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Health workers and the lay public learned soon after the opening of direct contact between the People's Republic of China (PRC) and the United States of America (USA) that Chairman Mao Zedong had put "stress prevention" at the top of his health priority list. Yet, in the large amount of lay and scientific press reports subsequently produced about health in China, prevention and public health have received considerably less attention than clinical matters. In a sense this is not surprising—as one gets glimpses through a previously almost opaque curtain, dramatic features of popular interest will catch the eye first. Acupuncture turned out to be a fascinating mixture of science and myth, with scientifically demonstrated effects often confused by uncontrolled reports of therapeutic triumphs. The idea of the "barefoot doctor" caught the imagination, but once again there was difficulty distinguishing real accomplishments from unwarranted claims. Herbal medicines and other "natural remedies" received a sharp boost throughout the Americas, repeating the common error of not separating a certain amount of wheat from a large amount of chaff. Reports published in the USA reflected Chinese medical publications, which have been predominantly concerned with therapy in various forms, ranging from the simple to the highly sophisticated.

Thus, a real landmark in the US literature on China is represented by the supplement to this issue of the Journal, a comprehensive reivew of the health services in Shanghai County, a semi-rural area of some 500,000 people, just outside the urban limits of the huge city of Shanghai. The report is the outgrowth of a conference held in China July 6–10, 1981 under the USA/PRC exchange program signed in Peking in the summer of 1979.

The report represents a number of firsts. By wisely concentrating on a single, relatively homogeneous area, a reasonable goal was established for depth as well as breadth. Recognizing that a number of specialized areas needed attention, Chinese specialists in those areas were recruited for the conference and the report. In some instances, authorship is shared by Chinese health workers, in others Chinese-American cooperation is represented, and a few papers have only American authors. Achieving this kind of cooperative effort can not have been easy, and the editors, Alan Hinman and Robert Parker and their Chinese colleagues, deserve real credit and thanks for the accomplishment. Some areas of interest have not been previously described in anything like the specificity attempted here and rarely have such amounts of detailed data been presented on so many issues. Of particular importance is the relation of the various articles to a single setting, offering the chance to put the data in perspective. Since the data deal with the same broad population base one can draw some inferences on interrelationships, however tentative.

Almost all the papers contain new and interesting information. Many visitors to China have pointed out the need and the opportunity for sample surveys. The chapter on a health interview survey is thus revealing and informative on many aspects of health habits and the use of health services. The analysis of infectious disease morbidity likewise reports trends in a number of major diseases. Unfortunately, as is characteristic of much of Chinese medical literature, the specific numerical basis for

rates and graphs are not given. While specific details are presented in relation to schistosomiasis in 1953, later follow-up is reported in more general terms. The papers on health care organization, financing, and costs contain significant information not previously available, but they indicate also the principle noted by many visitors—there is a remarkable amount of decentralization and a great deal of local autonomy in providing health services in China.

Some words of caution are in order. Many of the previous papers on health services and health conditions in China have led to implications about the country as a whole, based on extrapolation and generalization from superficial observations. In this series, avoidance of superficiality has clearly been a goal, but despite the clear limits set by the editors some readers may fall into the trap of unwarranted generalization. Although it seems too obvious to need repeating, one must not forget the size of China. Five hundred thousand people (although greater than the national population of 20 members of the United Nations!) represent but five one-hundreths of one per cent of China's population. Furthermore, Shanghai County is next to one of the world's largest cities. The per capita income in Shanghai and environs is far more than the national average. There is some overlap of the urban and rural health systems in the Shanghai area, and the frequency with which rural workers may be recruited into the urban work force means that they may be involved in both health systems. Although many aspects of public health—such as the way disease surveillance is organized, the programs for environmental sanitation, and the multiple ways of organizing and financing personal health services—may be part of a general pattern, Shanghai County can hardly be considered representative of the People's Republic of China. Time and again, visitors from China have pointed out the heterogeneity of that vast country. Coldness and warmth, mountains and plains (only 11 per cent of the Chinese land area), aridity and humidity are all set in a country where self-sufficiency in food is based on an intensity of cultivation known in few other places in the world. Furthermore, 80 per cent of the population of the People's Republic is rural, and it is explicit national policy that the 80-20 ratio will be maintained.

The editors have been remarkably successful in covering many more aspects of public health than previous publications. Therefore it is no reflection on their effort to point out some of the things one would like to know more about. Nutrition action programs, dental public health, and food protection are examples, as are relationships to the schools in provision of health services and as an avenue for health education. One would also like to know more about the role of "political" and other local committees in the health education of the public and the effectiveness of their efforts.

Mental health is barely touched on. It would appear that in China, as in many health jurisdictions in the USA, mental health is carefully separated from other parts of public health. Moreover, in many revolutionary societies it is often claimed that mental illness is much less common. Indeed, visitors to China in the early 1970s often reported considerable difficulty in visiting institutions or services for the care of the mentally ill. Apparently, this problem is faced more openly now; consultants from abroad have been asked to help develop social psychiatry and community mental health programs. One may thus expect more information on mental health to appear in the future.

It is now barely a decade since first hand knowledge of health problems and health programs in China has been generally available in the USA. The variety of content and the perspective achieved in the wide-ranging series of articles in "Health Services in Shanghai County"[1] are a major achievement and will constitute an almost unique resource not only for students of public health in China but for all interested in adapting lessons to be learned from abroad for use at home.

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Vital and Health Statistics for the US Hispanic Population

The United States has the sixth largest Hispanic population in the world, exceeded only by Mexico, Spain, Colombia, Argentina, and Peru. The growth potential of the US Hispanic population is particularly noteworthy given their age distribution, which is younger, and their fertility, which is higher than the overall US population; and given the migration of people from the world's largest Hispanic country with which we share a 2,000 mile border.

Hispanics are a heterogeneous group comprising individuals of numerous national origins. Their families may have resided in the US for hundreds of years or only a matter of days. They may be proficient in English, proficient in Spanish, proficient in neither, or proficient in both. They share a common denominator, however: the effects of neglect by the health research community. At present we do not even know how many Hispanics die each year in this country, let alone their health status, use of services, or unmet health care needs.

In 1978, the National Center for Health Statistics (NCHS) recommended for the first time the addition of a Hispanic identifier on certificates of birth and death. The recommendation suggested the use of two possible reporting