NEWS

GENE TESTING COMPANY DEVELOPS DIAGNOSTICS PROGRAMME THAT MATCHES DIET WITH GENETIC PROFILING

In a South African first, Cape-based company GeneCare has developed an early disease risk detection programme that combines testing a person's genetic predisposition to certain diseases with how they should eat.

'Gene testing attempts to determine the causes of illness and reduce the risk thereof by examining someone's likelihood of getting cardiovascular disease, cancer, thrombosis, and so on. It has a fundamental role to play in the holistic management of a patient's health, even when disease symptoms are present. In the healthy, it's effective as a preventive health measure through lifestyle and nutritional intervention,' says GeneCare Managing Director, Maritha Kotze.

The programme links a patient's genotype with his or her overall risk profile and choice of intervention strategy. In other words each person's unique genetic profile may make them susceptible to certain diseases. Some variations also determine how particular foods are metabolised. By altering the nutrients in their diet to match their genetic profile, patients' risk of disease can be considerably reduced.

From next month, a follow-up system will be implemented in collaboration with a network of dieticians to monitor the compliance and wellbeing of individuals who have had genetic tests. Personalised health goals will include increased physical activity, improvement of diet quality, and weight loss, if appropriate.

Kotze says that while having a balanced diet and exercising regularly will go far in minimising health risks, certain genetic predispositions may call for more specific nutritional interventions. For example, a person's exposure to high levels of oestrogen and increased need for folate are two factors that may increase his or her risk of developing cancer.

Says Kotze: 'Genetic testing averts the need for blood tests. Taking a DNA swab is simple and involves rubbing the inside of the cheek for a minute. The swab sample is part of a kit that includes a questionnaire on a patient's family history and personal health status. This information is then used to evaluate the overall risk and select the appropriate gene variations to be tested for.'

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HIV/AIDS AMONG HEALTH WORKERS THREATENS TO UNDERMINE DELIVERY OF HEALTH CARE IN SOUTH AFRICA

An article on doctors and nurses with HIV and AIDS in sub-Saharan Africa, published in the 10 September issue of the *British Medical Journal (BMJ)*, attempts to assess the possible impact of HIV/AIDS-related illness and death among health workers on health care delivery systems and resources in central and southern African countries where high prevalence rates are already placing unremitting pressure on hospitals and other health care facilities.

The article points out that very little attention has been paid to the HIV seroprevalence among health care practitioners and the associated impact on the health care delivery system.

In South Africa, statistics show that the country carries 10% of the world's burden of HIV and AIDS, yet is home to only 1% of the world population. Only preliminary and sketchy data exist on the impact of HIV and AIDS among health professionals on the capacity and integrity of the South African health care system. While the critical shortage of nurses in this country has been attributed to a combination of emigration to countries offering more attractive remuneration packages and increasing incidence of AIDS-related illness, almost nothing is known about HIV and AIDS among doctors.

The only population-based survey on the epidemiology of HIV in South Africa undertaken to date is that of the South African Human Sciences Research Council (HSRC), which estimates South Africa's overall HIV prevalence in the general population (defined as those aged 2 years and older) at 11.4%, rising to 15.5% for the adult population (defined as those aged 25 years and older).

In a separate investigation into the impact of HIV and AIDS on the health sector, commissioned by the South African health ministry in 2002, the HSRC team found that the HIV seroprevalence among professional health care workers, at 15.7%, was not dissimilar to that of the general adult population.

The investigators concluded that the HIV/AIDS epidemic will have an impact on the health system through loss of staff due to illness, absenteeism, low staff morale, and also through the increased burden of patient load; and that impact was already being felt, with the nursing profession (being) the most affected. Sadly, secrecy and silence prevented the researchers from obtaining the full facts.

Commenting on the scenario painted by the article, Dr Andrew Jamieson, Medical Director: SAA-Netcare Travel Clinics, says that the natural course of the HIV epidemic is in three waves, the depth and duration of which can be moderated

by interventions for modifying sexual behavioural and antiretroviral treatment. They are:

- an expanding incidence of new cases, which in South Africa is deemed to have peaked around 1998
- increasing prevalence, thought to be peaking in South Africa currently
- increasing mortality, which is spiralling upwards across much of sub-Saharan Africa.

Says Dr Jamieson: 'The South African health care system is already under pressure and will be undermined even further by the attrition of health professionals as a result of the [HIV/AIDS] epidemic.'

GLOBAL HEALTH LEADERS CALL FOR ACCELERATING EFFORTS TO IMPROVE PATIENT SAFETY

One in ten patients worldwide becomes sick, is injured or even dies as a result of the health care they receive. Many of these adverse events in health care delivery, including medical errors, are preventable. To combat this problem and improve patient safety, global health leaders and the World Health Organisation (WHO) launched the World Alliance for Patient Safety on 27 October 2004 in Washington, DC, at the Pan American Health Organisation (PAHO).

WHO, as the global public health agency, is spearheading efforts to bridge the safety gap between patients and health care provision and to tackle patient safety issues on a worldwide scale. The launch will bring together ministers of health and senior representatives from several countries to advance the goal of patient safety and strengthen common action to integrate patient safety issues in national health policy and practice.

AFRICAN UNION LEADERS LAUNCH LARGEST EVER CROSS-BORDER POLIO CAMPAIGN IN HISTORY

More than one million polio vaccinators in 23 African countries embarked on a massive immunisation campaign, aiming to immunise 80 million children against polio in just over 4 days, as part of the single largest public health campaign in history. Leaders of the African Union joined Heads of State from across the continent in Kano, Nigeria to officially start these activities. The Global Polio Eradication Initiative partners – WHO, Rotary International, US Centers for Disease Control & Prevention (CDC) and UNICEF – welcomed the African leaders' swift and decisive response to safeguard Africa's investment in a polio-free future for children.

Thousands of volunteers, health workers and Rotary members will go door-to-door, house-to-house, village-to-village, on foot, by car, and by boat across 23 African countries. Their aim is very clear: to find every single child under the age of 5 years and vaccinate them against polio. This massive logistical undertaking can succeed, but only with the tireless efforts and commitment of the people of Africa, and the governments of Africa.

The polio campaigns, which began on 8 October, are vital to protecting African children from a looming polio epidemic and getting Africa's polio eradication programme back on track. Sub-Saharan Africa had made tremendous progress in eradicating polio, stopping the disease in all but two countries (Nigeria and Niger). Over the past 18 months, however, 12 polio-free African countries have been re-infected by the virus. The current campaign is aimed at stopping the spread. The second round of the campaigns will begin on 18 November, with similar activities planned throughout 2005.

'Polio anywhere is a threat to children everywhere', said UNICEF West and Central Africa Regional Director Rima Salah. 'The African Union's leadership in the upcoming synchronised polio national immunisation days from 8 to 12 October is proof of Africa's determination to stop polio transmission in Africa and achieve a great development victory for the world. This visible leadership of the AU will inspire every one of the thousands of health workers, volunteers and Rotary members who are travelling house-to-house to ensure that no child is missed.'

Once households are reached, many vaccinators will have to alleviate parents' concerns regarding the safety of the polio vaccine. Since mid-2003, unfounded rumours concerning vaccine safety, originating in northern Nigeria, have been circulating widely, leading to substantial confusion across the region, particularly in the poorest communities where access to basic health care is limited. To help reassure families, vaccinators have been trained on the importance of re-assuring parents that polio vaccination is safe and the only way to protect their children from lifelong disability caused by the polio virus.

WHO LAUNCHES NEW INITIATIVE TO ADDRESS THE HEALTH NEEDS OF A RAPIDLY AGEING POPULATION

To help tackle the public health implications of an increasing number of aged people, the World Health Organisation (WHO) launched Towards Age-Friendly Primary Health Care, new general principles that will serve as guidelines for community-based Primary Health Care (PHC) centres.

Released during the International Federation on Ageing's Seventh Global Conference on Ageing in Singapore, the

principles are based on qualitative research in five countries, both developing and developed, and address three critical areas where more leadership, training and better information are needed if the PHC centres are to meet the challenge of older people's needs. These are:

- information, education, communication and training for PHC providers
- PHC management systems
- the physical environment of PHC centres.

Today there are 600 million people in the world aged 60 years and over. This figure is expected to double by 2025 and to reach 2 billion by 2050, the vast majority in the developing world. Population ageing is characteristically accompanied by an increase in the burden of chronic non-communicable diseases (NCDs) such as cardiovascular diseases, diabetes, Alzheimer's disease and other ageing-associated mental health conditions, cancers, chronic obstructive pulmonary disease and musculoskeletal problems. As a consequence, pressure on health systems worldwide will increase.

Early detection, appropriate intervention, management and follow-up of chronic conditions take place mainly at the PHC level. Older people already account for a sizeable proportion of PHC centre patients and as populations age and chronic disease rates climb, that proportion is expected to increase. PHC centres are ideally positioned to provide the regular and extended contacts and on-going care that older persons need at community-based level.

Opportunities missed by health systems to deal with or manage age-related chronic NCDs will lead to increases in the incidence, prevalence and complications of these diseases and may take resources away from other priorities, such as child and maternal health.

In the first instance, the Age-Friendly Principles will serve as a tool for awareness raising among older people and their health care practitioners. A second step will include the testing of a tool kit with information and training materials to support the implementation of the Age-Friendly Principles. The project is expected to culminate with the establishment of minimum standards to determine the age-friendliness of PHC centres. The Age-Friendly Principles project was initiated in 2001 with the support of the Australian Government and, more recently, the Merck Institute on Ageing and Health.

FNS

NATIONAL CONVENTION ON DISPENSING – UPDATE TO MEMBERS

This report normally appears in CME, *but as there is no December issue of* CME, *it is included here for the information of SAMA members.*

There appears to be the perception that the National Convention on Dispensing (NCD) or the South African Medical Association are not addressing the dispensing fee issue. Like all organisations belonging to the NCD, SAMA has generally kept a low profile and has let the NCD take the lead. You don't hear of the SGFP, SAMCC, GPNet or the DFPA doing or saying this or that. We have all sublimated our sectorial interest for the sake of unity and the cause that the NCD drives.

The NCD gave an extensive written (partly based on research undertaken by the constituent groups of the NCD and Deloitte and Touche) and oral submission, presented by Drs Lex Visser and Danie Struwig, to the Pricing Committee on the dispensing fee on 17 March 2004. This was followed up by further information at the request of the Committee.

The NCD's submission validated that the dispensing fee needed to be a minimum of 32%/R32 in order to cover dispensing overheads, and while we understood why the two-tiered fee, i.e. a percentage for R99 and under, and a fixed Rand amount above R100 was introduced, it did not protect the doctor who needed to keep expensive drugs and we suggested an incremental increase of the dispensing fee as the SEP increased above R200. The NCD also showed how the National Treasury gained in relation to a dispensing doctor after R114, in respect of VAT paid over and called for the abolition of VAT on medicine. It is evident that our submission was ignored.

The NCD agreed to defer further action as the pharmacists' case took its course, as the judgment period gave doctors' grace and a positive outcome would have held direct benefit for us. Alas, this was not to be.

In October the NCD addressed a letter to Dr Zokufa of the DOH, saying that, according to the lay press, the DOH was willing to talk to the chemists about their dispensing fee and we wished to be accorded the same privilege. No answer or acknowledgement was received and another letter has been sent. The NCD also requested sight of the proceedings of the Pricing Committee apportioned to the calculation of the dispensing fee in order to determine how they arrived at 16%/R16. The DOH responded that we would need to apply for this information through the Promotion of Access to Information Act (PAIA).

The NCD has accordingly completed and submitted the appropriate PAIA form. To date there has been no response to our application and according to the provision of the Act this must be deemed to be interpreted as a denial. The next step is to lodge an internal appeal once the obligatory 30 days have run their course. The NCD feels strongly that its endeavours to

obtain this information be pursued because if the Pricing Committee did indeed 'thumb-suck' (Judge J Traverso, dissenting judgment – Clicks & others v. Department of Health) a dispensing fee without basing it on either the NCD's submission or figures of an independent actuary, we are entitled to know this.

Dr Lex Visser reported that he recently attended a conference where Dr Anban Pillay of the DOH mentioned that they had received a spreadsheet from the UK that they were modifying for the chemists as a questionnaire, in order to determine their overheads. Dr Visser requested that the same facility be granted to the dispensing doctors to which he agreed in principle. After a prompting letter, he has subsequently requested the NCD to send him information that he can incorporate into a questionnaire for dispensing doctors – hopefully this signals a change of heart of the DOH and we can proceed to negotiate a higher dispensing fee for our dispensing members.

Dr Danie Struwig is championing this on behalf of the NCD and would welcome suggestions. His e-mail is **struwig@iafrica.com**.

Dispensing

Task team members of the NCD have been asked what the NCD has done in terms of the dispensing licence legislation. We believe that proximity of a doctor's dispensary to a pharmacy would have played a major role in a doctor not being granted a licence, which it hasn't. The fact that all doctors who have complied with the licencing provisions have been granted a licence is wholly attributable to the representation and publicity of the NCD through its court challenges. The R1 000 that colleagues have donated to the NCD have allowed it to expose the injustices of Act 101 and its Regulations and secure a licence to all applicants. It has circumvented the lengthy appeal process in terms of a doctor being denied a licence, which we believe would have been a reality facing many, if not most, dispensing doctors without the NCD's intervention. Hopefully the Constitutional Court will see the merits of the NCD's case.

In order for the NCD to continue representing you, we urge those doctors who have to date not given any financial assistance whatsoever, to do so. Please send your contribution of at least R1 000 to Gwyneth at the NCD, PO Box 30227, Kyalami, 1684, accompanied by a cancelled prescription page, or deposit your contribution into one of the following accounts:

- ABSA Bank – Empangeni Branch (632-005), A/c No: 906-216-2669 or
- Standard Bank – Athlone Branch (5909), A/c No: 278-486-460, Serial No. 001.

Please fax your deposit slip plus your details to NCD office (see details below). Please ensure that cheques are made payable to the Affordable Medicine Trust.

National Convention on Dispensing, tel (011) 312-1862, fax (011) 312-2136, e-mail: **ncd@interdoc.co.za**