Editorial

National Health Insurance in South Africa

In South Arica approximately 75% of surgeons are in private practice rendering a service to approximately 30% of the population. The remaining 25% are in public service catering for 70% of the population. Most orthopaedic surgeons – both private and public – are centred in the large metropolitan areas and a smaller number in regional hospitals which are a referral base for district hospitals where the majority of the population live. Many of these hospitals are inadequately resourced and attracting specialists, nurses and including orthopaedic surgeons is difficult despite the improved salaries. In Southern Africa (Zimbabwe, Zambia, Kenya, Malawi, Mozambique) there are approximately 150 orthopaedic surgeons serving the region. Most primary care treatment in the region is provided by general surgeons and clinical officers. The number of orthopaedic surgeons in this region is grossly inadequate by developed world standards to provide valuable and timeous treatment to our population.

How do we address these inequalities and provide acceptable care for patients in rural areas?

Some of the effective short-term management strategies must include regular outreach programmes by surgeons from the regional and academic hospitals. Apart from ward rounds and undertaking minor procedures, focus should be placed on teaching community-service doctors, medical officers and nurses to improve the immediate care of fractures (open wounds, compartment syndrome, pain relief and immobilisation). Medical officers from these hospitals who develop an interest in orthopaedics could be recruited into the training programme. Doctors and nurses may further enhance their skills by spending time in regional and academic hospitals to consolidate trauma management and thereby improve patient care. Discussions between members of the outreach programme and the provincial health authorities will further enhance the quality of care. The outcome of a fracture depends ultimately on early, timeous management prior to appropriate referral.

In the mid- to long-term strategy it would be appropriate for Government (central and provincial) to identify hospitals in rural areas for further infrastructure development to provide adequate services. We are inundated with trauma, which constitutes approximately 60% of orthopaedics.

The orthopaedic service in the outlying areas may be further improved by introducing community service for the newly qualified specialists. This exercise may provide a better understanding of the demographics of trauma and the plight of the rural poor. Frequently the newly qualified specialists leave for centres abroad for subspecialisation which may be too soon. Newly qualified specialists should practise the basic art of trauma and improve the service especially in multiple complex trauma. Trauma in state hospitals constitutes 70% of a trainee's work. If the substantial volume of trauma is undertaken in appropriately equipped state hospitals the training of registrars could be further enhanced by including elective work such as arthroscopy and arthroplasty.

In South Africa, the HIV pandemic has affected young, economically active adults. Musculoskeletal trauma is overwhelming in this region due to poor road transport, unroadworthy motor vehicles, inadequate policing and monitoring of roads, and lack of education. The burden is further increased by inadequate emergency medical services in rural areas to provide resuscitation and adequate stabilisation at the scene of the accident prior to hospitalisation. Morbidity and mortality are high in remote areas, especially in patients with polytrauma and open injuries. This is primarily due to poor resources, and these patients frequently present late to referral hospitals with severe infection and deformity following inadequate initial treatment of open and closed fractures. The management of such patients in limited-resource settings poses a major challenge.

Injury is the leading cause of death among people between the ages of 5 and 45 years in low- and middle-income countries. For each mortality following trauma, three to eight additional people are permanently disabled. Injury currently accounts for 12% of the global burden of disease, and is predicted to increase to 20% in 2020. Road-traffic injuries, now ranked the ninth leading cause of disability-adjusted life years lost, will be the third leading cause of death for the global population. Road-traffic injury is currently the third leading cause of death in children of 5-15 years of age in low-income countries. Deaths resulting from traffic accidents are three times higher in low-income countries. Daar *et al* estimated that 10% of all deaths in developing countries, and 20% of the deaths among young adults, could be prevented by simple, timely surgical intervention.

The World Health Organisation has estimated that by 2020 approximately 20% of GDP would be spent on trauma in sub-Saharan Africa due to the carnage on our roads. Improving policing and regular road safety campaigns must be instituted to lower the trauma following motor vehicle accidents.

The recent staged implementation of the Occupation Specific Dispensation (OSD) has improved the salaries of state doctors. This may stem the exodus of our doctors to greener pastures (private practice, overseas). RWOPS should be monitored to ensure adequate public health services delivery. The future of health services, especially in orthopaedics, in South Africa should be a joint effort ensuring collaborative effort between the health authorities and orthopaedic surgeons.

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Note from the Editor-in-Chief

Little can be added to Prof Govender's broad and very clear discussion of the present situation in South Africa.

On a personal note, the following:

I was privileged to be part of some of the outreach programmes in the RSA. Most of us were members of the Department of Orthopaedics, University of Pretoria. I shall never forget our visit to Lesotho. A patient got ill with acute appendicitis. My partner did the appendicectomy. Other visits included the Philadelphia Mission Hospital near Groblersdal and the Kgapane Mission Hospital near Tzaneen. On one occasion the pilot forgot to take his map with him and those who had been there before had to search for the landing strip on a farm. We also attended the Thusong Hospital near Lichtenburg. We learned that surgery done under circumstances where you cannot follow up your patients yourself should not include risky procedures such as a triple arthrodesis.

Some 20 years ago we started visiting Tlamelang School and Gelukspan Hospital on the same premises, near Mafikeng. There were many children with mainly cerebral palsy; two to three visits per year lasting two to three days were necessary. During this period we operated on 220 children (489 procedures). This project still continues.

Prof RP Gräbe, Editor-in-Chief