



Choices in health care spending

To the Editor. It is encouraging that the US Medical Director of a major drug company endorses the concept of 'accountability for reasonableness'.¹ However, the company's position cannot be accepted uncritically. Drug companies often emphasise cost-effectiveness analyses as the primary factor in deciding whether or not a new drug is 'affordable'. Thus the drug company promoting an expensive new product asserts, as in the case of Xigris, that the cost of just under US\$50 000 per quality-adjusted life-year saved compares favourably with other procedures (e.g. kidney transplantation).

In our editorial² we rejected a narrow, technically orientated approach. We argued that although highly technical procedures such as calculations of cost-effectiveness and estimates of life-years saved are necessary, this must not be the *only* factor considered in making allocation choices. A decision about how to spend society's limited medical resources is a value judgement that specifies and balances all morally relevant factors — including distributive justice, social utility and economic efficiency — without giving any single one an *a priori* advantage.³ In the case of an expensive new drug such as Xigris society may, when forced to make a tough choice, reasonably decide that its moral values compel saving or extending the lives of *identifiable* patients — say those afflicted with HIV/AIDS or patients who may be cured with a kidney transplant — rather than the few who could be saved by paying an equivalent amount to treat 16 patients in order to save one unidentifiable life.

Cost-effectiveness analyses based on US dollars are largely irrelevant to South Africa and other developing countries. The US alone spends more than 50% (US\$1.2 trillion — 14% GDP, with per capita expenditure of almost \$5 000) of the total health care expenditure in the world on 5% of the world's population. In contrast, South Africa spends about 8.1% of GDP on health care, with a public sector health services budget of US\$3.4 billion in 2000/01 — about 4% of GDP, amounting to R779 per person (approximately \$100 per capita). South Africa ranks 94 on the Human Development Index, not far above Zimbabwe at 117. South Africa's health administrators must be very selective about what they learn positively from recommendations from the US, and there is much negative that we can learn from them. Drugs that are affordable as a matter of course in the US and other rich nations may not be relevant or affordable in our context.

Debate such as has occurred in this and the previous issue of *SAMJ* should be encouraged. However, the discussion must be carried forward in full recognition by all stakeholders of the stark realities that face health administrators in South Africa. Demands for health services have increased exponentially, and the capacity of the public sector to provide decent quality services to all citizens has shrunk. The AIDS pandemic will

exacerbate an already critical situation. It is in this context that our health administrators must assess the claims of drug companies and manufacturers, often based on data and cost-effectiveness analyses more relevant and useful in the rich countries of the developed world than in developing countries like South Africa.

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1. Macias WL, Levy H. The value of innovation (Debate). *S Afr Med J* 2003; **93**: 502-503 (this issue).
2. Benatar SR, Fleischer TE. New treatments: costs, benefits and decision-making procedures (Editorial). *S Afr Med J* 2003; **93**: 433-434.
3. Beauchamp T, Childress J. *Principles of Biomedical Ethics*. 5th ed. Oxford: Oxford University Press, 2001.

Drotrecogin alfa (activated) in South African private hospital ICUs

To the Editor: We wish to comment on the article by Taylor and Burns.¹ They advance several concerns with the PROWESS trial of drotrecogin alfa (activated protein C) (DroAA) in severe sepsis² as reasons for withholding this agent from patients covered by their medical scheme in South Africa. These concerns may be valid and have been extensively debated at both local and international congresses. However, the fact is that DroAA is accepted by the FDA in the USA and regulatory authorities in Europe as an effective treatment of severe sepsis.

Bleeding complications are an inherent risk of all drugs with anticoagulant activity, including heparins, warfarin and antiplatelet agents. Excess bleeding in trial patients has not prevented various anticoagulants from being used in the treatment of thrombotic disorders such as acute myocardial infarction and deep-vein thrombosis, especially with pulmonary embolisation. Healthy debate follows the introduction of any new intervention in medical practice but cannot be cited by funders, whose primary concern is financial rather than clinical, as an excuse to withhold even expensive treatment from deserving patients. By the current standards of evidence-based medicine, DroAA is an acceptable agent for treatment of severe sepsis.

DroAA is particularly important in the treatment of patients with meningococcal septicaemia,³ in which situation it was available on compassionate grounds throughout the world before release. Should the agent be withheld from patients with meningococcal septicaemia, the risk of complications is dramatically increased and mortality and length of stay in the ICU and in hospital are increased. The cost of the agent in this setting will be more than offset by the reduced need for ICU and hospital care, as demonstrated by a recent case in