



Deaths in the first year of life and perinatal mortality and stillbirth rates, England and Wales 1965-86.

mortality rates are based on many fewer deaths than the rates for England and Wales as a whole and thus are much more prone to yearly fluctuations.

This applies also to Scotland, where total births each year are around a tenth of those in England and Wales. In 1986 the trends in Scotland were the reverse of those in England and Wales, showing a rise in perinatal mortality and a fall in mortality in the rest of the first year of life. The Chief Medical Officer's report commented, "The overall downward trend continues, although at these relatively low rates year to year fluctuations may be observed."¹¹ Closer inspection showed, however, that the upward fluctuation in perinatal mortality was confined to multiple births and also that the twinning rate had increased in 1986.¹²

It is premature to look for specific reasons why post-neonatal mortality rose in England and Wales in 1985 and 1986 after falling in 1983 and 1984. So far only the overall mortality rates have been published, and we must await tabulations by factors such as certified cause of death, social class, and mothers' country of birth and analyses by season of birth and death. In the light of the Scottish experience we should also take account of the rise in the incidence of multiple births,^{13 14} which was particularly steep in 1986. It is also wise to allow statistically for the fact that many babies who die in the postneonatal period in a given year were born in the previous year so that the conventional denominators are not wholly right.¹⁵

It is not too soon, however, to make some general points. While socioeconomic circumstances may affect mortality at all stages during the first year of life, early neonatal mortality is also closely linked to the quality of maternity and neonatal care. Whether the slowing down of the fall in mortality in this age group reflects pressure on the maternity services or whether the potential for further reduction through improv-

ing maternity care is now limited is not clear. Interpreting statistics for this age group has become more difficult because of the increasing tendency for very tiny babies, who in the past would have been regarded as miscarriages, to be given intensive care. As a result they are now also included in registration and notification statistics.¹⁶

Internationally countries with lower perinatal and infant mortality rates than ours tend to have a lower proportion of low birthweight babies and a lower incidence of lethal congenital malformations. There is a strong association between adverse socioeconomic conditions and both low birthweight and some lethal malformations.⁵

In contrast, although mortality in the postneonatal period possibly includes an increasing number of babies who die after long periods of neonatal care, postneonatal mortality is much more a reflection of parents' wider social and economic circumstances.¹⁷ Thus the rise in infant mortality in 1986 is more likely to be associated with public health problems than with the distressing waits for paediatric operations. Once death registration data have been thoroughly analysed, we may have to ask about the impact on babies' health of poor housing conditions, low pay, and unemployment. Although caution is essential when interpreting statistics and asking these questions, there are no grounds for complacency.

ALISON MACFARLANE

National Perinatal Epidemiology Unit,
Radcliffe Infirmary,
Oxford OX2 6HE

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Acheson: a missed opportunity for the new public health

The reason for establishing the Acheson committee's inquiry into public health in England was the failure to respond adequately to two major outbreaks of communicable disease. The committee immediately saw that behind these failures lay a broader crisis in the practice of public health by community physicians. Many of its practitioners had been unable to adapt effectively to the new era of public health with its much greater emphasis on promoting good health

and preventing non-infectious disease. The successive stripping away of functions from local authority public health departments and the siting of community physicians and preventive medicine in health authorities after 1974 had contributed to the confusion and had weakened the professional response. For many the advent of general management to the National Health Service in 1982 was the coup de grâce.

The committee's report is summarised on p 303. It enthusiastically embraces the World Health Organisation's strategy of health for all with its commitment to reducing inequalities in health by reorientating medical care towards health promotion and prevention. Public participation and an intersectoral approach, which are central to this strategy, are essential if the view is accepted that most health is gained and lost outside medical services. Yet in moving from diagnosis to recommendations for action the committee has failed to take account of its own assessment. The result is a document that is overinfluenced by the self interests of community physicians and environmental health officers and that largely ignores the part to be played by the general public and the voluntary sector; initial misgivings about the composition of the committee appear to have been justified.

The committee proposes that district and regional health authorities should have directors of public health who will be issued with clear guidance on their responsibilities by the Secretary of State, will set targets, and produce an annual report. It is assumed that by meeting regularly with the chief environmental health officer the district director of public health will be able to coordinate an intersectoral approach. There is little to justify such a belief, and the outcome is likely to be a consolidation of the traditional professional and technical approach to public health; many of the actors will be the same ones who have resisted attempts by community and self help groups to participate fully in public health programmes. They will include those community physicians who have been unable to deliver effective programmes in, for example, family planning, immunisation, cervical screening, and accident prevention—all programmes that have been failures in Britain compared with in other countries.

It is ironic that the committee should be proposing this model at the very time when local authority vigour in tackling health problems is increasing and when so many local authorities are establishing real intersectoral committees along the lines recommended in the WHO's healthy cities project.

Superficially, the creation of a district control of infection officer seems a good idea. On closer examination, however, what is being proposed appears to have been heavily influenced by a treatment rather than a prevention approach. The suggested membership of a district control of infection committee includes a health authority member, an environmental health officer, a general practitioner, a microbiologist, a control of infection nurse, a local representative of the Public Health Laboratory Service, a senior infectious disease specialist, and a specialist in genitourinary medicine. Such a committee might be right for preventing infection in hospitals, but AIDS shows us that those members of the community most affected and the mass media are just as important as the technicians in preventing and combating the disease. The AIDS epidemic has shown up the anachronistic paternalism of traditional public health practice. This can be seen by comparing it with the success of the genuine partnership between community organisations and the public health department in San Francisco.

Almost hidden away in the section on public health legislation and reserve powers is the implication that with the change in responsibilities to an infection officer based in a health authority it would follow that powers should pass from local authorities to health authorities. This can be seen as yet a further attack on local authorities, which are democratically elected unlike the largely unaccountable and locally unresponsive health authorities. This recommendation is particularly poignant when we remember that the inquiry was established because health authorities failed to meet their responsibilities.

The report assumes that restoring annual reports will provide accountability and scope for health advocacy, but there is no evidence for this assumption. Community physicians are keeping their heads down and avoiding contentious issues that affect public health. Many are reluctant to reveal unmet need that will generate a further demand on shrinking resources. Exactly what will go into annual reports and how they will be handled is likely almost immediately to be subject to political interference; we only have to consider the increasingly propagandist nature of much of the work of health authority public relations departments. The demise of the Health Education Council and the recent experiences of community physicians suspended for offering contentious advice does nothing to assuage the fears of those who believe that those working in public health should be able to speak out at least as freely as policemen. The public health voice on behalf of the homeless, the unemployed, and the poor and in defence of the National Health Service has been muted.

Where the report is strongest is in its suggestions for an interdisciplinary unit within the Department of Health and Social Security to monitor public health, for proper regional epidemiological support, and for developing interdisciplinary education and training for public health. The suggestion of establishing schools of public health deserves to be given priority despite the cost implications. All across Europe schools of public health are opening and expanding: the Nordic School of Public Health in Gothenburg has doubled in size in the past year, and expansion is under way in the school in Zagreb, Yugoslavia; new schools have been started in Grenada and Valencia in Spain, and there are proposals for a school in Barcelona; and The Netherlands plans to start a national school. We need a new type of practitioner for a new public health. The new public health is about giving away knowledge, power, and skills; it is about enabling individuals and communities to take control of their own health. This requires a radically different training and style from the past with more input from social science and community development. In the new public health, professionals should be on tap not on top.

The best location for public health schools may not be in existing institutions and particularly not in those that are heavily biomedical in their orientation or which have no meaningful link with their host community or local authority. A polytechnic may be as good as a university and a department of adult education as good as one of community medicine or a school of hygiene. We may need to start again on neutral territory with a genuinely interdisciplinary and intersectoral directorate. One welcome legacy of the Acheson inquiry will be that the practitioners will be able to reclaim the name of public health for their work.

JOHN ASHTON

Senior Lecturer in Community Health,
University of Liverpool,
Liverpool L69 3BX