however. Wholegrain bread was produced by nearly a quarter of German bakeries by 1943, compared to only 1% in 1939, following appeals from the health Führer Len- onardo Conti that wholegrain bread should be eaten "for the benefit of individual health and the health of the nation." 

The legacy of healthy eating campaigns are even less easy to discern than those of the anti-smoking campaigns. Germany has an overall mortality picture which is unfavourable given its high gross national produc- tion and Nazi campaigns against alcohol, against smoking, against animal fat, and in favour of fruit and vegetables, wholemeal bread and milk which were marketed particularly at the same youth who are now the generation contributing substantially to national mortality rates – had no discernible long term impact. Indeed the postwar legacy may have been unfavourable, with the Pres- squelle ("wave of gussling") which followed the deprivations of war having adverse conse- quences with respect to obesity and obesity related diseases.16

Fertility
Proctor also comments on our reference to Martin Gumpert, who intimated that the Nazi campaigns to increase fertility were failing. Gumpert managed to escape from Germany before war began and did much to advertise the level of misery in Hitler's state. His book Hail Hunger was an attempt to demonstrate that a popular contemporary view – that the Nazis had improved health in Germany – was incorrect and widely quoted outside of Germany and appears to have been an effective intervention. When discussing the fertility campaign Gumpert was referring to the later stage of the "battle for births", rather than its early days. As Proctor points out there was an increase in the birth rate and marriage rate immediately following the im- position of the Nazi rule. The birth rate in- creased from 15.1/1000 in 1932 to 18.9/1000 in 1936.14 But, this should be seen against the decline which preceded it. From a rate of 35.6/1000 in 1900 the fertility rate declined to 31.6/1000 in 1910, 26.8/1000 in 1914, 20.3/1000 in 1925 and 17.5/1000 in 1929 and by the early 1930s it had reached an all- time low.13 Seen in this light the "success" of the pronatalism campaign was modest.11,14

Interest-free marriage loans were offered from 1933, and many couples had passed tests of political and eugenic reliability. Family allowances, with one-off payments at the birth of each child, and propaganda intended to encourage working women to return to the home to raise children.13 Increasing legal sanctions against abortion were imposed, culminating in the death penalty in social law and by the early 1930s it had reached an all- time low.13 Seen in this light the "success" of the pronatalism campaign was modest.11,14

Legacies of Nazism
The legacies of Nazism in contemporary Ger- many are complex and contradictory.15 A moti- vated systematic rejection of the Nazi period can be seen in everything from functional architecture, the staid and apologetic nature of universities and television, the desire for press freedom even when it produces the embarrassment that is Bild (Europe's biggest selling newspaper, which can on occasions make the English Sun read like New Left Review), and consensus Government, through to the more extreme and obvious counter-reaction to the Nazi period by the Baader-Meinhof Group and Red Army Fac- tion,16 or the alternative living situations in squats of many German cities of the Ausstiger and Spontis. Some commentators consider that through it all an intense sense of heir- formity remains.16 With these contradictions, the direct translation of policies enacted dur- ing the Nazi period into what has happened in Germany since the war is problematic, but then again so is simply ignoring history.
Tuberculosis among homeless people at a temporary shelter in London

SIR—Each year the charity Crisis sets up temporary Christmas shelters, not for “the homeless” but for homeless people. Kumar et al use the former term on 23 occasions in their report of a chest x-ray screening programme.1

Issues of concern were the high prevalence of tuberculosis and suboptimal management of known and presumed cases due to patient “denials”. These problems have been previously documented in a very similar group of homeless people in London during the mid 1980s.2 In the earlier survey, there was a noticeable association between tuberculosis and alcohol (ab)use,3 which may have an impact on treatment compliance. Data from the Crisis Open Christmas4 could perhaps be used to ascertain whether there was an association between “loss to follow up” and accommodation status of “no fixed abode” or self reported “regular alcohol consumption”.

The documented health care needs of single homeless, homeless and roofless people are multiple.4,5 The prevalence of mental illness noted by Kumar et al,6 low by comparison with other survey data,7 may have been significantly underestimated by selection or reporting bias.

A comparably wide range of accessible and acceptable health care provision therefore seems appropriate and is, indeed, a feature of most dedicated services for homeless people.8 Recommendations to improve current provision, based on specialist outreach respiratory/tuberculosis services, will have limited capacity to address important and potentially confounding morbidity.

The most effective means of delivering comprehensive health care to homeless people, including case finding and management of those with tuberculosis and their contacts, needs formal evaluation. However, the views of professionals in primary and community health services and in the voluntary sector, who best understand the motivating factors and influential social networks of works of homeless people, should not be overlooked. Indeed, the suggestion of patient held records was recently raised in The Big Issue.9

Reply

Dr Cheung points out correctly that the age–cohort model we used to estimate cohort life expectancy in Taiwan has an implicit assumption of constant age patterns across cohorts. Dr Cheung also explains why such an assumption is unlikely to be met, especially in a population under epidemiologic transition. I fully agree with his views.

In the context of age-period–cohort analysis, the problem of non-parallelism in age patterns has been explicitly addressed.23 Unfortunately, the proposed methodologies are a bit too complex for the present purpose. Instead of sorting to models with interaction terms, I feel that a practical solution to this problem may be to perform a “separate analysis”. For example, we can break down the data by age into, say, “childhood”, “adulthood”, and “elderly” group, each modelled separately, and then the results combined. By this method, different segments of the population assume different cohort trends. Alternatively, we can break down the all-cause data into their component causes, modelled separately and then combined—an approach suggested in our paper.1 Clearly, such an approach pays due respect to the different roles of communicable and the non-communicable diseases during the epidemiologic transition. However, the benefits we gain from these more “sophisticated” approaches must be weighed against what we can infer from “crude” but “simple” age–cohort modelling as shown in our paper.

Finally, Dr Cheung has stated that the assumption of parallelism is not met in our data after the 1961 cohort. I wish to point out that we also refute the results after 1961, though for a different reason.

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Figure 1 Age specific mortality rates in selected cohorts in Taiwan. The 1941 curve is close to the 1951 curve. It is excluded to avoid visual confusion. The legends mid-points of the five year cohorts.