

our optimisation hypothesis on central blood pressure, which is known to be strongly correlated with arterial stiffness, rather than on blood pressure variability.

We fully agree with Jack E James regarding the importance of not only the treatment of cardiovascular risk factors (including high blood pressure), but also the prevention of their occurrence. At the population level, prevention of hypertension is related more to non-drug strategies than to optimisation of pharmacological solutions. Nevertheless, our Viewpoint¹ comes from the clinician's perspective rather than that of public health specialists. As James points out, individual measures, including pharmacological strategies, and collective measures, including behavioural and non-pharmacological approaches, account for most of the epidemiological evolution. We could consider the onset of hypertension at the individual level as a failure of preventive strategies. The fact remains that in such situations, medical treatment is mandatory. The sole objective of our proposed new strategies is to optimise this pharmacological management. Hypertension prevention strategies at the population level are widely acknowledged;⁵ nevertheless, the key to effectively and collectively reduce body-mass index or salt or alcohol consumption, and promote physical activity, has yet to be found. Moreover, should the choice be between collective prevention and individual treatment, or should the two be combined to the best of local and environmental capacities? Collective actions are the responsibility of public health professionals and politicians; individual measures are the responsibility of clinicians.

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Effect of staffing on improving newborn health

As one of the authors of the *Lancet* Series on stillbirth, it fills me with an immense sense of hope to see the ambitious targets that the Government is taking to provide world class newborn care in the UK.

A stillbirth every 90 minutes is unacceptable. A death from group B streptococcal infection every week is unacceptable. Having a higher stillbirth rate that Estonia, Slovenia, Poland, and Croatia is unacceptable, especially

considering our 1.1% reduction in stillbirths per year is 114th in the world.

I welcome the target to reduce stillbirths, neonatal deaths, and maternal deaths by half between 2016 and 2030, and the £5 million funding to back this up, along with further pledges for more money and greater transparency in maternal and newborn services.¹

I attended the UK parliamentary debate on Baby Loss on Oct 13, 2016. Hearing the commitment across parties to improve newborn care filled me with great hope for the future. The loss of a child is something no one should have to go through, yet the degree of the problem was illustrated by the number of Members of Parliament who had lost babies themselves. Improving newborn and maternal care unified parties with a shared vision for working together to do something that everyone believes is important.

However, the debate on improving newborn care cannot be separated from ensuring safe, effective staffing levels in maternity units, with a healthy and motivated workforce. Paediatrician morale is at an all-time low, and services are stretched beyond safe levels.² A quarter of paediatric registrar posts are unfilled in London,² and I have seen shifts where no junior doctors were rostered to be working.

I urge the government to address paediatrician morale and recruitment as an inseparable issue from other policies to improve newborn care, as without it, any chance of success in this area will be greatly diminished.

I declare no competing interests.

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For the *Lancet Series on stillbirth* see <http://www.thelancet.com/series/ending-preventable-stillbirths>