NEWS

CABINET TO LOOK INTO ARV COSTS

Government has announced that the leadership of the departments of health and the Treasury are due to meet soon to consider a report on HIV / AIDS-related treatment options presented to the health Minmec (meeting of health minister Manto Tshabalala-Msimang and all health MECs) last week. This is part of the process leading up to the presentation of the report to Cabinet for decision.

The report has been compiled by a joint team consisting of the two departments' officials who have been tasked by government to investigate resource implications for various HIV / AIDS-related options.

Established in April last year, this team was also tasked to look into comprehensive costs and benefits of various treatment options. This after it had reaffirmed the position that antiretrovirals (ARVs) could improve the health of people living with HIV / AIDS 'if administered at an appropriate stage in the progression of the condition in accordance with international standards'.

At the time, government stated that it would continue to address the barriers to introduce ARV therapy, including high drug prices, weaknesses in the health infrastructure and concerns around HIV / AIDS-related treatment compliance.

Health department spokesperson Sibani Mngadi said the Minmec, held late April, discussed the report and sought clarifications. Mr Mngadi said the report gave various options relating to HIV / AIDS-related treatment options. However, the team was expected to examine the draft in the light of the comments made by Minmec.

Updating the nation on the implementation of the strategic plan against HIV / AIDS in March, Cabinet said it would consider the findings of the task team and any policy option that could have major costs ought to be thoroughly examined. However opposition parties say the government has too long delayed its decision on ARV roll-out, and pressed the Minister of Health to set out a time-frame for government action.

THE AIDS THREATS FACING SOUTHERN AFRICA

Extracts from Pulsetrack by Virginia van der Vliet

When Stephen Lewis, the UN Secretary-General's Special Envoy for HIV / AIDS in Africa, visited southern Africa in December 2002, he witnessed an unfolding humanitarian crisis which, he said, threatened the 'very existence of whole countries'. Each of the southern African countries affected had suffered a different mix of onslaughts – floods, inadequate rainfall, agricultural mismanagement, political mayhem – but a common thread running through all of them was HIV / AIDS. With regional infection levels averaging over 20% in adults aged 15 - 49 years, the epidemic had greatly magnified the impact of the natural and man-made crises.

Health care is obviously in the frontline as the epidemic grows, with up to 70 - 80% of the bed space in hospitals given over to HIV / AIDS cases. In 2002, Zimbabwe spent half its health budget on AIDS patients, expected to rise to two-thirds by 2005. At the same time, increasing numbers of health care workers themselves succumb to the disease. To compensate for losses, the training of doctors and nurses would have to increase between 25% and 40% between 2001 and 2010 in southern Africa. Emigration seen in this sector may well be due to the stress of dealing with the epidemic, especially where the sick are denied access to antiretroviral (ARV) drugs. While African governments agreed at the Abuja Conference in 2001 to allocate 15% of their total annual budgets to health care, many have done little about it.

One response to the crisis in health systems has been the widespread emergence of community-rooted home-based care initiatives. Often based in religious or non-governmental organisations, with links to formal health care and welfare support, the majority relies on unpaid (or almost unpaid) volunteers. As the epidemic grows, supporting and funding such initiatives will be critical.

'The pandemic's steady weakening of national governments and its erosion of their social services call for measures that go beyond building capacity; it is also time to speak of capacity replacement and replenishment,' says Lewis. 'Action requires a combination of political will and resources. The political will is increasingly there; the money is not.' Accusing donors of 'mass murder by complacency', he said that those who watch it unfold 'with a kind of pathological equanimity must be held to account. There may yet come a day when we have peacetime tribunals to deal with this particular version of crimes against humanity'.

While South Africa is seen by some as part of the problem, others in the neighbourhood are beginning to get to grips with the situation – as far as limited resources allow. Nobody expects Zimbabwe's current leadership to devote much effort to the AIDS issue, but Lewis points to 'a sturdy municipal structure for dealing with AIDS'. Zambia, after years of denial under the previous president, has seen 'a dramatic change' under the new leader. Botswana, Malawi, Zambia, Mozambique, Namibia, Zimbabwe and Lesotho are either starting, or considering starting, pilot ARV programmes.

So while Lewis' tour of southern Africa revealed just how deep HIV / AIDS has bitten into the region, he came away believing that 'it is absolutely certain that the pandemic can be turned around with a joint and Herculean effort between the African countries themselves and the international community'.

ANNUAL PSA SCREENING IS UNNECESSARY IN SOME MEN

It has become almost a habit to perform screening procedures annually. This is seen in serum cholesterol, pap smears, glaucoma testing and prostate specific antigen (PSA), among others. There does not, however, appear to be a proven biological basis for inferring that annual screening is correct and appropriate for PSA. In a recent report, researchers participating in the European Randomised Screening for Prostate Cancer trial suggest that biennial screening is appropriate for some men.

In a group of Swedish men in the trial, over 5 000 men underwent baseline screening. The subjects with PSAlevels of 3 ng / ml or higher (N = 660) were referred for biopsy; the remaining subjects were rescreened 2 years later. In those subjects with baseline PSAlevels lower than 1.0 ng / ml (N = 2 950), none had a level of 3.0 ng / ml or when rescreened after 2 years. There is a shortcoming in this study in that while the authors conclude that biennial screening would be more appropriate for men with initial PSAlevels as high as 2.0 ng / ml, the report does not provide enough detail about outcomes in men with initial PSAconcentrations of 1.0 - 2.0 ng / ml.

Data from the other large ongoing PSAscreening trial – the PLCO trial in the USA– support the European assertions. PLCO investigators have reported that 99% of men with initial PSAlevels lower than 1.0 ng / ml still had levels lower than 4.0 ng / ml after 4 years of annual screening. Among those with initial levels between 1.0 and 2.0 ng / ml, 99% still had levels lower than 4.0 ng / ml after 1 year. For men who are undergoing prostate cancer screening, these findings suggest that annual PSAtesting is unnecessary if the initial concentration is lower than 1.0 ng / ml and possibly even when it is lower than 2.0 ng / ml.

The financial implications are obvious – if PSAtests are conducted less frequently, in the correctly selected patients, this will result in reduced screening costs with no deleterious impact on the prostate cancer detection rate.

(Brett A S *Journal Watch*, May 16, 2003 abstracted from Hugosson J *et al.* Prostate specific antigen based biennial screening is sufficient to detect almost all prostate cancers while still curable. *J Urol* 2003 May; **169**:1720-1723.)

WHO TO SUPPORT PRODUCTION OF INDIGENOUS ANTIMALARIAL MEDICINE IN AFRICA

Malaria kills more than one million people worldwide every year. Of these, 90% are in Africa. Most of those killed on the continent are children. One out of every five African children dies from malaria before the age of five.

The World Health Organisation (WHO) is to provide technical support for the development and commercial production of dihydro-artemisinin, a plant-based antimalarial medicine reputed to have the highest cure rate for the disease, the WHO Regional Director for Africa, Dr Ebrahim Samba, has said.

The medicine is extracted from *Artemisia annua*, a Chinese medicinal plant which also flourishes in Tanzania, and is grown in commercial quantities in the country's southern and northern highlands. The indigenous variety of *Artemisia annua* in Tanzania is 10 - 15 times more potent than the varieties found in China and Thailand, making commercial production of the medicine in Tanzania a viable commercial proposition. Currently, *Artemisia annua* grown in Tanzania is exported to Europe where it is processed into antimalarial medicines which are subsequently imported by African countries and sold for US$6-7 per dose, far beyond the reach of most people who need them. Dihydro-artemisinin, if produced locally, could be sold for an affordable US$2 per dose in Tanzania and other parts of Africa.

In addition to affordability, the artemisinins, when combined with another efficacious antimalarial medicine, need to be taken for only 3 days compared with week-long treatments for other medicines. Furthermore, WHO experts say, dihydro-artemisinin is the only known antimalarial medicine to which *Plasmodium falciparum* species, the deadly malaria parasite, has not yet developed resistance.

'This year, WHO plans to provide the government of Tanzania with the process technology for the local production of the medicine', Dr Samba said. 'We will also provide pure artemisinin (the active medicine in the medicinal plant) and dihydro-artemisinin to serve as reference substances so as to guarantee the quality of local production. The third element of our support will be provision of technical monitoring to ensure the development of the requisite process technology locally.'

Dr Samba added that WHO would also encourage the government of Tanzania to increase the quantity of commercial cultivation and conservation of *Artemisia annua* in order to ensure sustainable raw materials.

WHO's support to Tanzania is being facilitated by the Canadian International Development Agency (CIDA) which is funding a five-year 10.5 million Canadian Dollar (US$6.5

million) project for strengthening traditional health systems for malaria control and prevention in the WHO African region.

Other potential herbal antimalarial medicines in three member states are also being evaluated. These evaluations are expected to reach the level of comparative clinical trials shortly.

Contrapuntally, a press release from Medinfo expresses some doubt about the success of such a venture:

A report by Médecins Sans Frontières (MSF), cited in an article that appears in a recent *British Medical Journal* (*BMJ*), states that traditional antimalaria drugs such as chloroquine and sulfadoxine-pyrimethamine are virtually useless due to the high degree of resistance developed by malaria-causing *Plasmodium* sp. in many parts of Africa. Indeed, the WHO guidelines on malaria treatment recommend that these drugs be replaced with artemisinin-based combination treatments.

However, the practical implementation of these guidelines is proving challenging, given the higher associated costs. Not only do artemisinin-based medicines cost US$1.50-2.40 per treatment compared with US$0.10 for chloroquine, but also a significant investment of funds is required to institute a change in treatment regimen. This said, MSF believes that an initial large injection of funds is required, after which the needs would be reduced as a result of the improved control over malaria leading to an overall decline in costs.

MSF estimates that providing artemisinin-based treatments in those African countries where it offers the most effective option would cost between US$100 and US$200 million. Not only is this an amount that international donors would be able to fund with relative ease, but also it would be an investment with significant return in terms of controlling malaria.

While no large-scale, prospective economic evaluation has been done, the efficacy of artemisinin-combination antimalarials is being monitored by organisations such as SAA-Netcare Travel Clinics. Says SAA-Netcare Travel Clinics medical director, Dr Andrew Jamieson, 'We have found artemisinin-based treatments extremely effective in several regions where the *Plasmodium falciparum* is responsible for the majority of malaria cases. In southern Africa it is resistant to traditional treatments. Our research in this area is ongoing, with a view to providing quantitative evidence that supports the WHO's guidelines while motivating a change of course for donor funds. Above all, we acknowledge the critical role that funding plays and will continue to play in rolling back the scourge of malaria and thereby facilitating economic development on the continent. As such, we are keen to ensure that these funds are invested wisely.'

MANAGED CARE

MANAGED CARE - ETHICAL ISSUES

Part I of a three-part series to be published in the July, August and September 2003 issues of the *SAMJ*.

Introduction

Health care is far more than just treating an illness. Since many treatment methods include an element of risk and harmful side-effects, morality is always a factor. There is often a need to justify the cause of these adverse features. Health care providers and patients should also concern themselves not only with what is good medical care, but also what constitutes good ethical care. There is often conflict between these clinical and moral goals since clinical practice is dissimilar to clinical ethics.

Decisions regarding health care are complex. Many medical interventions involve moral as well as medical deliberations and ethical concerns further complicate the decision-making process. The complexity arises from three main sources:

- both the doctor and the patient are involved in making decisions and there may be disagreement about what is considered proper medical treatment
- the patient's ability to make decisions might be lost or limited
- health care decisions often involve important moral issues and good clinical decisions are not always good moral decisions.

Almost all health care decisions have two objectives, namely deciding what will be good health care for the patient on the one hand and what will be morally good for the patient and the providers of health care services on the other. Deciding what is good health care for the patient is often very difficult. Some will argue that good patient care is treating to cure disease and preserve life, but although true in many cases – it is not always the case. In certain cases good care might consist of declining or discontinuing treatment because the interventions cause more harm than any possible benefits they could provide. In this case the objective becomes comfort and not cure – a recognition of medicine's inherent limitations.

Managed care introduces business considerations in the traditional doctor-patient relationship. In the USAmany large managed care companies are traded on the stock exchange. The business press regularly reports their profits along with the compensation of the chief executive and chief financial officers,