National Health Insurance – what the people want, need and deserve!

To the Editor: At the 2008 SAMA conference 'The Future of Health Care in South Africa – How Will It Be Provided and Funded?', I addressed the history of South Africa's health policy, in particular the views of the mass movements on health and access to health care, traced back to the Freedom Charter (1955). Their continued appeal for a state-run preventive health scheme, free medical and hospital care (with special attention to mothers and children) and better access to health care is highlighted in frameworks such as the Reconstruction and Development Plan (1994), the ANC's National Health Plan for South Africa of 1994 (developed with the World Health Organization and UNICEF), the Constitution of the Republic of South Africa (1996), the White Paper for the Transformation of the Health System of South Africa (1997) and the National Health Act (2004).

National Health Insurance (NHI) was an aspiration of the people as a human right; its development was therefore inevitable. Despite detractors, this vision came to fruition in the Policy on National Health Insurance (Green Paper), gazetted on 12 August 2011. This argues for the necessity for such a system and that the NHI will ensure that 'everyone has access to appropriate, efficient and quality health services'. It meets our constitutional obligation (Section 27: '[e]veryone has the right to have access to health care services ...') and our obligation to do what is socially and morally just.

The NHI Green Paper refers to the previous government's attempts at health care reform, e.g. the Commission on Old Age Pension and National Insurance (1928), the Committee of Enquiry into National Health Insurance (1935), Gluckman's National Health Service Commission (1942 - 1944), and subsequent committees and task teams of the current government. The NHI principles and objectives cannot be contested, because it underpins respect for social justice. It recommends piloting to deal with the challenge of *implementation*.

Health professionals committed to better health care are called on to support and to add constructive comments to the NHI proposal. It proposes strengthening the South African health system based on a re-engineered primary health care approach and system that focuses on outreach services and emphasises prevention of ill health and disease and promotion of good health and wellbeing. Special mention is made of a District Clinical Specialist Support Team of specialists in obstetrics and gynaecology, paediatrics, family medicine and anaesthetics, supported by appropriate professional nurses. Consideration should be given to include specialists familiar with planning, programme implementation, monitoring and evaluation of health and health services at a community level to support the District Specialist Team, i.e. public health medicine ('community health'), community psychiatry, community dentistry, and occupational medicine. Public health medicine is already incorporated into the draft Human Resources for Health for South Africa Plan in the 'leadership' of public health units at district level to provide a strategic role in addressing health priorities. Extending this specialist support to the district specialist team is therefore logical. The role of the 'community health' nurse too should be revisited in this regard.

Much increased and appropriate production of health professionals is required. Medical and dental schools and nursing colleges are called on to take up the challenge, with special emphasis on targeting recruitment from rural areas. Together with intersectoral efforts to reduce determinants of health such as poverty alleviation, improved access to good education, water and sanitation, adequate nutrition, shelter and an enhanced social welfare network, this will improve health outcomes, impact positively on the economy and make this country better for its citizens. Congratulations to the Minister and the National Department of Health for leadership, for commitment and for initiating this policy milestone.

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Time to decriminalise drugs?

To the Editor: The editorial on the decriminalisation of drugs,[1] and the debate that it sparked off,[2] refer. The potential medically beneficial effects of cannabis were alluded to in the editorial. My personal dealings with a family with a child with Friedreich's ataxia, who has skeletal deformities causing constant severe pain, have convinced me that there **is** a place for the medicinal use of cannabis. In this case, albeit anecdotal, the only treatment that helps is cannabis. Opioids are virtually useless and are complicated by nausea and severe constipation. After personal communications some years ago with the late Professor Frances Ames, then a senior neuropsychiatrist at Groote Schuur Hospital, cannabis was tried. It was obtained illegally, as my letters and appeals to the police chief concerned were all left unanswered. In this case, cannabis provides significant pain relief and some degree of euphoria, which helps the patient through his otherwise cheerless days. He is highly intelligent, and fully aware of his hopeless prognosis.

Unfortunately, however, the use of cannabis is, and remains, a criminal offence, even for medicinal purposes. Therefore, in this case it is technically a crime to relieve this young man's pain. Cannabis is the only drug that helps him.

Maybe the torchbearers of a lily-white, idealistic, drug-free society must look a little deeper. This particular patient, by his own admission, would much prefer a little immune supression, a little 'harming of the brain', and even death to living with unbearable and unrelenting severe skeletal pain.

Surely we need to give decriminalisation (of at least cannabis, for medicinal use) another think. It may indeed be medically criminal **not** to.

Alcoholism is a disease (it is surely not a crime) that will never be cured by the criminalisation of alcohol use. Drug addiction is a disease (surely it is also not a crime) that likewise cannot be cured by labelling the addict a criminal.

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1. Van Niekerk JPdeV. Time to decriminalise drugs? S Afr Med J 2011;101:79-80.
2. Van Eeden A. Harm reduction – more than just side-effects. S Afr Med J 2011;101:358-359.

Antimicrobial resistance patterns in outpatient urinary tract infections – the constant need to revise prescribing habits

To the Editor: We commend the retrospective survey of antimicrobial susceptibility at 3 Military Hospital in Bloemfontein[1] and appreciate the concern about very high rates of culture-negative urine received at the laboratory. Possibly many such samples came from patients

already receiving antimicrobials. We feel that it would have been better to screen urine samples received for culture for the presence of any antimicrobials in the sample to ensure judicious therapeutic intervention.

Recently, investigators at the Hamad Medical Corporation, Doha, Qatar, carried out antibiotic screening of 1 680 urine samples (employing *Escherichia coli* ATCC 25922 and *Staphylococcus aureus* ATCC 25923) that were being processed for culture. There were 2 494 culture-positive urine samples that included 388 samples with antibacterial substances. Among these samples were 345 sterile samples, 32 with insignificant growth samples, and 11 with mixed growth.[2]

Screening urine samples received at 3 Military Hospital in Bloemfontein1 would not be an insurmountable task. Antibacterial substance screening of urine samples was feasible even more than 40 years ago at the All India Institute of Medical Sciences, New Delhi, India,[3] where screening of 426 urine samples was done by employing the standard Oxford strain of *S. aureus*. There was demonstrable antibacterial activity in 127 samples, accompanied by bacterial growth in 63 samples. Isolates included *E. coli* – 28 isolates, *Klebsiella* species – 13, *Pseudomonas aeruginosa* – 10, *Proteus spp*. – 6, *S. aureus* – 3, *Alkaligenes faecalis* – 2, and *Streptococcus faecalis* – 1. A history of prior antibiotic use could be obtained in 25 cases only, though there was no relevant information in the laboratory requisition slips. It was also possible in 7 cases to identify the antibiotics being used by the patients. The isolates in the urine samples were resistant *in vitro* to the prescribed antibiotics. Even with an adequate amount of antibiotic in the urine, there was little benefit to the individual.

Obviously, any sterile culture report on a urine sample from a patient with a demonstrable antibacterial activity could be erroneous unless a subsequent urine culture is found to be sterile. Laboratory personnel would not ignore patients with rather low bacterial counts in any urine sample with concurrent antibacterial activity. Such isolates might represent either a declining population of susceptible bacteria or an ascending antibiotic-resistant bacteria population.

Last but not least, any expenditure for carrying out concurrent screening for antibacterial substances in all urine samples cultured at 3 Military Hospital in Bloemfontein[1] or elsewhere would be cost-effective, and will lead to better management of urinary tract infections and would ensure rational disease management.

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1. Bosch FJ, van Vuuren C, Joubert G. Antimicrobial resistance patterns in outpatient urinary tract infections – the constant need to revise prescribing habits. S Afr Med J 2011;101:328-331.
2. Wilson G, Badarudden S, Godwin A. Antibiotic screening of urine culture as a useful quality audit. J Infect Dev Ctries 2011;5(4):299-302.
3. Arya S C. Screening of urine samples for bacteriuria and antibacterial activity. Indian J Medical Sciences 1967;21:715-720.

Dr van Vuuren replies: All urine samples included in our study were processed by the National Health Laboratories Services (NHLS) in Bloemfontein. In line with standard procedure, *Bacillus subtilis* ATCC 6633 was used to screen for the presence of antibiotics, and a leukocyte count performed on all urine samples sent for culture at the NHLS. If there is no growth of bacteria in the presence of antibiotics, significant numbers of leukocytes warrant further investigation.

As we excluded culture-negative samples from our analysis, we obviously cannot comment on the number of samples with no growth due to the presence of antibiotics. Apart from the possibilities mentioned in our article, antibiotic administration prior to sample collection may be another cause for negative cultures.

Questioning the UCT Lung Institute

To the Editor: The enthusiastic account of the 10th anniversary of UCT's Lung Institute (Pty) Ltd in the June issue[1] raises many questions. Is medicine a caring profession or a business? Is it desirable that the replication of such initiatives be encouraged? Is it possible to replicate it even if one wanted to? Is the Institute sustainable in the light of its dependence on the exceptional ability and determination of a unique individual?

Judged as a business, the Lung Institute seems to be a resounding success. Starting 10 years ago with a little 'nest egg' and support from a pharmaceutical company, it is now a limited company with a budget, according to Professor Eric Bateman – founder and CEO – of R40 million a year.

Although it sounds as if he is proselytising, Professor Bateman says he is not, and I believe him. To enable others to follow would require that he instruct them in the finer arts of the business such as how the Institute is kept 'light on its feet' and circumvents burdensome bureaucracy, which he identifies as 'the enemy of enterprise'. Every successful businessman is entitled to his secrets, and no businessman in his right senses would deliberately open up his market to competition.

However much I admire the achievement, I find the self-promotion distasteful. There are several aspects of the arrangement that I don't understand, and one of them is of deep concern.

What I don't understand is what the university gets out of its wholly owned tax-free subsidiary for 'educational and charitable purposes'. There are presumably no dividends, because 'Surpluses are utilised for the activities of the institute in pursuant of goals'.[2]

How much does UCT earn from government subsidies from Institute publications in peer-reviewed journals? How does the Institute add value to the core university function of teaching? A few postgraduate researchers are mentioned, but what about a contribution to medical student and postgraduate registrar instruction and supervision?

What is of greatest concern to me is the fact that the Lung Institute and GINA[3] – the Global Initiative for Asthma, of which Professor Bateman has been appointed [sic] Chair of the Executive and Science Committees[4] – are both dependent for their existence on the pharmaceutical industry.[5]

For me it's like a nightmare come true. At about the time the Lung Institute was founded, John Le Carré, the noted author, was warning:

'But Big Pharma is also engaged in the deliberate seduction of the medical profession, country by country, worldwide. It is spending a fortune on influencing, hiring and purchasing academic judgement [sic] to a point where, in a few years' time, if Big Pharma continues unchecked on its present happy path, unbought medical opinion will be hard to find.'[6]

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1. Bateman C. Helping comrades over the social upliftment line (Izindaba). S Afr Med J 2011;101(6):374-376.
2. Lung Institute. http://www.lunginstitute.co.za/content/governance.html (accessed 25 July 2011).
3. GINA – About us. http://www.ginasthma.org/about-us.html (accessed 30 May 2010).
4. GINA – the Global Initiative for Asthma. http://www.ginasthma.org/about-us-executive-committee.html (accessed 25 July 2011)
5. GINA – Sponsors. http://www.ginasthma.org/sponsors.html (accessed 30 May 2011).
6. Le Carré J. In Place of Nations. http://www.nancho.net/newchau/bigpharm.html (accessed 20 July 2011).

***SAMJ* News Editor Chris Bateman replies:** The article was the result of a confluence of events. Firstly, several deans of medicine