

National Health Insurance: Sufficient human, financial and management capacity?

Does South Africa have sufficient human and financial capital, let alone the management capacity, to carry, birth and nurture to full maturity the anxiously awaited National Health Insurance (NHI) baby, due in 2012? Debate during the South African Medical Association (SAMA) NHI conference at the Emperor's Palace in Gauteng in October was fierce, but all 360 delegates agreed: without urgent reform of the public health care system, any NHI will at best splutter along, ailing and unable to achieve its vital and noble goals. The private sector and SAMA are keen to help, but want full NHI details – asap. Chris Bateman expands in three Izindaba articles.¹⁻³

Chronic pancreatitis: Diagnosis and treatment

Chronic pancreatitis (CP) is an often debilitating disease. It is a continuing inflammatory disease of the pancreas characterised by irreversible morphological changes, often associated with pain and with the loss of exocrine and/or endocrine function. Alcohol is the predominant cause of CP in the Western world, and is particularly prevalent in South Africa. Bornman *et al.*⁴ provide comprehensive guidelines for the diagnosis and treatment of CP.

The entire pancreas is usually involved, and in most cases there is progressive pancreatic duct dilatation associated with strictures. Clinically significant fat and protein deficiencies do not occur until over 90% of pancreatic function is lost. Overt diabetes mellitus occurs late in the course of the disease, and most patients with diabetes secondary to CP require insulin. Patients may occasionally present with the complications of CP, e.g. duodenal obstruction, bile duct obstruction or pancreatic pseudocyst.

CP can be diagnosed by morphological criteria alone or combined with functional criteria. Computed tomography, magnetic resonance cholangiopancreatography (MRCP) and increasingly endoscopic ultrasound have become the screening methods of choice.

Autoimmune pancreatitis is an important condition to recognise as the lesion responds to treatment with corticosteroids.

Medical management of CP should focus on relieving symptoms and preventing the development of complications; aiming to attain cessation of alcohol consumption and cigarette smoking; determining the cause of and relieving abdominal pain (neurolysis has no place in the long-term control of pain in CP); treating pancreatic exocrine insufficiency; early detection and treatment of endocrine insufficiency; nutritional support; and screening for pancreatic adenocarcinoma in cases of hereditary pancreatitis.

Surgery provides the best chance for long-term pain relief in uncomplicated disease and can also address associated complications such as bile duct or duodenal obstruction. Only symptomatic pseudocysts should be treated – in suitable cases, endoscopic treatment is the preferred treatment.

South Africa's health priorities: Policies and practice

Three papers⁵⁻⁷ examine priorities in South Africa's health care systems and suggest ways of improving our services.

Hofman and Tollman⁵ note that South Africa (SA) commands financial health care resources comparable to Brazil, Mexico and Thailand. However despite spending similar amounts in the public sector these and other countries have better health outcomes than SA. The immense impact of HIV and tuberculosis only partly explains the plummeting life expectancy in SA from 63 years in 1990 to 45 years

in 2007. SA is one of only 12 countries worldwide with a marked reversal of maternal and infant mortality. The authors outline some of the challenges and how an initiative called PRICELESS (Priority Cost Effective Lessons for Systems Strengthening) has started to address some of these problems.

Rispel and Barron⁶ focus on whether disease control priorities improve health systems performance in South Africa. SA is gripped by a complex disease burden, consisting of the twin epidemics of HIV and tuberculosis, as well as non-communicable diseases and injuries. Despite an enabling legal and policy framework, health system challenges include sub-optimal leadership, insufficient resources for many national policies, lack of a broad public health approach to service delivery, and poor utilisation of existing information for decision making. Provided these and other health systems issues are addressed, cost-effectiveness studies and interventions may be beneficial in improving the functioning of the health system in SA and in getting better value for money.

The possibilities of cost-effectiveness analysis (CEA) for priority-setting in SA are explored by Jane Doherty.⁷ She concludes that some capacity to undertake costing and CEA already exists and has influenced clinical decision making and policy. Possibilities of CEA to contribute further to decision making in SA include promotion of dialogue on health and health care priorities as well as affordability; advocacy against interventions that are clearly cost-ineffective and unaffordable (especially at central hospital level); advocacy for interventions that strengthen the district health system (because of the highly cost-effective nature of primary and district hospital care), including motivation for increased funding from Treasury; advocacy for acceptable pricing of drugs and vaccines; assessment of innovative new interventions, including those for emerging conditions; identifying clusters of interventions that can enhance the shared use of inputs, reduce costs to patients, achieve synergy between interventions, reach related individuals, and screen patients at the primary level to increase efficiency of referral; and clarification of the roles of different providers and levels of care.

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