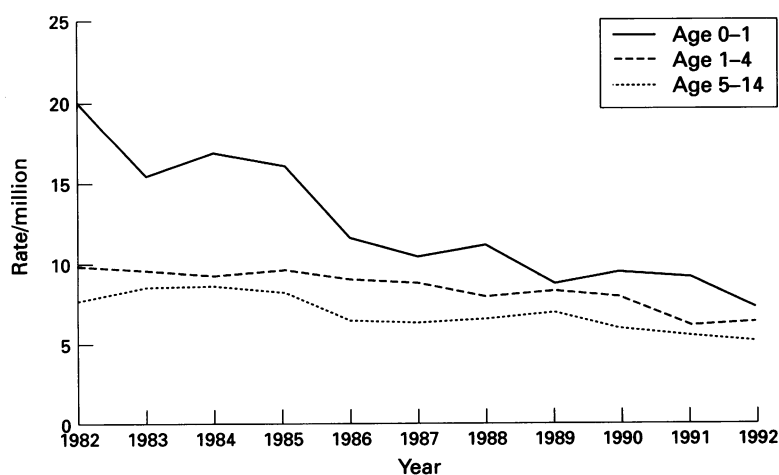
Source: OPCS series DH3, *Mortality Statistics*.

Table 7 Infant mortality by social class based on the father's and mother's occupation, 1986-90 combined in England and Wales

Social class	Based on father's occupation	Based on mother's occupation
All stated	8.6	6.1
I	6.6	6.1
II	6.6	5.7
IIIN	7.5	5.7
IIIM	8.4	7.0
IV	10.5	7.0
V	13.1	10.8
Armed forces	7.8	6.3
Other	21.4	10.0
Not stated	See footnote*	9.9

Source: *Population Trends* No 74, Winter 1993.

*No father's occupation means that no father's details were given at birth registration. This only occurs when a birth outside marriage is registered solely by the mother.

Figure 3 Deaths by accident from 28 days old/million population by age for England and Wales (ICD E800-E949). (Source: OPCS Series DH2, *Mortality Statistics*.)

improvement has occurred in neonatal mortality for babies weighing 1500-1999 g with a reduction of 45% over the five year period. This observation needs to be tempered by the fact that there is increasing registration of live births weighing <1500 g. In the past many of the smallest of these would have been considered non-viable and not registered. Therefore the improved mortality in the <1500 g group would be affected by the increasing registration of vulnerable extremely low birthweight infants as live births.

A caveat needs introduction here because the birthweight groupings are not strictly comparable with those shown in the two previous statistical reviews. The previous groupings were less than or equal to 1500 g, 1501-2000 g, etc, that is, those infants weighing exactly 1500 (or 2000) g would be in different groups in the previous publication.

INFANT MORTALITY BY SOCIAL CLASS

Mortality statistics by social class are usually based on the father's occupation as stated at birth registration. However, details of the mother's occupation when registering live births have been recorded since 1986 and when registering infant deaths, since 1982. Examination of infant mortality by mother's occupation becomes important with increasing numbers of dual income and single parent families. Infant mortality by mother's occupation displays a similar pattern to that for father's social class, although the social class differential is not so great (table 7). The mortality rate in children for whom the mother has not stated an occupation is 62% greater than that in children for whom the mother's occupation was given.

However, these data should be treated with caution as the mother's occupation was only stated in 30% of infant deaths and 42% of live births and a non-response bias is likely.

ACCIDENTS

The accident prevention key area of *The Health of the Nation* white paper¹ is particularly relevant to children. Most accidents are considered preventable, and therefore the aim is to reduce mortality and morbidity through measures such as education, training, and environmental improvement. *The Health of the Nation* target is to reduce the death rate for accidents among children aged under 15 by at least 33% by 2005 (from 6.6/100 000 population in 1990 to no more than 4.4/100 000).

Much of the observed reduction in deaths as a result of accidents has occurred in the less than 1 year old age group (fig 3). However, part of this trend may be an artefact of diagnostic transfer, that is, deaths previously attributed to natural factors, environmental factors, submersion, suffocation, or foreign bodies (*International Classification of Diseases* (ICD) codes E900-915) may now be attributed to sudden infant death syndrome. A similar, but less marked, downward trend is also observed in the other age groups.

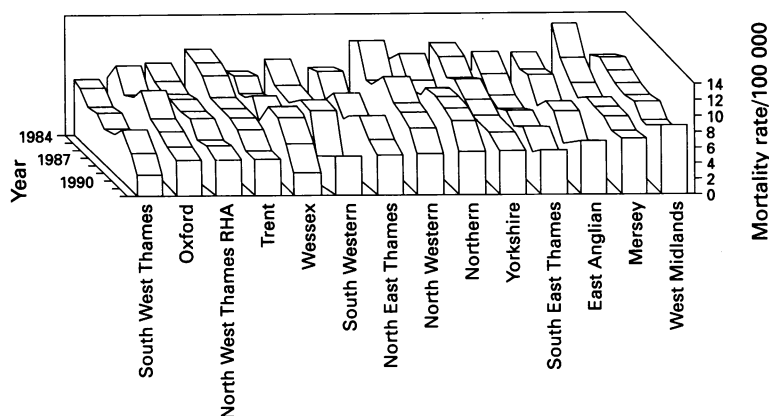


Figure 4 Regional age standardised accident mortality rate/100 000 children less than 15 years old (ICD E800-E949). (Source: Public Health Common Data Set, 1993.)

Table 8 Age standardised regional mortality rate/100 000 from accidents in 1992 for children under 15 years old (ICD E800-E949)

Region	Accident mortality rate
England and Wales	5.7
England	5.5
West Midlands	8.7
Mersey	7.2
East Anglian	6.9
South East Thames	5.8
Yorkshire	5.7
Northern	5.6
North Western	5.3
North East Thames	5.1
South Western	5.0
Trent	4.8
North West Thames RHA	4.7
Oxford	4.7
Wessex	3.3
South West Thames	2.8

Source: Public Health Common Data Set 1993.

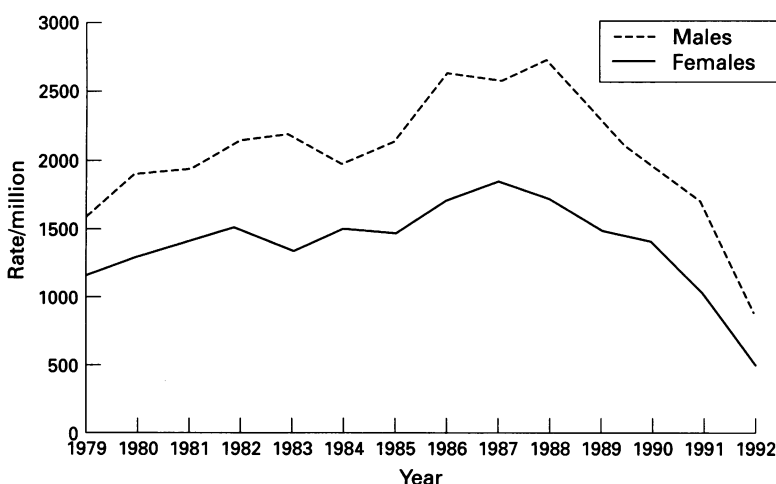


Figure 5 Age standardised death rate/million population (deaths from 28 days old) in England and Wales for sudden infant death syndrome (ICD 798.0). (Source: OPCS series DH2, Mortality Statistics.)

All regions have shown a reduction in mortality rates due to accidents in children since the early 1980s (fig 4). In 1992 five of the regions had a mortality rate more than double that of the lowest (table 8).

SUDDEN INFANT DEATH SYNDROME

The last 15 years has seen large changes in sudden infant death rates which increased to a peak in 1987-8, and then declined (fig 5). This has been attributed to the campaign advising mothers not to put their babies to sleep in the prone position.

Infectious diseases

MENINGITIS

There has been a trend towards lower meningitis mortality rates in children, particularly in those aged less than 1 year (table 9). The annual fluctuation for the older age group is mainly attributable to random variation associated with the small number of deaths.

Monitoring of mortality rates due to meningitis following the introduction of *Haemophilus influenzae* b immunisation in 1992 will be of interest. However, some deaths may have been, and may continue to be, recorded as meningitis of unspecified cause (ICD 322). Also *H influenzae* b is a cause of death from acute epiglottitis and septicaemia. It will therefore be necessary to follow mortality trends in all these conditions to fully assess the impact of the introduction of the immunisation.

MEASLES

The combined measles, mumps, and rubella (MMR) vaccine was introduced in 1988, replacing the single measles and rubella components. The single measles immunisation was introduced in 1968 and resulted in a drop in notifications from up to 800 000 to between 50 000 and 180 000. In the UK deaths attributed to measles fell from 1000 in 1940 to only 13 over the 14 year period, 1970-83.² The notification rates for measles continue to decline (table 10). This is likely to be due to the increasing immunisation uptake rates attributed to changes in the way general practitioners are remunerated, and changes in the immunisation schedule as a result of the introduction of the MMR immunisation.

An epidemic of measles of 100 000-200 000 cases is predicted to start early in 1995.

Table 9 Death rate/million population due to meningitis (ICD 320-322) by age and sex in England and Wales

Age (years)	Sex	1978	1980	1982	1984	1986	1987	1988	1989	1990	1991	1992
Under 1*	Male	165	125	117	97	75	74	56	41	40	55	55
	Female	126	93	120	63	48	44	46	46	20	35	16
1-4	Male	12	14	8	9	9	13	8	10	10	12	10
	Female	8	11	6	9	11	10	5	5	6	6	5

Source: OPCS series DH2, Mortality Statistics.
*Death for ages over 28 days.

Table 10 Notification rate for measles and whooping cough in England and Wales (rate/1000 population)

Cause	Age (years)	1988	1989	1990	1991	1992
Measles	<1	10.4	6.2	4.3	3.9	3.5
	1-4	13.2	4.1	2.1	1.5	1.4
	5-9	10.5	2.4	0.8	0.4	0.5
Pertussis	<1	1.0	2.0	2.3	0.9	0.5
	1-4	1.0	2.0	2.3	0.8	0.3
	5-9	0.5	1.2	1.8	0.6	0.2

Source: OPCS series MB2, *Communicable Disease Statistics*.

Table 11 Notifications of congenital malformations in England and Wales (rate/10000 total births)

Cause	1985	1987	1988	1989	1990	1991
All babies	202	198	187	180	116	102
Central nervous system malformations (E320-E359)	11.0	7.5	7.3	6.2	5.1	4.6
Anencephalus (E740)	0.9	0.5	0.6	0.5	0.4	0.3
Spina bifida (E741)	5.5	3.1	2.3	2.0	1.7	1.5
Hydrocephalus, not with spina bifida (E742.3)	2.0	1.7	2.0	1.6	1.3	1.5
Malformations of heart and circulatory system (E390-E459, E745-E747)	13.2	13.5	10.4	11.9	8.6	8.2

Source: OPCS series MB3, *Congenital Malformations Statistics*.

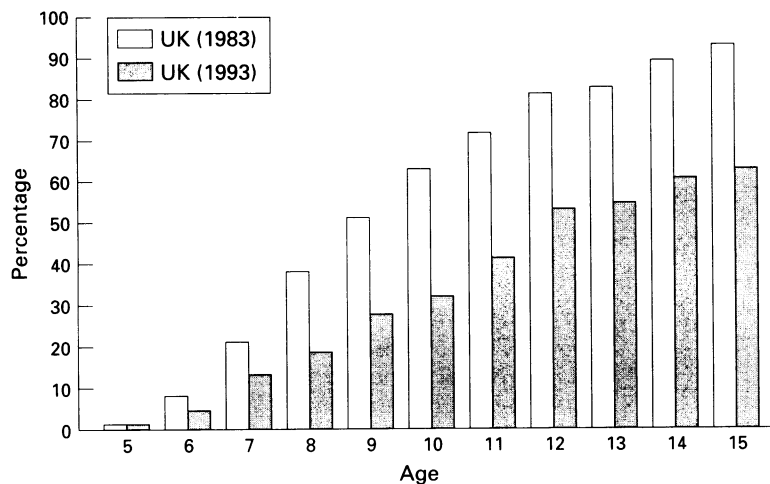


Figure 6 Percentage of children with any decay experience in the UK for the years 1983 and 1993. (Source: OPCS Monitor, SS94/1.)

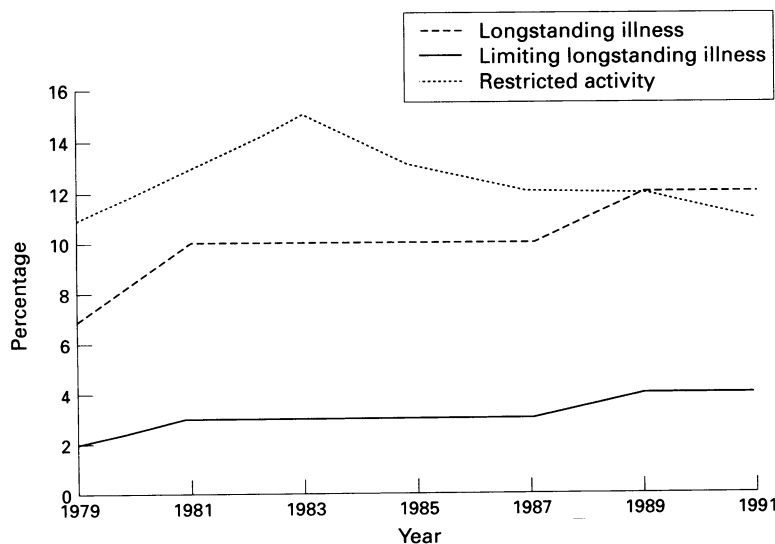


Figure 7 Trends in self reported sickness 1979-91 in Great Britain age 0-4 years. (Source: GHS.)

PERTUSSIS

In 1991 pertussis immunisation had risen to 88%.² Changes in pertussis notification rate (table 10) are now due to natural cyclical variation which is characteristic of many infectious diseases.

In 1990 there were six deaths from pertussis, all in children under 4 months of age. In 1991 when the immunisation schedule was accelerated there were no deaths.

Morbidity

CONGENITAL MALFORMATIONS

The birth prevalence of congenital malformations continues to improve (table 11). This is only partly attributable to improved antenatal diagnosis and therapeutic termination. Malformations of the heart and circulatory system remain the commonest congenital malformation.

DENTAL HEALTH

A survey of the dental health of 17 000 UK schoolchildren was carried out in 1993.³ Previous surveys covering the UK were carried out in 1973 and 1983. The survey revealed that the dental health of all age groups has improved since 1983. The proportion of children with active decay in permanent dentition has reduced as has the proportion of children with filled or extracted permanent teeth.

The proportion of children with any decay experience is measured by the sum of decayed, missing, or filled teeth. Although dental health has improved, over 60% of children in the UK have some decay experience by the age of 15 years (fig 6). Most of this decay occurs before the children become teenagers.

SELF REPORTED SICKNESS

The General Household Survey (GHS) has included questions on self reported health since 1971. For children the questions are addressed to the person responsible for them. The GHS defines chronic sickness to be longstanding illness, disability, or infirmity. Those people who report longstanding illness are also asked if it limits their activities in any way. Acute sickness is defined as the restriction of normal activities, as a result of illness or injury, during the two weeks before interview.

It should be noted that these measures are based on people's subjective assessment of their health, and may show temporal change as expectations vary. Additionally, certain symptoms are more troublesome in particular age groups, which may lead to variations in the effect of an illness and the reporting of whether such an illness is limiting or not. However, perceptions of health status are important in influencing demand for health services.

The most noticeable result from this survey is the increase in longstanding illness, accompanied to a lesser extent by an increase in limiting longstanding illness, in childhood (figs 7 and 8). In those under 5 years acute illness is showing a downward trend since a peak

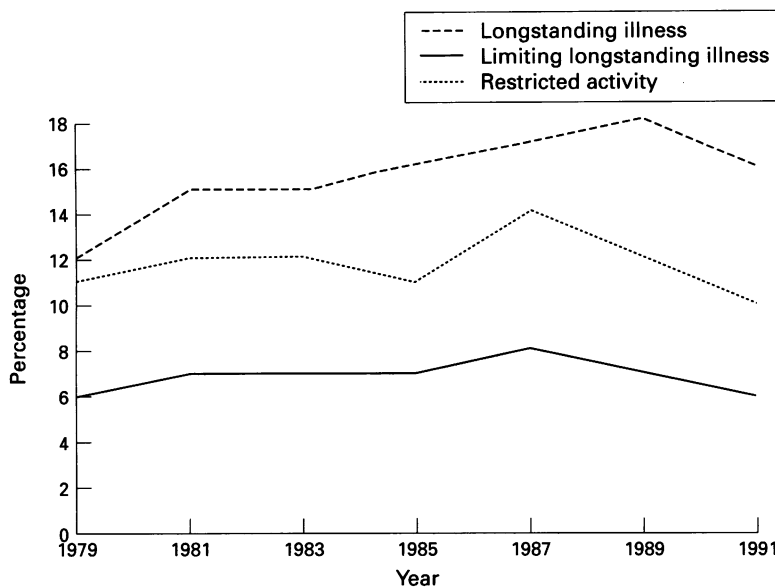


Figure 8 Trends in self reported sickness 1979-91 in Great Britain age 5-15 years. (Source: GHS).

Table 12 Average number of NHS GP consultations/person/year in Great Britain

Age (years)	1976	1979	1982	1985	1987	1989	1990	1991	1992
0-4	4	5	7	7	8	8	8	7	7
5-15*	2	2	3	3	4	3	4	3	3

Source: GHS, No 23.
*This age group was 5-14 from 1976 to 1978.

Table 13 Location of NHS GP consultations: percentage of persons consulting a doctor in the 14 days before interview, by age and site of consultation in Great Britain

Age (years)	1973	1976	1978	1980	1983	1986	1988	1990	1991	1992
Surgery										
0-4	67	71	72	75	81	84	82	80	84	87
5-15*	80	73	79	81	86	83	86	84	86	84
Home										
0-4	30	24	20	18	16	13	15	12	12	12
5-15*	17	21	13	13	9	7	8	8	9	6
Telephone										
0-4	8	9	14	13	9	6	13	7	9	10
5-15*	7	12	14	12	8	11	9	8	10	12

Source: GHS.
Percentages add up to more than 100 because some people consulted at more than one site during the reference period.
*These age groups were 5-14 and 15-44 in 1973 to 1978.

Table 14 Ordinary and day case admissions in England

Main speciality function	Financial year	Ordinary admissions	Day case admissions	Total	Day case as a % of ordinary admissions and day case admissions
Paediatric dentistry	88-89	772	1 003	1 775	57
	89-90	711	1 181	1 892	62
	90-91	542	1 380	1 922	72
	91-92	620	6 581	7 201	91
	92-93	917	5 999	6 916	87
Paediatric surgery	88-89	38 667	7 462	46 129	16
	89-90	42 034	8 144	50 178	16
	90-91	37 840	9 391	47 231	20
	91-92	35 487	11 273	46 760	24
	92-93	34 768	13 352	48 120	28
Paediatrics	88-89	939 591	14 279	953 870	2
	89-90	1 003 568	12 645	1 016 213	1
	90-91	1 038 758	12 242	1 051 000	1
	91-92	1 045 543	15 658	1 061 201	2
	92-93	1 017 371	18 579	1 035 950	2

Source: Department of Health, Statistics Division 2.

in the early 1980s. There does not appear to be any significant change in self reported acute illness in the 5-15 age group. The data do not allow analysis of the cause of these trends.

PRIMARY CARE ACTIVITY

The GHS has also collected information relating to primary health care activity since 1971. The survey indicates there has been little change in the average number of general practitioner (GP) childhood consultations since 1982 (table 12). This is surprising in view of the increase in self reported illness. The contrary trends in self reported acute and chronic illness may account for the stability of GP consultation rates.

Although there has been little change in the numbers of GP consultations, there has been a reduction in the number of GP home visits and a reciprocal increase in consultations within the surgery (table 13).

HOSPITAL ACTIVITY

Since 1988 the total number of completed consultant episodes for paediatric surgery and paediatrics has increased by 4% and 9% respectively (table 14). In comparison, the total number for paediatric dentistry has increased fourfold. There has been a marked increase in the number of paediatric surgical and dental day cases. Day case paediatric surgery has almost doubled while day case paediatric dentistry has increased sixfold. The reciprocal trends in paediatric surgery, ordinary admissions, and day cases indicate that the policy of minimising admission of children to hospital is having an effect.

The increase in paediatric dental surgery is likely to have been caused by the introduction of the new contract for general dental practitioners in October 1990. This replaced 'fee per item of service treatment' with payment on a 'capitation' basis. The publication of the Poswillo report in March 1990 highlighting the need for improvements in general anaesthesia will also have an effect on dental practice.

Socioeconomic indices

SMOKING

The Social Services Division of the Office of Population Censuses and Surveys (OPCS) carries out a biennial survey of smoking among secondary schoolchildren. The survey covers all types of secondary school and estimates the prevalence of smoking in children aged 11-15 in England, Scotland, and Wales. By the age of 13 years, 8% of boys and 11% of girls are smoking. The female/male differential persists such that by the age of 15 years 27% of boys and 32% of girls are smoking.

POVERTY

The part played by poverty in affecting child health always bears re-emphasis. A variety of indicators are showing an increasing gap

Table 15 Usual gross weekly household income for families with dependent children* by family type (%) in Great Britain 1992

Family type	Usual gross weekly household income						
	£0.01- £100.00	£100.01- £150.00	£150.01- £200.00	£200.01- £250.00	£250.01- £300.00	£300.01- £350.00	£350.01 and over
Married couple	4	7	6	7	9	8	59
Lone mother	42	21	11	7	6	3	11
Single	54	15	8	4	4	4	12
Widowed†	[16]	[12]	[4]	[24]	[16]	[0]	[28]
Divorced	33	26	18	6	6	3	9
Separated	41	26	7	10	7	1	9
Lone father	23	10	12	10	10	8	8
All lone parents	40	20	11	7	6	3	12

Source: GHS, No 23.

*Dependent children are persons aged under 16, or aged 16-18 and in full time education, in the family unit and living in the household.

†These results are based on a sample size of under 50 respondents.

between the haves and have nots. There is a vicious cycle of the effect of poverty on health with children bearing the brunt of the adverse outcomes.

Income is a major determinant of poverty. Of married couples with dependent children, 59% have a joint income above £350/week while 11% have an income less than £150/week (table 15). In the case of lone parent families the pattern is reversed, with 60% having an income of less than £150/week. In particular 63% of lone mothers, who account for most of the one parent households, are having to care for dependent children with an income of less than £150/week.

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- 1 Department of Health. *The health of the nation: strategy for health in England*. London: HMSO, 1992.
- 2 Department of Health, Welsh Office, Scottish Office Home and Health Department, DHSS (Northern Ireland). *Immunisation against infectious diseases*. London: HMSO, 1992.
- 3 OPCS. *Dental caries among children in the United Kingdom in 1993*. (OPCS Monitor, SS94/1.) London: OPCS, 1994.