Fairer distribution of medical resources?

The National Department of Health has been taken to task on several issues, among them being the incomprehensible delay on the development of a plan to deal with HIV/AIDS, including the provision of antiretroviral drugs, forcing the special licensing of dispensing doctors, and the proposed Certificate of Need (regulating where doctors may practise in future). Taylor and Burns (p. 180) review some of the positive aspects of recent developments in health care with regard to changes within the medical scheme environment.

Funding disparities include the private sector health care spending being more than five times the per capita expenditure of the public sector and, until recently, discrimination within the private sector against the sick and those with lower incomes. Since South Africa's progressive Constitution includes the individual's right to access to health services, one of the government's objectives in health care funding reform would be to reduce inequities in health care financing, enabling a 'public health' approach to resource allocation.

In its regulations, the Medical Schemes Act of 1998 includes open enrolment, community-rating as opposed to risk-taking and prescribed minimum benefits. The paper addresses several other issues including the establishment of alternative reimbursement models and prioritisation of resource allocation.

The authors conclude that legislation has enabled an environment of fairer budget allocation within the private sector and protects drainage of public-sector resources by medical scheme members. For the intentions of social health reform to be realised, the health care market must respond responsibly, there must be acceptance of population-based prioritisation of health care resources that must be based on sound scientific, economic and ethical thinking.

In his editorial, Johann van Zyl (p. 170) suggests that the solutions proposed are based largely on existing paradigms and that increases in medical scheme contributions have been the trend. The total insured population has decreased and the major portion of the costs associated with health care in the private sector is still borne by the members themselves, despite the tax subsidisation. He considers it debatable that the introduction of prescribed minimum benefits has decreased the burden on public sector resources.

All agree that it is critically important for all role-players, especially practising providers of care, to participate in the debate and influence decision-makers meaningfully.

Pentoxifylline for heart failure

Scientific and medical papers have been declining in South Africa for some time. It is therefore encouraging that the *SAMJ* has been receiving an increasing number of good student papers, such as the systematic review on pentoxifylline by Kathryn Batchelder and Bongani Mayosi (p. 175). Readers will also have noted the increasing number of published systematic reviews that add to our growing evidence-based knowledge and thereby, it is hoped, will influence medical practice.

Heart failure, typically a progressive disease, now affects 22 million people worldwide. Despite strides in the treatment of end-stage heart failure, these measures remain largely palliative. Pentoxifylline has vasodilatory, anti-inflammatory and anti-apoptotic properties that have made it a prime candidate for the treatment of heart failure.

The systematic review findings suggest that pentoxifylline may be effective in improving symptoms and cardiac function in people with heart failure due to idiopathic and ischaemic cardiomyopathy, and that it may have a promising effect on mortality. However the existing trials included a small number of patients, so they may not provide reliable and robust estimates of the effect of pentoxifylline on important outcomes such as mortality. The authors conclude that, on the basis of the currently available evidence, pentoxifylline cannot yet be recommended for routine use in patients with heart failure.

Amiodarone-induced thyroid dysfunction

Thyroid dysfunction (TD) is a common complication of amiodarone therapy. Ross and colleagues (p. 184) report on a large analysis of TD associated with amiodarone therapy. Amiodarone is a widely used anti-arrhythmic drug with a considerable potential to cause TD because of its 35% iodine content. It is generally accepted that the frequency of hypothyroidism and hyperthyroidism is accounted for by differing levels of iodine intake.

Although hypothyroidism was the commonest TD in this study, it constituted a smaller proportion than in previous studies. The prevalence of thyrotoxicosis was 7.3%. Management of amiodarone-induced TD is difficult and withdrawal of amiodarone may not be possible, particularly when used for ventricular arrhythmias.

ICU tracheostomy outcomes

An unfavourable outcome of patients discharged from the intensive care unit (ICU) is reported by Mpe and Mphahlele (p. 188). Tracheostomies are performed on ICU patients to facilitate airway management, particularly in those who need an artificial airway over weeks. A Glasgow Coma Scale (GCS) of 8 at discharge is associated with increased mortality and there was a mortality of 92% in patients with a discharge GCS of less than 4.

The mortality figures, which are in excess of other published values, may be due to the unit performing tracheostomies on patients who have an overall poor prognosis, and the care of tracheostomies in general wards may be inadequate. The study also raises important moral and ethical questions of fair use of resources in a resource-limited environment.

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