NHI: State sunk without private sector help?

The biggest bonus (so far) of National Health Insurance (NHI), due for incremental phasing in from next year, is that it's forcing government to confront its dysfunctional public health sector (and, one can argue, the inflationary private sector, especially medical aids and hospitals).

Izindaba's Chris Bateman[1] takes some soundings and discovers that two significant private doctor bodies are coming to the party, one at the request of national health minister, Dr Aaron Motsoaledi, and the other in pragmatic preparation for where willing members can help deliver services.

In his Health Budget speech this May, Motsoaledi confirmed that a (probably more efficient) version of the old District Surgeon system is under construction, leaning heavily on private specialists. Concurrently, independent practitioner associations (IPAs) are encouraging members with an eye on optimally positioning themselves as NHI service providers, to embraced tiered quality accreditation standards. They believe that this will put them at the front of the queue when it comes to NHI certification, not to mention enable better clinical practice. Most stakeholders agree that increased access to and equity in health care are no longer debatable. The explosive debate lies in the how – and the impending White Paper will soon light that fuse.

South African Indian genetic disorders

The Indian community recently celebrated the 150th anniversary of their arrival in South Africa. Winship and Beighton[2] record their genetic heritage, based on records and experience going back more than four decades.

The first ship from India carrying indentured labourers to work in the sugar cane plantations that were being developed in Natal arrived in Durban in 1860. More than half of those who completed 10 years as indentured labourers chose to remain in Natal, and by 1886, 20 877 were free and only 895 were indentured. These were predominantly Bengali Tamils of the Hindu faith from Southern India, who came via Calcutta and Madras (now Kolkata and Chennai). Smaller numbers of Muslims from Gujarat in the Punjab arrived in South Africa from 1870 onwards on their own initiative, as did Hindus from the Surath coast in present-day Pakistan. There are currently about a million persons of Indian ancestry in South Africa, most of whom live in Durban, with smaller communities in Johannesburg, Cape Town and other centres.

The Indian people who came to Natal originated in regions where malaria was endemic, and many were heterozygous for a thalassaemia trait that protected them from malaria. It is not surprising that thalassaemia is the most common single gene disorder found in their descendents in Natal. The biological advantage of these genes is largely negated by immigration to non-malarial regions.

The authors also record a large number of diagnoses of genetic, cytogenetic and multifactorial disorders in persons of Indian ancestry. There is a high frequency of diabetes mellitus in the Indian community, and hypercholesterolaemia and hypertension are common.

In medical practice, awareness of the presence of a specific genetic disorder in a particular community is an important aspect of the diagnostic process.

Hospitals of optimal size

With the proposed introduction of a national health insurance (NHI) there will be an increasing focus on escalating public and private sector health care costs in South Africa. Dorfman and colleagues[3] review the evidence on optimal hospital size and discuss the implications for the planned reconstruction of major hospitals.

South Africa has several hospitals of immense size. The authors note that there is a common misperception that a larger hospital is invariably more efficient because of economies of scale. Whether hospitals are 'public' or 'private' the most efficient mix of hospital types and sizes must be sought, e.g. a few large general hospitals, a higher number of smaller, more specialised hospitals, and several medium-sized general facilities.

A study in three South African provinces showed that only 13% of the public sector hospitals studied operated at an efficient size. Smaller and more specialised hospitals, such as the planned Nelson Mandela Paediatric Hospital of 200 - 300 beds in Johannesburg, also allow for a more focused scope of activities (economies of scope). The specific size required to optimise efficiency is context-specific, but is highly likely to be well below 1 000 beds.

Optimisation requires careful strategic planning, not only during construction or revitalisation, but ensuring maximum efficiency by adapting to ongoing changes in patient mix. We should be brave enough to change size if required.

HIV/AIDS increases use of blood products

Was a substantial increase in the use of blood products in the medical wards at Groote Schuur Hospital a result of the increased burden of HIV/AIDS? Ntusi and Sonderup[4] set out to answer this question.

HIV infection is associated with cytopenias of all major cell lines. Anaemia occurs in up to 70% of patients with HIV/AIDS and thrombocytopenia, neutropenia or lymphopenia in 40 - 70%. The incidence and severity of cytopenias correlate directly with the degree of immunosuppression. The causes of haematological abnormalities in HIV infection are multifactorial. Anaemia is the commonest haematological complication in HIV and was the commonest cytopenia necessitating transfusion (69% of patients).

The authors demonstrated that the use of blood and blood products is significantly increased in HIV-infected patients. However, an encouraging observation is that patients on ART required significantly less blood and blood products compared with HIV-positive patients not on ART.

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