Table—*Odds ratio for various sampling devices for detecting mild dyskaryosis or worse relative to extended tip spatula alone. Odds ratios have been calculated by pooling all studies and adjusting for underlying rate in each study.*

	All studies		Screening only		Referral only	
	No of smears taken	Odds ratio (95% confidence interval)	No of smears taken	Odds ratio (95% confidence)	No of smears taken	Odds ratio (95% confidence)
Extended tip	27 939	1.00	11 302	1.00	905	1.00
Ayre	14 329	0.87 (0.79 to 0.96)	1232	0.49 (0.24 to 1.01)	1039	0.92 (0.69 to 1.23)
Ayre plus*	11 459	1.09 (0.97 to 1.23)	7373	0.57 (0.26 to 1.29)	911	1.63 (1.24 to 2.15)
Extended tip plus*	12 023	1.08 (0.95 to 1.22)	7342	1.14 (0.77 to 1.69)	954	1.77 (1.27 to 2.46)
Brush or swab	2302	0.75 (0.62 to 0.90)	1050	0.32 (0.15 to 0.70)	1252	1.04 (0.79 to 1.36)
Cervex	10 054	1.05 (0.96 to 1.16)	3381	1.00 (0.62 to 1.61)	280	1.37 (0.87 to 2.14)
Cytopick	3406	1.08 (0.68 to 1.73)	3406	1.10 (0.66 to 1.82)	0	—
Bayne	4320	1.12 (0.80 to 1.57)	4320	0.59 (0.25 to 1.40)	0	—

*Cytobrush or cotton swab.
Note that some studies had a mixture of screening referral smears or were conducted in gynaecology clinics and have only been included as "all studies."

whenever the transformation zone is not visible. "The most important variable is probably the operator's skill."[8] Screening programmes should monitor the inadequacy rates of smear takers, and anyone with a particularly high rate relative to that of the local laboratory should be offered retraining. Cervical screening in Britain has improved considerably since 1988, and it is probably preventing some 2000 cases of invasive cancer each year.[9] Much can still be done to improve the quality of smears. It is hoped that Buntinx and Brouwers' paper will lead to the universal replacement of the Ayre spatula.

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Home birth

Safe in selected women, and with adequate infrastructure and support

See pp 1302, 1306, 1309, 1315

Birth is an event of great importance in family life. Although pregnancy and delivery are, under healthy conditions, normal social and physiological processes, childbirth has become hospital centred in most industrialised countries. The assumption is that hospital based deliveries are safer for mother and child. Yet the Cumberlege report sees home birth as a real option,[1] and the wishes of women to have home births must be viewed in that light. A randomised controlled trial would help to resolve the controversy over the relative safety of home and hospital birth,[2] but conditions for a "fair" trial are difficult to achieve. Such a study would require large numbers because of the low frequency of adverse events, and the necessary environment of experienced home deliveries has virtually disappeared. In the absence of a randomised trial, observational studies are welcome, and this week's *BMJ* carries four papers reporting on the safety, professional support, and patient satisfaction of home births.[3-6]

The first of these, from the Northern region's perinatal mortality survey, reports 134 perinatal losses in 3466 births outside the hospital,[3] about four times the number of losses in hospital births. At first sight this seems to endorse the view that hospital is the safest place to deliver. But 97% (131) of these perinatal deaths at home were recorded in women who were actually booked for a hospital delivery or had no prearranged plan for delivery. The perinatal outcome in planned home births was better than for all women giving birth in the region—a result in line with Swiss and Dutch findings also reported in this week's *BMJ*.[4,5] This supports the safety of home birth provided it is offered to women at low risk of obstetric complications. Most perinatal deaths occur in women with health or obstetric problems that existed before or developed during pregnancy, and these women can be identified and referred before the onset of labour.

Assessing a woman's risk and providing appropriate care is bread and butter to general practitioners. The key to the consistently good results of home births in Dutch primary care settings[5,7] is meticulous selection of women at low risk of obstetric complications. This results in equal or better obstetric outcome compared with hospital birth, and fewer interventions, for a large number of women in the community.[7] Risk assessment is based on a protocol for referral[8] (the Kloostermanlist, named after its designer), which is used routinely in the community[7] and serves as the national reference of good practice.

Promotion of home birth is not restricted to Europe: there have also been initiatives in the United States and Australia.[9,10] In our view such initiatives should be integrated in comprehensive primary care, as the roles of general practitioner and midwife are not limited to the place of birth—they cover the whole of pregnancy, delivery, and neonatal care.[7] However, some primary care practitioners may need to be persuaded to provide the option to their patients: the survey from Britain's Northern region found that general practition-

ers, and to a lesser extent midwives, often had reservations about the safety of home birth and tended to discourage it.

General practitioners and midwives have responsibility for creating the right circumstances for safe and satisfying home births. This means, firstly, selecting women who are not at high risk of complications; secondly, establishing an infrastructure for safe obstetric interventions—such as providing elevated beds and ensuring adequate hygiene; thirdly, providing support during labour and in the days after delivery, for which maternity home care assistants are important; and, finally, allowing access to hospital facilities—this is vital, as serious complications during labour can never be excluded. Transfer during labour can be safe,[6 7] but safety must not be assumed, and the availability of obstetric care must be established beforehand. Coordinated planning between primary care practitioners and obstetricians is crucial, and much will depend on local conditions: hospital facilities are usually available within 15 minutes in densely populated Holland, but transfer will take much longer in remote areas of North America and Australia. Such variation underlines the importance of comprehensive care for pregnant women. This should focus on patients' individual needs, based on a proper assessment of risk and local circumstances, rather than simply accommodating patients' demands.

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The future of the NHS

Reorganisation fatigue has set in; now for service development

By publishing its white paper on the future of the NHS at this point in the election cycle,[1] the British government has got its retaliation in first. The white paper reaffirms the government's commitment to maintain and develop the NHS and outlines a number of strategic objectives for the future. These objectives are to create a well informed public, a seamless service, decision making based on the latest clinical evidence, a highly trained and skilled workforce, and a service that responds to patients' needs. The white paper also restates three of the founding principles of the NHS—a commitment to universal population coverage, high quality care, and availability on the basis of clinical need—and for good measure adds a fourth—responsiveness to the needs and wishes of patients and carers.

Leaving on one side cynicism about the timing of the white paper and concerns that the time and skills of civil servants have been harnessed in the pursuit of party political objectives, there is much in the government's proposals that makes sense. The lack of a strategy to guide the NHS reforms has been the subject of considerable criticism,[1] and the white paper is a first attempt to address this. A programme of work has now been set in hand to produce improvements in three key areas. These are the use of information and information technology, professional development, and managing for quality. Like the listening exercise on primary care, this programme will involve doctors, managers, and others from within the NHS and will result in proposals for strengthening the NHS into the next decade and beyond.

The obsession with structural change that has dominated health policy in recent years has thus given way to a focus on how staff and services can be developed for the benefit of patients and the public. Big bang reform is out, to be replaced by pragmatic problem solving. As in other countries, policy makers in Britain have embraced a new realism, recognising the intractability of many of the problems confronting health services and the need to make progress one step at a time. For health service staff, the prospect of a period of organisational stability will come as a relief. The NHS is showing all the symptoms of reorganisation fatigue, and the opportunity to concentrate on developing services rather than changing structures will be widely welcomed.

The most contentious part of the white paper is the argument that the NHS will be able to cope with the pressures arising from demographic and technological changes and rising public expectations with the prime minister's promise to increase the resources allocated to health care in real terms each year. Not only does this fail to acknowledge the current underfunding of the NHS (an omission compounded by the use in the white paper of scarcely credible fictitious case studies of what the government's plans mean for individual patients), but it also does not address the question of what specific level of increase the health service needs to keep pace with demand. As recent experience shows, problems arise when growth levels of 3% give way to increases barely sufficient to allow for health service inflation. The health secretary, Stephen Dorrell, has done well to win extra resources for the NHS for 1997-8 in the public expenditure negotiations, but in a climate of tax resistance it may be difficult to sustain this in future years.

This opens up a chink in the government's armour for opposition parties to exploit. That they have not yet done so is testimony to the caution that new Labour is showing in its commitments on public spending. In an intriguing reversal of roles, it is the Conservative government that has promised to increase NHS spending, with Labour emphasising the scope for using existing budgets more effectively rather than seeking to outbid the government in the expenditure stakes. With left leaning think tanks lending support to the opposition's position,[2] the argument