

discharges. This year budget day was chosen to publish the worst hospital waiting list figures for four years and the worst homelessness figures ever. Chance alone could not account for the number of reports, unfavourable to the government, that find their way into the House of Commons library just before the end of a parliamentary session.

What can be done? Government statisticians at the Royal Statistical Society's meeting obviously felt maligned. Why, asked Mr Jack Hibbert, the government's chief statistician, was a distinction so rarely made between the statistics produced by the Government Statistical Service and the uses to which others—both inside and outside government—put them? By posing the question like this Mr Hibbert seemed to be indicating a way out of conflict. Few statisticians at the meeting and, one suspects, few members of the public, doubt the integrity of the government's statisticians. But few doubt that decisions about which statistics to collect and how they are interpreted and released rest almost entirely with their political masters.

The suggestion to set up a National Statistical Council to oversee the use of statistics, first floated by Sir Claus Moser in 1979,⁵ has surfaced again, although the experience of the Press Council, Arts Council, Sports Council, and Health Education Council in the 1980s does not inspire confidence that a council would provide the answer.

How other countries organise their services may well provide a guide—many seem to manage their statistical services without Britain's current discontent. The *Handbook of Official Statistics in ECE Member Countries*, which summarises each country's legal and operational framework, shows that many grant their statistical services greater independence than does Britain, in some cases making them answerable to the head of state rather than to the government of the day.⁶

The 1980s was not a happy decade for official statistics in Britain, and some way of depoliticising them needs to be found, and fast. Statisticians at the meeting who believe that their profession has fallen into disrepute were the first to endorse this, but it is in everybody's interests to have a reliable source of data on which to base their actions.

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Saving children's lives by vaccination

Much achieved but much more could be done

Three quarters of the world's population lives in the developing countries of the South. A decade ago, \$40 billion flowed every year from the North to the South. Now \$20 billion flow annually in the opposite direction. In the North at least four fifths of all born are likely to enter retirement at the age of 65. In the South there are still many communities where three quarters will die before the age of 65—and half of these deaths will be in childhood. Ten years ago the median figure for

health expenditure per person in the North was \$220, whereas in the South it was just \$4 each year. Over the past 10 years Unicef has shown that in the poorest 36 countries this spending on health has halved and that in some countries infant mortality is rising.¹ Yet spending on armaments has continued. Can we hope that the changes in Eastern Europe will lead to a worldwide decline in military expenditure? Just one fifteenth of the world's military spending would provide all basic health care needs for developing countries.²

Not all is gloom, however, for health care in developing countries. A quiet public health revolution has been taking place, instigated by a resolution of the World Health Assembly in 1974 to provide immunisation for all children of the world by 1990. At that time less than 5% were immunised. The expanded programme of immunisation now prevents around 2 million deaths from measles, pertussis, and neonatal tetanus and almost a quarter of a million cases of paralytic poliomyelitis each year.³ There are still, however, nearly three million children who die, 200 000 who are paralysed, and 150 000 who are blinded by diseases that can be prevented through immunisation.

Population growth

Preventing these child deaths has wider implications. No country has reduced its population growth without first reducing child deaths. In Africa, the current average family size is 6.7 children, and the World Bank has calculated that this must be cut to 3.4 to keep in step with growth in agriculture.⁴ Demographers have shown that halving the child mortality in the next 10 years would substantially reduce the final stable world population.⁵ Population growth in relation to resources available remains the greatest ecological threat for the future.

The eradication of smallpox fired the imagination of the international community. Out of this arose the enthusiasm for the programme of worldwide immunisation against six diseases: diphtheria, pertussis, tetanus, poliomyelitis, measles, and tuberculosis. With able guidance from the World Health Organisation an effective cold chain and training and management programmes were set up in every country. Unicef played its part in funding and social mobilisation, gaining political commitment through heads of states and popular publications such as the yearly *The State of the World's Children*. Many other organisations such as the United Nations Development Programme, the Save the Children Fund, and the Rotarians played their parts, but success depended heavily on individual governments. In the early years few believed the 1974 resolution could be more than a pipe dream. Improvement has been rapid, however, and the current projection is that by 1990 four fifths of children in the most populous countries—India, China, Nigeria, Bangladesh, and Indonesia—will have received their third dose of oral polio virus and diphtheria, pertussis, and tetanus vaccines.³ This year there will be fewer than 30 cases of paralysis from wild poliomyelitis in all the Americas, and possibly both they and Europe will achieve eradication by the end of 1990.

Deaths from measles

Measles continues to kill at least 1.6 million children a year, and new research suggests that this is an underestimate. After severe measles mortality is increased for many months from other causes, particularly diarrhoea and respiratory infections. The increased mortality is related to the size of the infecting

dose rather than malnutrition in the children.⁶ Vaccination gives substantial protection, reducing child mortality from the age of vaccination by at least 30%.⁷ A big difficulty in many countries is that up to the present measles immunisation cannot be given to children aged under 9 months. The World Health Organisation recommends, however, that in 1990 a high titre of the more immunogenic Edmonston-Zagreb vaccine should be made available. This concentrated vaccine will overcome residual maternal antibodies and may be used at the age of 6 months.⁸ Unicef hopes to have supplies available for sub-Saharan Africa by the middle of 1990.

What about other new vaccines? All the vaccines available were already in use as long ago as 1974. There are many exciting potentials for the improvement of existing vaccines and new vaccines against major killer diseases, but resources for the development of new vaccines are limited. Many countries allot half of their research resources to the military. Can we hope that a proportion of this could be deflected to research on saving children's lives? Even then, particularly at this time of year, we need to consider the saying, "The difference between children and adults is the size and complexity of the toys they play with." World wide there is an unholy alliance between the developers of adult toys and their manufacturers and the medical profession, and it is this that absorbs so much research money. In Britain we suffer from vociferous pressure groups wanting investment in a £10 million cyclotron, though there are grave doubts over its medical value and a cost benefit analysis that would be absurd.⁹ Such monetary resources could save the lives of thousands of children.

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On the state of the public health

Thought provoking and readable—at last

Most years since 1856 the chief medical officer of the Department of Health has produced an annual report—documents of variable style, content, and value. When Sir Donald Acheson became chief medical officer in 1984 he reviewed past reports, talked to colleagues, and set about making his annual accounts of the nation's health "an unbiased record of topical events relating to health and a commentary on progress and on important unsolved problems."¹

The latest report achieves these aims and does so in a style that encourages doctors who dip their noses into the pages to read on.² Necessarily, much of the comment deals with events no longer in the headlines—but it is helpful and reassuring to have verdicts on aluminium in drinking water (no cause for immediate concern) and on the risks of listeriosis for the

average healthy citizen (very small indeed). There are masses of data on health statistics, including international comparisons that show England and Wales well down the league table for infant mortality but close to the leaders for life expectancy. The report refers repeatedly to geographical variations in disease and mortality within England and Wales but makes little mention of social class differences in adults—yet these are very substantial: the gap between the rich and poor is as wide in health as it is in other more obvious features of lifestyle. Each year Sir Donald has one chapter focused on a particular aspect of health. This year it was the health of children. May we suggest another topic for next year—the health of the poor?

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Pay in the public sector

More review bodies needed

The tenacity with which ambulance workers in Britain are pursuing their pay dispute this winter is scarcely surprising: together with several other public sector employees they have had a raw deal under the current administration. Ten years ago the distribution of pay in Britain was much more equal than it is now. In 1979 someone 10% from the bottom of the pay distribution received around half the pay of someone 10% from the top. Today that same person on a low wage earns only one third the amount at the top end of the scale. Many public servants have clearly been the losers in such a change.

For most employees in the public sector the 1980s have seen a decline in their pay relative to private earnings—in some cases (teachers, soldiers, and health service ancillaries) aggravating a trend begun in the 1970s. The modest increases in real wages received by these groups look meagre in comparison with those awarded in the private sector.

Wishful thinking by governments cannot ignore the fact that managers in the public sector have to accept influences from the private sector on the pay of their employees. Whether employers cite "labour market" factors as key determinants of pay or unions plead notions of equity, in effect both are arguing on the basis of comparability. And both know that public servants are increasingly losing that race.

For those at the bottom of the public sector pay league it is cold comfort to know that most of them do not fall within any standard definition of low pay: only women employed in the NHS as domestics can claim this dubious distinction. None the less, real wages have been shoved downwards as cash limited NHS managers have held down the pay of manual workers to fund unexpectedly high increases for nurses. Another factor in the NHS and in local government has been the adverse effect on earnings caused by compulsory competitive tendering for certain services. Higher productivity has been demanded, and crucial sources of additional income such as overtime have been removed. In many cases savings have been made—at the expense of filthy hospitals and roads and in the quality of other services.

Not only the less skilled have lost out. Public sector top