

simple, feasible, and safe. The data presented by Girard and co-workers might seem appealing even with the potential shortcomings of difficult to conduct trials such as this one. But uncertainties about the control group in this study, and about the resources needed for implementation, mean that more information is needed to show that the approach is feasible and safe in everyday practice. Additionally, I am concerned that indiscriminate use of the technique could be harmful in cases in which sedation is helpful to the patient.

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I am named as one of the inventors of a system for ventilation and weaning which is being commercialised by Dragër Medical. Dragër fund part of my research on this system.

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Does improved detection of ill babies improve mortality?

Faced with the suffering of so many babies and their families in areas with scarce health-care facilities, clinicians in countries with poorly distributed resources desperately seek tools to help reduce the gap between recommended care and reality. When it comes to child health, this scarcity of services is well known: many ill babies are not brought to clinics, and healthy babies sometimes take up the valuable time of expert personnel. What can be done to address this problem?

By setting the Millennium Development Goals (MDGs), world leaders have agreed to make living conditions better for all inhabitants of the planet; unfortunately they have not concomitantly trimmed other expenditures to increase health budgets, but they have suggested investment policies.¹ Under MDG 4, child mortality in children less than 5 years of age is meant to drop by two-thirds between 1990 and 2015. Assuming a linear decrease, in 2008 we should be halfway to this goal: a landmark far from being reached.²

In today's *Lancet*, The Young Infants Clinical Signs Study Group, a group of clinicians in six countries,³ report a score that optimises the screening of babies up to age 59 days in an effort to avoid overburdening of local hospitals. The study group were also concerned with the achievement of MDG 4. Can we anticipate the results of using the score? Will it help improve the care of ill babies? And will it contribute to the achievement of MDG 4?

The study group's screening technique was designed to withhold further care from infants with a low enough

risk of serious illness not to be referred to a hospital. The accuracy of the method (85% sensitivity, 75% specificity) is good enough to optimise hospital resources, because it would reduce the number of healthy babies referred. As a consequence, concerned clinicians will be reassured, although there is a cost of 13% false negatives—ie, babies labelled as being at low risk who will develop a disorder that needs hospital care.

In recognition of the limited services in many countries, the rationale behind the use of risk scores is that further care should be reserved for patients needing it (ie, those at high risk). Until a decade ago, WHO and the Pan American Health Organisation (PAHO) fostered the risk approach in allocating patients to different levels of care⁴ in the hope that better use of available resources would improve overall health. Scarce resources could be devoted to difficult cases, leaving primary care for patients with low risk of complications.

But the risk approach is difficult to implement: patients at high risk are, in practice, denied access to appropriate treatment.⁵ Additionally, patients at low risk do have complications. For example, in Tanzania,⁶ despite use of the risk approach to refer women with high-risk pregnancies, only 21% of such women living more than 5 km from a hospital gave birth in it, and 5% of pregnancies labelled low-risk were followed by complicated deliveries. In general terms or for optimisation of resource use, administrators may accept a 5% figure, but 50 patients per 1000 with no access to

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further care might affect mortality rates by the same order of magnitude. This effect is because the risk approach, although theoretically giving access to further care when high risk is detected, confines low-risk patients to health facilities with fewer resources or less experience.

Therefore the risk approach, often mentioned in public-health contexts in the last quarter of the 20th century, is no longer popular because health systems have learned that to do well, all care dictated both by evidence-based medicine⁷ and medicine-based evidence⁸ should be available to all. There are no short cuts.

The study group acknowledged the limitation of services for all in their six countries. If the study group's score is used, existing services will not be overburdened,

but mortality or its proxy indicators will probably remain unchanged because most infants—those labelled at low risk—will still face the consequences of not having access to the best available care.

The use of scores, such as that devised by The Young Infants Clinical Signs Study Group, is of great interest clinically, but lower mortality figures will be reached only if all patients are treated according to the same best available standards, with constant and easy access to higher-level facilities and prompt referral as soon as indicated.

If distance to the MDGs is to be reduced, health-care resources must be increased rationally. Spending more and more wisely will give us a good chance of meeting the health-related MDGs if enough time is allowed for the additional resources to work.

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I declare that I have no conflict of interest.

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Incentives, priorities, and clinical integration in the NHS

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When I was seconded to work in the UK Department of Health in 2000, the Government's top priority for the National Health Service (NHS) was to reduce waiting times for treatment. At a time when some patients waited up to 18 months for surgery, the laser-like focus on the improvement of access to care was right and proper.

In practice, the reduction of waiting times was not easy and ministers became frustrated at the ability of the NHS to absorb additional resources without increasing

the numbers of patients treated. Alan Milburn, then Secretary of State for Health, therefore instructed his officials to change the flow of funds in the NHS to reward productive hospitals. Milburn's instruction was the genesis of the current English health reforms with their emphasis on patients choosing hospitals and money following patients' choices. These reforms, together with tightly controlled targets for cutting waiting times, have had the desired effect.