

and morbidity can be achieved only in well-staffed large units the move back to domiciliary delivery currently being advocated¹⁰ would be a retrograde step. Home delivery may be more satisfying emotionally, but the family and the community have a heavy price to pay whenever it goes wrong. The report rightly points out the enormous cost of the morbidity caused by poor care, and it might have been more constructive to recommend holding conferences on perinatal morbidity as well as on perinatal mortality.

The accumulated evidence succinctly reviewed in the report makes the issue clear. If we intend to reduce perinatal mortality and morbidity, large well-equipped and staffed units must be provided, especially in areas with a high proportion of social classes IV and V. Building one or two intensive care regional units is not enough. The alternative is to allow Britain to lag behind other European countries. The DHSS must decide which policy to follow and not leave it to the whim of local consultants or the chicanery of parochial politicians.

- ¹ DHSS Health Circular: *Health Services Development*, Report of the working party on the prevention of early neonatal mortality and morbidity. HE(76)40.
- ² Chamberlain, R, et al, *British Births 1970, vol 1, First week of life*. London, Heineman Medical, 1975.
- ³ BPA/RCOG Liaison Committee, *Recommendations for the Improvement of Infant Care During the Perinatal Period in the United Kingdom*, Discussion Document. London, British Paediatric Association and Royal College of Obstetricians and Gynaecologists, 1978.
- ⁴ Butler, N R, and Bonham, D G, *Perinatal Mortality. First Report of the 1958 British Perinatal Mortality Survey*. Edinburgh, 1963.
- ⁵ Davie, R, Butler, N, and Goldstein, H, *From Birth to Seven*. London, Longman, 1972.
- ⁶ Bowes, W A, Halgrimson, M, and Simmons, M A, *Results of the Intensive Perinatal Management of Very Low Birth Weight Infants (501-1500 g) in Preterm Labour. Proceedings of the 5th Study Group of the Royal College of Obstetricians 1977*. London, RCOG, 1978.
- ⁷ Committee on Child Health Services (chairman, Professor S D M Court), *Fit for the Future*, volumes I and II. London, HMSO, 1976.
- ⁸ Report of the Expert Group on Special Care for Babies (chairman Sir Wilfred Sheldon), Rep Publ Hlth Med Subj No 127. London, HMSO, 1971.
- ⁹ Sub-committee of the Standing Maternity Advisory Committee, Central Health Services Council (chairman Sir John Peel), *Domiciliary and Maternity Bed Needs*. London, HMSO, 1970.
- ¹⁰ Kitzinger, S, and Davis, J, *The Place of Birth*. London, Oxford University Press, 1978.

Three centuries of British drinking

The 19th century may have seen the peak of Britain's achievements as a world power; certainly it saw the high point of the nation's alcohol consumption, with an average annual intake of 10 proof pints (5.5 l) per person a year. Variations in alcohol intake over the past three centuries have recently been reviewed¹ by Josephine Spring and David Buss in a paper which deserves recognition as a classic. They have analysed per caput consumption of beer, spirits, and wine in Britain for the last 300 years. There are periods for which data are incomplete, and Spring and Buss show proper critical awareness of the difficulties in handling these statistics; but with due allowance for error and artefact the main conclusions stand out boldly. Over the centuries there have been enormous variations in what the British have drunk, and it has been the alterations in the price of alcohol that have repeatedly powerfully influenced consumption.

After the alcoholic summit at the beginning of this century the consumption of spirits fell until the 1950s, when it was

down to little over one pint. In contrast, by 1975 consumption of spirits had edged sharply upwards to nearly three pints per person. Wine consumption has shown the most dramatic recent change, and from about 1.5 pints per person per year in 1950 it had moved to 9 pints in 1975—a change in national drinking habits of a quality and quantity never recorded. Beer drinking has steadily declined over the centuries, though again there has been a slight recent increase in consumption. If all sources of alcohol are added there was a gradual and continuing trend towards decrease from the 18th century until the 1950s, when this historical decline reversed with summated per caput alcohol consumption almost doubling in the 25 years up to 1975.

Is the nation's drinking any more than a feature of increased affluence? The statistics must be interpreted in the setting of a mass of recent research which indicates that per caput consumption is positively related to rates of alcoholism.^{2,3} Empirical evidence shows, indeed, that, if alcohol consumption doubles, the number of heavy drinkers goes up more than proportionately, and perhaps by as much as four times. Drinking and alcoholism cannot be separated, however much we might wish to persuade ourselves otherwise; hence the importance of a report which warns that the alcohol consumption rates are climbing. The statistician can provide the data, the epidemiologist can point out the health implications, but then society and Government must decide how much pleasure is worth how much pain.

In 1950 the price of a large loaf was equivalent to nine minutes of a manual worker's wages; in 1976 the equivalent was 11 minutes. In 1950 a bottle of whisky cost 569 minutes, while in 1976 it cost 209 minutes.¹ We want our pleasure, but, with the pointers of alcohol-related harm all moving upwards since 1950,⁴ society may have to consider whether alcohol has become too cheap—and politicians find the will to do something about it.

¹ Spring, J A, and Buss, D H, *Nature*, 1977, **270**, 567.

² Bruun, K, et al, *Alcohol Control Policies in Public Health Perspective*, vol 25. Helsinki, Finnish Foundation for Alcohol Studies, 1975.

³ Schmidt, W, in *Alcoholism: New Knowledge and New Responses*, eds G Edwards and M Grant, p 48. London, Croom Helm, 1977.

⁴ Orford, J, and Edwards, G, *Alcoholism. A Comparison of Treatment and Advice, with a Study of the Influence of Marriage*. London, Maudsley Monograph: Oxford University Press, 1977.

Glycolysated haemoglobin and diabetic control

Microvascular complications of diabetes are believed to be the consequence of years of poor diabetic control, yet its assessment by random blood glucose measurements is seriously inadequate, as is our knowledge of the metabolic consequences of poor control. Recently, however, and for the first time a raised blood glucose concentration has been shown to alter the composition of a protein after its synthesis:^{1,2} persistent hyperglycaemia modifies haemoglobin A at a constant rate during the life of the red blood cell with the formation of increased amounts of haemoglobin A_{1c}. This glycolysated haemoglobin has a hexose attached to the amino-terminus of its β -chain. Normally HbA_{1c} accounts for between 3% and 6% of the total haemoglobin—a little more in normal pregnant women.³ This proportion is increased three- or four-fold in poorly controlled diabetics.⁴⁻⁷ Glycolysated haemoglobins A_{1a} and