

There is a fundamental divide between the purpose of clinical trials, where results may determine medical interventions in millions of patients, and that of observational research that searches to understand the occurrence of disease. In clinical trials, a mere flight of fancy from a data analyst should never be allowed to affect the health of future patients. But for an analysis of observational data that modifies scientific explanations, the reader needs to know how the hypothesis arose and what other science may support it, irrespective of whether it was formulated before or after seeing the data.³

Another profound difference from randomised trials is that, in observational research, registration is unlikely to lead to knowledge of the “totality of the evidence”, which is often achievable in meta-analyses of randomised trials. It is impossible to ascertain all databases that may have observational information.

These differences between randomised trials and observational research were not discussed in the document to which the Editorial refers,⁴ but should be clearly defined before the concern with publication bias leads to measures that are adopted by major medical journals.

I declare that I have no conflicts of interest.

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Scaling up financing for health

Robert Fryatt and colleagues (Jan 30, p 419)¹ acknowledge limitations of the Report of the High Level Task Force on Innovative International Financing for Health Systems.²

The report's recommendations are aimed at low-income countries, many of which are constrained in their ability to scale up funding and have limited capacity to mobilise resources through innovative means—the report's key recommendations—in comparison to countries with emerging economies. The latter are a variably defined group of nations (depending on the classification they are four to 20 in number) undergoing a process of rapid growth and industrialisation. Although poverty, inequities, poor health status, and gaps in health financing are pervasive in many of these countries, their macroeconomic growth is a sound indicator of stable institutions and consistency of policy direction. Both these institutional characteristics are essential for institutionalising changes that are needed to achieve endpoints envisaged by the report.

These countries have the fiscal space and the ability to ensure debt limitation, fiscal responsibility, revenue mobilisation and labour market interventions—all of which can enhance public means of health financing and therefore help in addressing systemic anomalies, which undermine equity and quality in mixed health systems.³ Additionally, better overall governance can improve public finance management, and therefore improve use of resources and limit pilferage.

Since many of these countries are also off track in meeting stipulated targets, the opportunity that these countries present for achieving health Millennium Development Goals must be capitalised, and hence the remit of the recommendations broadened with appropriate adaptations.

I declare that I have no conflicts of interest.

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Adjustment of dosing of antimicrobial agents for bodyweight in adults

In their Viewpoint (Jan 16, p 248),¹ Matthew Falagas and Drosos Kargogopoulos argue for adjusting antibiotic dosing in adults to the patient's bodyweight to improve drug effectiveness and safety. Such bodyweight-adapted dosing could be achieved by using liquid formulations. However, liquid dose forms have some disadvantages: limited shelf life, potential dosing errors, high transport cost, difficult taste masking, and low feasibility of controlling the release of the drug.

We want to draw readers' attentions to an innovative tablet design for bodyweight-adapted drug dosing in children.² This tablet has multiple score lines and can be broken into eight sub-units, with each subunit corresponding to a fixed drug dose equivalent to a certain bodyweight (figure).

Scored tablets already exist, but can only be broken into a maximum of

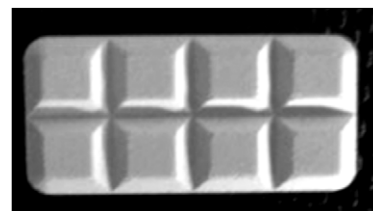


Figure: Tablet design (top view)