then treatment should begin when the risk of AIDS is high—that is, when the CD4 count falls below $0{\cdot}35\times10^9$/l.[10] If the benefits of zidovudine operate for longer in the asymptomatic phase then treatment of patients with counts above this should also be considered.

The Anglo-French (Concorde) study, which is due to continue for at least another six months, may help to resolve the dilemma.[3] If survival is similar in these two groups the relative merits of extending life expectancy during the asymptomatic phase compared with extending life expectancy when symptoms have supervened are likely to be a matter of continuing debate. This controversy will be fuelled by the recent publication from the Veterans Affairs showing no apparent survival benefit with early, as opposed to delayed, treatment.[16]

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# Marital breakdown and health

## *More than a broken heart*

Should the government adopt marital breakdown as one of the key areas in its strategy for improving the health of the nation?[1] One plus One, an organisation dedicated to "marriage and partnership research," argues that the question deserves careful consideration by doctors and the government, traditionally reluctant to accord social factors an important role in health. Its publication, *Marital Breakdown and the Health of the Nation*,[2] marshals detailed epidemiological evidence for a link between breakdown in relationships and poor physical and mental health and consequent increased mortality.

That divorcees of all ages and sexes are at greater risk of premature death than married people has been shown for every country with accurate health statistics for all ages and both sexes.[3] For men between the ages of 35 and 45 the risk is doubled.[4] Statistics from general practice also show a consistent overall increase in morbidity among divorcees compared with married people.[5]

This morbidity may result from stress and loss, increased susceptibility to disease, smoking and drinking, and psychological symptoms. Psychiatric consequences of marital breakdown include mainly affective and anxiety disorders, parasuicide, and misuse of alcohol. When the commonest cases of death are investigated divorcees, especially men, are shown to have higher mortality from cardiovascular and cerebrovascular disease,[6] cancer,[7] suicide,[8] and accidental death.[9]

The impact on the health of children of divorced parents is especially severe, with a higher risk of ill health from the time of parental separation until adult life; children under 5 when their parents divorce are especially vulnerable. Children of divorced parents are much more susceptible to subsequent psychiatric illness. Those whose parents have divorced are more likely to become divorced themselves.

Although an association between marital breakdown and subsequent ill health seems incontrovertible, the claim for a causal relation is less secure. Disturbed relationships resulting in separation or divorce; increased smoking and drinking; and physical illness associated with increased mortality may all result from affective or neurotic disorders.[10-12] Suffering from a potentially lethal illness may be the immediate precipitant of divorce in some cases. Sorting out what is cause and what is effect is therefore likely to be extremely complicated. And further questions arise. Which has the greater adverse effect on health—the emotional effects of the breakdown in relationships or the socioeconomic consequences of the changed legal status?

The more a form of behaviour deviates from current social norms the more likely are its perpetrators to differ from the rest of the population. Thus as marital breakdown, with separation and divorce, has become more common the differences in ill health experienced by divorced and married people compared with other people may have diminished. Some of the references quoted in *Marital Breakdown and the Health of the Nation* date from the 1960s and '70s, and replication of the studies now would provide valuable information on the importance of the breakdown of relationships to ill health. More recent studies, however, still show substantially better health status for those in continuing relationships.

If most of the data on which these authors base their polemic are well known and well validated and point so clearly to the advantage of marital over divorced status why has this not been more generally acknowledged and included in health education? The answer, once again, is complex—lying partly in doctors' insistence on accepting new evidence only when it is thoroughly proved and their reluctance to accept information that has practical bearings on individual behaviour. (Cigarette smoking and alcohol misuse spring immediately to mind.) Whereas the faintest suspicion of risk

from a drug will immediately preclude its use, evidence that affects our social behaviour has to be overwhelmingly obvious before it is acted on.

The authors make four recommendations for preventing marital breakdown and promoting good health. These are undertaking more research into the factors that cause strain in family relationships and what can be done to help; educating teenagers in personal relationships; making early intervention available for people with problems with relationships, giving them greater access to counselling, including that from trained general practitioners; and integrating health and family policy within a single government department. The first three points merit strong support; so would the fourth if it would truly provide a better service to those in need.

It should also be remembered that, although *The Health of the Nation* was presented to parliament by the Secretary of State for Health, most of the other government departments had made explicit or implicit contributions to its content. Shouldn't some of these departments be enlisted to improve the health of the nation through dealing more effectively with the antecedents and consequences of the breakdown in relationships? Fiscal measures, the law, housing, and employment are all relevant.

Doctors would do well to recommend that the government should consider carefully the link between marital breakdown and the ill health of the nation. The evidence for an association is irrefutable even though identifying causative factors is more difficult.

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# Private practice

## *Troubled insurers prepare to pass the buck*

All health insurers are receiving more frequent and more expensive claims from their subscribers. This has reduced their surpluses and in some cases led to record underwriting losses that have had to be met from reserves.[1] For the moment the haemorrhage has been staunched by increases in premiums substantially above the rate of inflation.[2] But what will be the consequences of these increases? Can the insurers weather the storm, and what will happen in the long run?

The key questions are whether the current price increases will lead to reduced demand and, if so, by how much? (In the language of economics: "What is the price elasticity of demand for private health insurance?") Estimation is difficult because of background changes in people's disposable income and in the perceived availability of alternatives, chiefly NHS treatment. The influence of these two factors over the past 35 years has ensured that despite a twofold increase in the real price of health insurance there has been a ninefold increase in the number of people covered.[3] The picture is also confused by a steady shift away from personal insurance towards large companies insuring their employees. A benefit that has been given to employees is hard to withdraw, and overall demand from this sector of the market is unlikely to be very sensitive to price rises (although, of course, demand for an individual insurer's products is highly sensitive to price, with corporate customers and their brokers regularly seeking fresh quotations).

In the personal sector, where the decision to lapse would affect only the person making it, we might expect greater elasticity. But the evidence does not support this: even when personal insurance made up almost the entire market there was a sustained growth in numbers insured despite real price rises. For example, between 1955 and 1962, although the real price rose by half, the number of people insured doubled.[3] If the market has proved so inelastic in the past are the current increases in premiums irrelevant?

Several factors suggest that this time they could be more significant. Firstly, superimposed on the steady increase in both price and demand over the past 35 years it is possible to show some short run elasticity in the market. For example, from 1974 to 1977 the price of private medical insurance increased by 35% above inflation and the number of subscribers fell slightly.[3] Many personal subscribers to the larger companies have experienced a price rise of similar size in the past 12 months alone. If they do not wish to lapse entirely they have the option of trading down to an insurance plan with more restricted benefits, reducing income to insurers, hospitals, and doctors alike.

Secondly, personal subscribers who lapse or trade down will tend to be the healthier ones. Anyone with chronic illness or early symptoms of disease is less likely to reduce insurance cover. This will increase the claims made on the insurers yet further—leading to still greater rises in premiums. Another reason for concern about the insurers' present situation is that although most corporate clients are unlikely to stop buying cover for their employees, the recession is forcing many to reduce their workforces or is putting them out of business entirely. Either way, the number of subscribers will fall. Finally, if the government's health service reforms are successful in reducing waiting lists and improving the quality of service, or are successful in creating the perception that they are doing so, any economically induced fall in the level of private health insurance may become a permanent one.

What would be the consequence for consultants with private practices of a fall in the number of subscribers? In most industries a drop in demand results in increased competition and falling prices. This will not happen spontaneously in private health care, mainly because price is not a major influence on those who choose the consultant—patients or, more usually, their general practitioner. Moreover, prices are to some extent maintained by the BMA's scale of charges. So