

Bio

GENERAL
ME 3:3 / IT 71
IT 71

DUE: *ASAP*
EVENT: *May 5, '71*

MEMORANDUM FOR MISS ELISKA HASEK

I enclose the text of a draft message which the Office for International Health would be pleased to have approved by your office. Their intention is that this message would be incorporated in the Surgeon General's statement to the World Health Assembly, in Geneva, to be delivered either May 5 or May 6.

I have not edited this material (although I was tempted).

Could you let me have your reaction as soon as convenient?

Fred Patton

*Surgeon General
will attend verbal
meeting per Mr. Teller
w/ Fred Patton. RKB is agreed.*

*EGH
4/28/71*

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IT 71

May 18, 1971

FGC-11-1

FINCH, ROBERT H.

Dear Mac:

Thanks very much for sending me the copy of your remarks at the 24th World Health Assembly.

Your point was well taken and I am sure it was well received.

It was good to see you in Geneva, and with kindest regards,

Sincerely,

Robert H. Finch
Counsellor to the President

Dr. Malcolm C. Todd
Memorial Medical Center
2865 Atlantic Avenue, Suite 205
Long Beach, California

RD
X-File
RHF Misc. Corres.

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~~Handwritten~~ FYI
Note. per RHF
of thanks & mild reaction to this.
GW

MAKING INFANT MORTALITY STATISTICS MEANINGFUL,

Malcolm C. Todd, M.D., F A.C.S. *

Read at 24th World Health Assembly of WHO
Geneva, Switzerland

* Dr. Todd is Assoc. Clinical Professor of Surgery,
University of California, Irvine; Chairman, Council
on Health Manpower, American Medical Association;
Member, National Advisory Committee on Health
Manpower ; Member, California State Health Planning
Council and Former President, California Medical
Association

EX-101

MAKING INFANT MORTALITY STATISTICS MEANINGFUL

Malcolm C. Todd, M.D.

This paper is a request to the 24th World Health Assembly to develop appropriate, uniform standards and guidelines in reporting vital statistics. It is particularly concerned with those statistics involving infant and maternal mortality and longevity rates among member-nations of the World Health Organization.

To those of us who frequently write or read scientific and professional papers, it is generally known just how casual and misleading the application of such statistics may be. Furthermore, the statistics themselves are not always the reliable indicators they might seem. Some may well result from intellectual dishonesty. Some can be manipulated so they appear to support several widely differing conclusions.

To the practicing physician in the United States, one of the most sensitive examples of the misuse of statistics has been the attempt to use infant mortality figures as a basis for the assessment of our nation's health. In turn, they have been used to assess the efficiency of the American health care system. With regularity, in fact, we witness such figures used as an

index purporting to indicate the comparative state of any nation's health.

Certainly such statistics do not provide an adequate index, even one that is at all meaningful. The variables in infant mortality and life expectancy are more symptoms of socio-economic conditions and cultural patterns than of the level of medical care provided.

It is equally disturbing that medical scientists have allowed a subject of such international importance as infant mortality to become so confused. In many cases, it has degenerated into little more than a name-calling contest. The major plea of this paper, therefore, is that standardized guidelines and assessment indices be established for use in presenting and reporting resultant data.

It is unfortunate that in the United States such comparative statistics have often been used politically, comparing American mortality and longevity rates with those of other nations for less than scientific purposes. The rhetoric and dialogue in this field is usually premeditated, largely emotional, and generally based on misleading data.

For example, infant mortality, as presented in the United Nations Demographic Yearbook 1969, the current source of international data, cannot be interpreted meaningfully apart from the context provided by that publication's introductory sections. In fact, even such explanation is inadequate to a fuller understanding of the statistics which appear in subsequent tables. For this reason, the American Medical Association was directed by its House of Delegates

to make a comprehensive analysis of methods and requirements used in reporting statistics to the World Health Organization. On behalf of the AMA, I might take this opportunity to express appreciation to all the member-nations who have answered our questionnaire.

Nations have traditionally measured the health level of their people by analyzing statistics on live births; fetal, infant, and maternal deaths; and average life expectancy. Obviously, a uniformity in the ground-rules for developing such information, before it is presented to this international organization, must be established. In the United States, the National Center for Health Statistics of the Public Health Service has the statutory authority for collecting all national vital and health statistics. However, the legal authority for the registration of vital events rests with the individual states. Most of our states require registration of all fetal deaths after 20 weeks gestation, though a few states require registration at any gestatory period.

It would appear that the most critical issue in deciding if infant mortality statistics are comparable is whether the nations concerned apply the same definition of "live birth". The United States, for example, uses the World Health Organization's definition. Some countries do not. Clearly, the significance of this point is that the higher the fetal death rate, the lower the infant mortality rate. Of course, this relationship is also conversely true.

We are all familiar with Table A, dealing with infant mortality. Sweden, you will recall, has impressively low infant mortality figures. In addition, that country has the lowest rates recorded in most statistical sources.

TABLE 1
MORTALITY RATES FROM SELECTED DISEASES

	<i>Infant Mortality /1000 Live Births</i>	<i>TBC /100,000</i>	<i>Pneumonia /100,000</i>	<i>Bronchitis /100,000</i>	<i>Ulcer of Stomach /100,000</i>
	1968	1967	1967	1967	1967
Denmark	15.8	1.7	24.9	17.9	7.0
Finland	13.9	10.3	28.8	9.6	3.7
France	20.4	13.0	19.5	5.2	3.2
West Germany	22.8	10.7	24.3	16.9	7.4
Netherlands	13.1	1.4	11.4	12.2	4.5
Switzerland	16.1	7.8	16.7	8.5	6.0
Japan	15.3	17.7	21.6	5.2	8.6
Australia	17.8	2.3	28.2	21.2	4.7
United Kingdom	18.8	4.2	66.4	57.5	8.0
Sweden	12.9	4.5	51.2	6.3	8.9
United States	20.8	3.5	28.0	3.2	5.0

Source: *World Health Statistics Report*, Vol. 23, Nos. 4, 5, 6, and 8, 1970. *Statistical Abstract*—1970, p. 809.

TABLE 2

<i>Year</i>	<i>Infant Mortality Rate</i>
1940	47.0
1945	38.3
1950	29.2
1955	26.4
1960	26.0
1965	24.7
1969	20.7

Statistical Abstract—1970, p. 55.

Nonetheless, for the most part infant mortality is more of a social than a medical problem. Such factors as poverty, malnutrition, poor housing, inadequate sanitation, low educational levels, ethnic and cultural differences are more closely associated with infant mortality than is the number of physicians and hospitals or the level of care they provide. For these reasons, rates of infant mortality, in and of themselves, do not provide a good index.

Some other comparative statistics in use, though not always the best possible indicators of relative health status, are far better than infant mortality rates for that purpose. When one considers that 70 percent of the deaths in the United States are related to cancer, heart disease, and stroke, and only 2.2 percent of deaths are classified as infant mortality, the relative significance of the latter can be seen in its true prospective.

Considering such facts, it would seem that infant mortality rates not only are a poor indicator of health status but serve as an even less significant index of comparative health status among nations. Statistical comparability is truly questionable. Also, the inferences suggested by such comparisons are simply not all valid.

Though it is not generally stated specifically, comparisons of United States mortality rates with those of Sweden, for example, have often been used to imply that the United States is negligent in not adopting the Swedish health system, or even the Swedish social system. Observation shows that these comparisons are most commonly used in my country by some social planners, partisan politicians, and others, as support for their own theories

of social progress. But if one logically extends the comparison between the two nations, some interesting facts emerge which further illustrate my earlier points.

Sweden has a population of eight million, the United States surpasses 205 million. Sweden covers 175 thousand square miles, about the same area as my home state of California. The area of the United States is over three and a half million square miles. Sweden has a relatively homogeneous population, while the American population is highly heterogeneous by any criteria: economic, social, cultural, ethnic, and so forth. Finally, there is little argument that the two countries are approximately at the same level in regard to medical knowledge and technology. Examining these facts, it seems only reasonable that the United States, with larger and more complex health problems, could be expected to have a higher rate of infant mortality.

Furthermore, many other comparative health statistics seem to lead; at first glance, to other over-simplified conclusions. One might say that the Netherlands has the superior health care system because it has the lowest death rate due to pneumonia and tuberculosis; or that the United States does because it records the lowest death rate due to bronchitis; or that France does because of the lowest death rate due to stomach ulcers. It is hardly necessary to point out why these are invalid. The statistics I quote, along with those of infant mortality, are merely part of a larger pattern. If any individual mortality rate is to be viewed meaningfully, it must be seen in the context of other health, social, and even geographic considerations.

Worthwhile conclusions, on the other hand, can readily be obtained by noting the increase or decrease over a period of time in statistics such as infant mortality. Infant mortality then can properly be treated as a social problem, as well as a health problem. Table 2 gives us the encouraging information that our infant mortality rates have dropped 50 percent in the period from 1940 to 1970. While this is a notable achievement, it can certainly be improved.

In the United States, the chief evidence of infant mortality is immaturity and prematurity. Accompanied by a low birth rate, there is a predisposition to respiratory illness within 24 hours of birth. We have learned that the greatest risks are found in teenage pregnancies and illegitimacy, both with low birth rate babies. Unmarried mothers, unwanted babies, and inadequate pre-natal care all lead to increased mortality rates. In my country, we note that citizens of the Negro race, for a multitude of economic and social reasons, rank high in infant mortality rates. These range from 5.3 percent, in the higher socio-economic levels, to 23.3 percent in the lowest. Here, obviously, is one example of how mortality statistics do serve an essential purpose, allowing us to focus increased attention on specific problem areas.

Life expectancy statistics provide another relevant subject for discussion here. Even assuming that international data is always valid and comparable, it is necessary to examine causes of mortality before estimating the effects of such other factors as increased numbers of physicians.

Here again, socio-economic conditions play a fundamental role,

1.
poverty being a major contributor to reduced longevity. On the other hand, national affluence may also contribute to unfavorable statistics. Heart disease continues to be a major cause of death in the United States. The over-abundant diet and sedentary habits of the average American, despite health education efforts and increasingly available physician services, undoubtedly contribute. A further factor is seen in the fact that in my country over 55 thousand people were killed in automobile accidents during each of the past several years.

Other trauma too are extremely significant in regard to mortality rates. The effects of tobacco, alcohol, drugs, and the stress of modern society have an important impact on these statistics in the United States and other countries. Certainly, all the above are independent of factors such as physician numbers in population and will not be affected significantly by simply increasing the ratio of physicians to the population.

To emphasize the point again, today it is often difficult and misleading to compare statistics regarding the health of one nation with those of another. And regardless of relative statistics, we can see them improved. This is a matter of concern not only to physicians but also to all those dealing with problems related to socio-economic and cultural differences. The most important use for health statistics such as mortality rates is as a guage for measuring progress.

In conclusion, if international health comparisons are to be made

valid, there must be standardization in guidelines and techniques of data collection. Combined with this, there must be uniform reporting registration. The assessment of organized statistics from a central data file logically can be a proper function and a continuing challenge to the World Health Organization. This compendium of statistics could then be made to serve a useful purpose and provide a valuable service to all nations.

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THE WHITE HOUSE
WASHINGTON

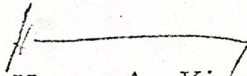
March 6, 1972

Dear Barbara: ^{*}WARD

Russell Train has passed me your memorandum of February 14 with its thoughtful points about the UN Stockholm Conference on the Human Environment. We have every wish to make this conference a success and are anxious to have widest possible participation in it. We hope this can be worked out.

I am aware of the good work that is being done in the United States in anticipation of the Stockholm Conference. In particular, I know that the book which you and Rene Dubos have completed will make a major contribution.

Warm regards,


Henry A. Kissinger

^{*}Lady Jackson
Room 1006
^{*}Columbia University
420 East 118th Street
New York, New York 10017

THE WHITE HOUSE
WASHINGTON

June 2, 1972

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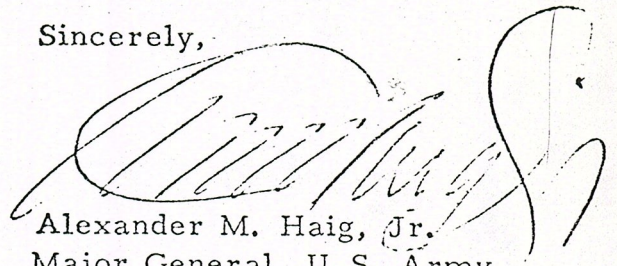
Dear Professor Bloomfield:

The President has asked me to acknowledge your letter of March 18 concerning the United States' position on East German membership in the World Health Organization and participation in the Stockholm Environmental Conference.

I believe we have a creditable record in regard to the Stockholm Conference and have gone to considerable lengths to ensure that East Germany can make a real contribution to conference work.

We were, of course, glad to receive your views on these issues and their possible implications.

Sincerely,



Alexander M. Haig, Jr.
Major General, U.S. Army
Deputy Assistant to the President
for National Security Affairs

Professor Lincoln P. Bloomfield
12 Chemin Thury
1206 Geneva
Switzerland

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