

BRITISH MEDICAL JOURNAL

LONDON SATURDAY 27 OCTOBER 1973

Free Milk from the Sacred Cow

The Government's decision to cut back on the provision of cheap milk for pregnant mothers and children below school age and to abolish the provision of free milk for school children over the age of 7 met with a good deal of anger and resentment when it was first announced by the Chancellor of the Exchequer on 27 October 1970. Indeed, so loud were some bellows of rage heard in the House of Commons that one might have been forgiven for thinking that the cows providing this milk were sacred. The further announcement that the Government also intended to abolish, in stages, the 40% subsidy on the cost of school meals as part of its new policy for public spending¹ served only to heighten the controversy, and in an attempt to fend off criticism the Government announced that it would monitor the effect of the proposed change.² A subcommittee of the Chief Medical Officer's Committee on Medical Aspects of Food Policy was therefore charged with the task of trying to detect any nutritional effect of this change of policy at a time when any harmful effect was still "likely to be mild and reversible."

Now, however, after an interval of nearly three years, the publication of the first report from this committee³ has passed almost unnoticed. (Such is the anodyne effect of appointing an expert committee and the ephemeral nature of much political controversy). The committee concludes that changes in birthweight and perinatal mortality and records of height and weight during childhood, supplemented by a dietary survey, are likely to provide the most objective and sensitive national index of the adequacy of nutrition during pregnancy and childhood. Unfortunately, while annual data on perinatal mortality are available, data on their relationship to birthweight, gestational age, and social factors are lacking. Furthermore, the records of height and weight at present obtained by the school health service are seldom sufficiently detailed or accurate to be of value in this context. Hampered by this lack of baseline data, the committee has initiated some prospective surveys specially designed to allow for the fact that only a proportion of children may be at risk and that the change it was monitoring had already taken place. No conclusions are likely to emerge for at least another two years.

It has been shown both in Great Britain^{4,5} and in the U.S.A.⁶⁻⁸ that the addition of supplementary milk to an otherwise free diet can accelerate the growth of children.

Lord Boyd-Orr once defined optimum nutrition as that state of nutrition which is not susceptible of improvement by the addition of any dietary supplement,⁹ and when E. M. Widdowson and R. A. McCance failed to increase the rate of growth of the German refugee children they had on a special experimental diet by offering supplementary milk they concluded that the experimental diet was probably optimal already.¹⁰ The subcommittee, however, drew back from any direct trial of dietary supplementation in children and decided to rely almost exclusively on an epidemiological approach. It may have had excellent reasons for coming to this conclusion, but it has not outlined them convincingly. To complain that it would be difficult to set up such tests is beside the point when deciding whether or not it is desirable to continue spending more than £9 million a year on free school milk, and to say that the results are likely to be equivocal would, in the light of previous reports,⁴⁻⁸ appear to be prejudging the issue. The committee is also alive to the growing problem of childhood obesity,^{11,12} and here its prospective anthropometric survey of preschool as well as primary school children should yield epidemiological information of great value.

Age at menarche is closely linked to other aspects of growth and physical maturation, and it is known to be delayed by undernutrition.¹³ Menarchal age appears to have been falling steadily for almost a century¹⁴ but a recent report indicates that this trend may have been halted in girls born since 1946, or even perhaps reversed.¹⁵ It is often suggested that the secular trend in stature and menarchal age is partly, if not largely, due to improved health and nutrition. If it is, the committee might profitably consider ways of documenting this landmark of adolescent developments more adequately. Is the nutrition of children in this country conceivably less good than it was during the last world war?

The school meals service has a long and distinguished history,¹⁶ and benefits in kind can sometimes do more than cash to relieve child poverty. We therefore need to know why nearly 200,000 children entitled to free meals are not taking up this option,³ and we also need to know more about the nutritional value of the mid-day meal eaten by the 3 million children who do not eat a school dinner each day, as, from figures made available to the committee,³ it is clear that the proportion of children taking a school dinner fell

by 20% when charges last went up and had not fully recovered 18 months later. The meals were started to ensure that children were capable of benefiting from the education they were being offered,¹⁶ and their continued relevance should be judged on this basis. Viewed in this light the timing of meals is in many ways as important as overall nutrition, since the child who arrives at school without breakfast, gets no morning milk, and eats an unsatisfactory lunch cannot be expected to give of his best in class. The school medical service is in no position to judge which children would benefit from help of this nature.

The committee says little about long-term surveillance, preferring to wait until it has gained experience from the surveys now in hand. But it is clear that no useful cost-benefit analysis of the Government's social welfare policy can be achieved without a long-term survey capable of providing information before as well as after change is initiated, and it is good to see that the committee intends to return to this theme in its next report. Fact needs to replace opinion if we are ever to achieve better value for money. Whether one considers the welfare cow sacred or not is largely a matter of political persuasion: such differences should not prevent us from uniting to exercise wise husbandry and secure the economic distribution of the animal's limited milk. If 1% of the money now spent on subsidizing school meals was made available to the committee, it would be possible to spend £1 million a year on survey work.

That there may still be room for improvement in childhood nutrition is apparent from recent reports that children of social class V born in 1958 were, on average, 3.3 cm shorter than children from social classes I and II at the age of 7, and that low birthweight and large family size are as important influences as the more obviously genetic effect of maternal height.¹⁷ Differences in stature actually increase in later childhood and, since the effect of family size on stature is greater in the poorer families, it is widely assumed that differences in nutrition contribute to the difference in stature.¹⁴ Only a large-scale Government-backed social experiment could finally establish whether nurture rather than nature and heredity is responsible for this difference. And it would seem to be an experiment that must eventually be undertaken by any Government pledged to tackle the cycle of deprivation¹⁸ that so concerns the Minister of Health and Social Security, Sir Keith Joseph,¹⁹ because mental attainment may well be compromised as much as stature.

"If one has seen a plant or animal in only one environment, all one knows about its genetic constitution is what it can do in that environment and not what it may do, or not do, in any other."²⁰

¹⁶ Clark, F. le Gros, *Social History of the School Meals Service*. London, National Council of Social Service, 1948.

¹⁷ Goldstein, H., *Human Biology*, 1971, 43, 92.

¹⁸ Birch, H. G., and Gussow, J. C., *Disadvantaged Children*. New York, Harcourt, Brace and World Inc., 1970.

¹⁹ Joseph, Sir K., speech to the National Association for Maternal and Child Welfare, 27 June 1973.

²⁰ Leitch, I., *British Journal of Nutrition*, 1951, 5, 142.

Too Little Time

Most doctors so far have been barely touched by the forthcoming change in the health services. Not so other staff, some of whom seem to be suffering from quite a buffeting.¹ London, apart from its general labour shortage, has faced specially difficult problems in reorganizing its health services. So much so, in fact, that the Secretary of State eventually imposed a new administrative pattern because agreement could not be reached between the conflicting health interests. But there have been danger signals from elsewhere,^{2,3} and evidently even outside the metropolitan areas, which have the greatest difficulties, all is not well. A joint liaison committee in East Anglia, for example, reports on overwork and insecurity among senior staff and consequent staff shortages.

Part of the trouble is that a politically inspired timetable, geared to parallel local government reform, has left the N.H.S. too little time for a smooth changeover. The talking has extended over several years but the action is expected to take place in England and Wales in a little over six months. Scotland was fortunate in having a little longer, and Northern Ireland has already reorganized its health services. The health departments have made a big effort to keep everyone informed, and facts, advice, and instructions are tumbling out. Nevertheless N.H.S. staff have to execute the changes for April 1974 while at the same time continuing the existing services, a formidable task. Joint liaison committees, which are interim bodies representative of all local health interests, have been working hard during the year collecting information and local opinion and laying plans for the transition. But only shadow authorities have the power of decision, and though membership of these at regional and area level is well on the way to completion (Wales and Scotland are already complete) with barely five months to "D" day only a relative handful of staff appointments have been announced, and, Scotland excepted, none of these have been medical. Regional health authorities and many area health authorities have already been meeting, but their work must be handicapped by lack of senior staff.

The doctors most concerned now in the reorganization are those in local authority services and regional hospital boards, many of whom are already enmeshed in the selection procedures for area and regional authority positions. District appointments are to follow. This is a time of great uncertainty for them, and for the more senior medical staff it has been aggravated by the Government's equivocation over early retirement procedures, which has even prompted a question in the House of Lords about the position of senior N.H.S. staff. The Government has partly given way to the B.M.A.'s protests on the original proposals,⁴ which the profession had thought unreasonable. Nevertheless, this is an unhappy example of maladroitness by the Department of Health of a matter which clearly has implications for recruiting medical staff.

¹ Treasury, *New Policies for Public Spending*, Cmnd. 4515. London: H.M.S.O., 1970.

² *Hansard*, 14 June 1971, cols. 42-167.

³ Department of Health and Social Security, *Reports on Health and Social Subjects*, No. 6. London, H.M.S.O., 1973.

⁴ Orr, J. B., *Lancet*, 1928, 1, 202.

⁵ Leighton, G., and Clark, M. L., *Lancet*, 1929, 1, 40.

⁶ Roberts, J. L., Blair, R., Lenning, B., and Scott, M., *American Journal of Diseases of Children*, 1938, 56, 287.

⁷ Spies, T. D., and Dreizen, S., *Journal of Pediatrics*, 1949, 34, 393.

⁸ Spies, T. D., Dreizen, S., Snodgrass, R. M., Arnett, C. M., and Hamilton, W. P., *American Journal of Diseases of Children*, 1959, 98, 187.

⁹ Orr, J. B., *Food, Health and Income*, 2nd ed., p. 7. London, MacMillan, 1937.

¹⁰ Widdowson, E. M., and McCance, R. A., *Medical Research Council Special Report Series*, No. 287, Part II. London, H.M.S.O., 1954.

¹¹ *British Medical Journal*, 1973, 2, 727.

¹² *British Medical Journal*, 1973, 3, 122.

¹³ Frisch, R. E., *Pediatrics*, 1972, 50, 445.

¹⁴ Tanner, J. M., *Growth at Adolescence*, Chapter 5. Oxford, Blackwell, 1962.

¹⁵ Dann, T. C., and Roberts, D. F., *British Medical Journal*, 1973, 3, 265.