Impact of withdrawal of Ritalin LA in the Western Cape

To the Editor: In 2008, the regional supply of Ritalin LA (long-acting methylphenidate) to children managed in the government sector was terminated after 2 years of access, returning to the immediate-release formulation. A specialist (FvBD) seeing children at the Red Cross Children's Hospital and some special schools monitored 57 children with attention deficit hyperactivity disorder (ADHD). By the end of the first term on the immediate-release formulation, 46 (80%) had experienced unfavourable consequences related to medication change. Their academic marks plummeted and they spent more time in detention or being disciplined. Their deterioration in behaviour at home caused additional problems, leading to the parents of 5 children buying Ritalin LA privately. In 2 cases use of Ritalin LA was erratic owing to economic constraints, and the children were at times given the immediate-release formulation. This cohort represented a small proportion of the total number of children in the Western Cape for whom Ritalin was prescribed.

Problems experienced with the immediate-release medication are:

- Given in 2 doses, it does not give a 'smooth ride'. The children, and the adults in their environment, notice the dip in blood levels, with features of ADHD manifesting.
- Older children, especially teenagers, have poor compliance with attending the school nurse for the second dose.[1] In schools where there is no nurse and teachers are busy, it is even less likely that a second dose will be given. If the first dose was given by parents before school, the medication would wear off at around 10h45, leaving the child and his classmates to negotiate the remainder of the school day without medication.
- An obstruction to compliance is the caution by teachers in administering a Schedule 6 medication without proper training about its legal and safety aspects.
- Complications with storage and delivery of the drug are inevitable, with some children not receiving the medication or not receiving it at the correct time, especially in mainstream schools without a school nurse.

The decision not to provide Ritalin LA was based not on its efficacy but solely on financial grounds. The company submitted an elevated tender price considered unacceptably high by the provincial government; this emphasises the lack of equity towards government patients – and the lack of ethics that allows pharmaceutical companies autonomy in pricing products. In some ways, the province was left with no choice but to refuse to pay. The tragedy remains that the policy impact falls on children who are constrained from reaching their full potential. The cost of the product has since been revised, and we hope that it may again be made available. However, these events demonstrate the need for legislation whereby companies cannot dramatically adjust product prices at short notice.

Fieke van Bever Donker
Child Development Department

Gillian Riordan
Behaviour Clinic

Jo Wilmshurst
Paediatric Neurology Department
Red Cross War Memorial Children's Hospital
Rondebosch
Jo.wilmshurst@uct.ac.za

1. Döpfner M, Gerber WD, Banaschewski T, *et al*. Comparative efficacy of once-a-day extended-release methylphenidate, two-times daily immediate-release, and placebo in a laboratory school setting. *Eur Child Adolesc Psychiatry* 2004; July: suppl 1: 93-101.

Task shifting in the public health sector – what is the evidence?

To the Editor: We read your editorial of May 2008[1] on task shifting in the public sector with great interest. With the chronic shortage of health professionals in the public health sector in South Africa and other countries in sub-Saharan Africa, task shifting is a very attractive strategy. This is especially true in the context of HIV/AIDS, which poses a significant threat to social security and food supplies in sub-Saharan Africa. While the rational use of effective antiretroviral (ARV) medication has changed the course of the disease in well-resourced countries, the same is not true for resource-poor countries in sub-Saharan Africa, where a critical shortage of skilled health workers has limited the provision of life-saving ARV drugs to a large proportion of those who need them.[2] However, moving specific tasks from highly specialised health workers to less specialised ones in our resource-poor health care systems should be based on solid scientific evidence.[3]

We searched Medline, EMBASE and The Cochrane Library, and found three systematic reviews that assessed the effectiveness of doctor-nurse substitution in the provision of care at the primary level.[4-6] These reviews synthesised currently available randomised controlled trials (RCTs) and controlled before-and-after studies, and found that unselected patients (coming to either primary care facilities or emergency departments) were more satisfied with care from a nurse than from a doctor; but there were no appreciable differences between doctors and nurses in patient health outcomes, the care process, resource utilisation or cost. These systematic reviews provide the scientific basis for task shifting at the primary care level. However, the studies included in these systematic reviews were conducted in high-income countries in Western Europe and North America and did not provide